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The Moral and Legal Status of Physician-Assisted Death: Quality Of Life and the Patient-Physician Relationship

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Abstract: The historical analogy of Nazi Germany is quite misguided and forestalls useful debate on euthanasia. Rightly practiced, passive euthanasia can be seen as a medical duty in certain cases. Indeed, even the use of active forms of aid in dying can be recommended. One can properly appeal both to the traditional goals of medicine (especially the relief of pain and suffering) and to the ethos of trust, comfort, and protection that naturally grows between patients and physicians. In advancing its dissenting argument, the article reviews the legal and historical backgrounds that guide recent discussions of euthanasia in the United States.

Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny.

Ronald Dworkin, *Life's Dominion*

It is an idle and perverse arrogance to frustrate the wishes of those who want to die or to preserve indefinitely the lives of those who have irrevocably lost personhood when the wishes of people who do not want to die are consistently and callously disregarded.

John Harris, "Euthanasia and the Value of Life"

I

DEBATE in the clinical, ethical, judicial, and legislative contexts regarding aid in dying has been, and continues to be quite interesting and robust, if

perhaps also somewhat superficial and acrimonious. Given what is at stake—for physicians, patients, family members, policy makers, and all members of society—care must be taken that the debate over the morality and legality of physician-assisted death be as deliberate, careful, and relevant as possible. Both sides have legitimate concerns, make careful distinctions, and present strong arguments; the opposing sides must fairly and accurately address these concerns, distinctions, and arguments. Does invoking the atrocities of both ideas and actions committed in Germany between 1920 and 1945 serve well the discussion over whether certain forms of physician-assisted death should be moral and legal? More specifically, should the Nazi experience in medical killing lead to concerns about a slide down the slope to similar horrors of mass killing of people against their will in the United States? I argue that the answer is no. In defending this assertion, I also argue for the moral permissibility and legality of physician-assisted death.

In questioning the relevance of the Nazi experience to euthanasia and the right-to-die movement in the United States, I take four different, but related approaches. First, I consider empirical data that sheds light on not only what the various parties think, but their reasoning as well. Second, I continue the descriptive approach by examining legislative statutes and judicial rulings regarding aid in dying. Third, I lay out reasons some have given for the assertion that there is a parallel between Nazi atrocities and any acceptance of euthanasia in the United States. Fourth, I want to look specifically at two concepts: quality of life and the patient-physician relationship. By way of conclusion, I claim that the Nazi experience and the concerns some have about parallels between it and the American euthanasia movement are not totally irrelevant.

Some clarification regarding terminology is in order. The phrases “aid in dying” and “physician-assisted death” are very broad, encompassing a wide range of actions, both of omission and of commission. In the broadest sense—and, I might add, in the least ethically problematic as well—almost all physicians aid or assist almost all their patients in dying. That is, few patients who die in hospitals die when they do because there was no other choice. As Loewy has so accurately noted, “The point that patients in hospitals today rarely die when nothing to prolong their life can be done is evident to all who have worked as nurses, physicians, or ethics consultants in a hospital” (1998, p. 51). Our concern is with a much narrower sense of “assisted death,” in which physicians actively perform an action that directly results in the death of competent or incompetent patients, and the action is done for the patient’s good or benefit. Also under consideration are those actions taken by patients

themselves to directly end their own lives, but with the help of a physician. Our focus, then, is on three forms of aid in dying: 1) active, voluntary euthanasia, 2) active, non-voluntary euthanasia, and 3) physician-assisted suicide. These are the most ethically problematic forms of aid in dying and the focus of concerns for those wishing to draw a parallel between Nazi Germany and current events in the United States.

II

Any attempt to draw a parallel between Nazi Germany and current actions and developments regarding physician-assisted suicide and euthanasia in this country must take into account empirical data regarding these practices. Empirical research furthers the broader, moral and legal debate. As Van Der Maas and Emanuel have claimed, “Findings from the behavioral and social sciences and ethnology, among other fields, can help us to assess the contextual factors involved in physician-assisted suicide and euthanasia” (1998, p. 151).

Surveys and polls of the public, patients, and medical professionals concerning their attitudes toward active euthanasia and physician-assisted suicide should usually be suspect. At least two reasons warrant the caution. First, various factors affect the development, implementation, and results of surveys and questionnaires. The sensitive nature of the topic may make it difficult to rely on the honesty of physicians and patients. There is the problem of low response rates, possibly due to concerns about legal repercussions—although, as Kleinman (1997) has noted, more and more physicians have said, both in print and in live interviews, that they actually do help patients take control over how they die. And, of course, there are factors and problems such as poor generalizability, small sample size, different study designs, wording of questions, geographical locations, and respondent bias that can skew results (Meier, 1994).

Second, one should be cautious because of the limitations of applying empirical data to ethical arguments. No doubt some arguments in the ethical debate can be somewhat addressed by appeal to facts. An example which is relevant to the present discussion is whether there is factual support for the position that once a few cases of active euthanasia are allowed, we will slide down the slippery slope to many cases of abuse. But other types of arguments or claims in the ethical debate will not be helped at all by appeals to facts. As Van Der Maas and Emanuel have noted:

[A] well-known sanctity-of-life argument states that human life is sacred and therefore should not be snuffed out under any circumstances. A counter-argument states that life's very sacredness means that it should not be allowed to linger in suffering or indignity, that physician-assisted suicide and euthanasia can be a greater form of respect for human life's sanctity. Polling data can measure how many people agree with either of the opposing positions, but the individual adherent to either position will be able to say that even if the entire world takes the opposite view, his or her own position is morally superior. (1998, p. 153)

Though we should keep these cautions in mind when reviewing data, results of surveys can shed some light on the possibility of the slippery slope fear being realized at *this* time and in *this* society.

In almost all surveys and polls, a majority of lay persons, patients, and physicians favor fewer restrictions on physician-assisted death (Meier, 1994; Roberts and Gorman, 1996). Lay persons report concern over issues of pain, quality of life, and personal dignity when they think about end-of-life matters. Patients report concern over losing control of their own lives, burdening their family, dependency on others, and losing dignity (Van Der Maas and Emanuel, 1998). Physicians report concern over what constitutes proper professional conduct as well as concern about patient suffering. Perhaps the main theme underlying these concerns is the fact that death no longer comes easily in America. Medical technologies such as mechanical ventilators, techniques for artificial nutrition and hydration, and immunosuppressive drugs now make it possible to sustain life long after the body has lost its natural ability to perform critical tasks. The degenerative dying process, not death, is what people fear most (Cantor, 1993). Some brief results regarding polling data for both the lay public and physicians might prove instructive.

According to Meier, the National Opinion Research Center reported that in 1989, 49 percent of Americans felt that a person with an incurable disease has the right to end his/her life (1994, p. 11). In 1990, this figure increased to 60 percent, and 72 percent felt that physicians should be able to end the lives of the terminally ill if the patient requests that assistance. A 1990 Roper poll, commissioned by the Hemlock Society and involving face-to-face interviews with 2000 adults, found that 63 percent felt that physician-assisted dying should be legalized (Meier, 1994, pp. 11-12). The favorable attitudes of Americans toward physician-assisted death became formalized on November 8, 1994, when voters in Oregon passed the Death with Dignity Act, the world's first assisted suicide law by a margin of 52 to 48 percent (Roberts

and Gorman, 1996, p.75).

Results from surveys of physicians' attitudes are quite interesting. Meier (1994) has pointed out that in 1988 the Center for Health Ethics and Policy at the University of Colorado surveyed all licensed physicians in the state regarding many aspects of life-sustaining treatment. Among respondents, 37 percent admitted giving pain medication with the effect (intended or not) of shortening life, 60 percent had cared for patients for whom they felt active euthanasia would be justified, and of these, 59 percent would have been willing to administer a lethal dose if it were legal to do so. A 1991 survey of 1000 internists conducted by the Society of Internal Medicine found that 20 percent had deliberately taken action that directly ended a patient's life, and almost 70 percent said that they thought suicide was a moral option for patients in great pain (Meier, 1994, pp. 14-16). While survey data indicates that the majority of physicians favor some form of helping terminally and chronically ill patients die, the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) continues to condemn any deliberate action that might be taken to directly end a patient's life (1992, pp. 11-15). The AMA wishes to keep the distinction between letting patients die and actively killing patients. Many medical ethicists agree with the AMA's policy on euthanasia and assisted-suicide (e.g., Annas, 1998; Finnis, 1995).

III

To what extent, if any, does the legislative and judicial process take public opinion, the fears of patients and their families, and the concerns of physicians into account? The answer is a definite "not sure." The very brief list of events below provides a snapshot of American judicial and legislative attitudes toward the moral and legal status of physician-assisted death (Roberts and Gorman, 1996, pp. 57-74). Noting some of these more important events facilitates evaluation of the slippery-slope argument.

- 1906 The first bill in the U.S. dealing with euthanasia is introduced in the Ohio state legislature. It receives almost 25 percent of the vote.
- 1912 A woman with an incurable disease petitions the New York state court to allow her doctor to put her to death painlessly. The request is denied.
- 1920 Frank Roberts of Michigan helps his ill wife commit suicide by placing arsenic within her reach. *People v. Roberts* is the first recorded prosecution for assisted suicide. Roberts is convicted of murder and dies in jail.

- 1925 Dr. Harold Blazer is tried in Colorado for killing his daughter, who had been an invalid for 30 years. The case is dismissed because the jury cannot arrive at a verdict.
- 1937 Nebraska Senator John Comstock introduces legislation called the Voluntary Euthanasia Act, which calls for the legalization of active euthanasia. It is never voted on but demonstrates an emerging interest in legislating euthanasia.
- 1938 Charles Potter, a Unitarian minister, founds the Euthanasia Society in New York. The group promotes passive forms of euthanasia.
- 1939 A bill to legalize euthanasia is proposed in the state of New York.
- 1946 The Committee of 1776 Physicians for Legalizing Voluntary Euthanasia in New York State comes into existence.
- 1965 The Supreme Court case *Griswold v. Connecticut* (a case involving the use of contraceptives) sets a precedent for the right to privacy as a constitutional guarantee. The Supreme Court rules that the Due Process Clause of the Fourteenth Amendment should be expanded to provide for privacy within the marital relationship. This case is extremely important because it sets the stage for judicial actions and decisions regarding abortion and the right to die based on privacy considerations.
- 1966 The Euthanasia Society of New York establishes a tax-exempt branch called the Euthanasia Education Fund to distribute information about dying to the public. The Society, in concert with Chicago attorney Luis Kutner, develops the first living will.
- 1969 Physicians, lawyers, ethicists, theologians, and journalists publish more than four dozen articles and a dozen books on euthanasia, the terminal patient, and laws (or lack of them) which deal with mercy killing.
- 1972 The Senate Special Committee on Aging holds meetings on “Death with Dignity: An Inquiry into Related Public Issues.”
- 1973 In its decision in *Roe v. Wade*, the Supreme Court rules that a pregnant woman has a specific constitutional right to privacy in matters of procreation, and that this right includes a right to an abortion if she so decides. The Court adds that a state’s reasons for overriding that right by making abortion a crime are not compelling.
- 1974 The first American hospice opens in New Haven, Connecticut.
- 1976 The New Jersey Supreme Court rules that the right to privacy is broad enough to allow families, in this case the family of Karen Ann Quinlan, the right to let their irreversibly unconscious relatives

- die. The court also recommends that cases such as Ms. Quinlan's should be handled by hospital ethics committees and not by the courts.
- Also Governor Jerry Brown signs into law the California Natural Death Act, the nation's first right-to-die statute.
- 1981 California doctors Neil Barber and Robert Nedjil are charged with murder for taking patient Clarence Herbert off a respirator and discontinuing intravenous feedings. The family had requested these steps, but a nurse notified authorities. The California Superior Court rules that artificial nutrition and hydration are medical treatments and their use is not always required.
- 1983 The Veterans' Administration issues a ruling that recognizes a patient's right to die. This allows doctors to write orders, but only at the request of a competent patient, that explicitly deny lifesaving therapy to critically ill patients.
- Also The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research asserts that patients should be allowed to refuse lifesaving treatments.
- 1990 The Patient Self-Determination Act is passed by Congress. It requires hospitals and nursing homes receiving Medicare and Medicaid funding to inform patients that they have a right to refuse medical treatment and requires these facilities to provide living will and power-of-attorney documents in advance of illness or disease.
- Also On June 4, Dr. Kevorkian helps Alzheimer's patient Janet Adkins die in his 1968 Volkswagen van.
- Also On June 25, the Supreme Court rules, by a 5-4 decision in *Cruzan v. Director, Missouri Department of Health*, that states may confine terminal decisions on behalf of incompetent patients to instances when that patient has previously expressed such a preference and that states may demand clear and convincing evidence of the patient's wishes.
- 1992 The Supreme Court rules, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, that the central holding in *Roe* should be affirmed. As Annas has noted, this case is famous for Justice Kennedy's poetic language. Kennedy writes, "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life" (1998, p. 206).

Even a quick review of this very brief list of events surrounding aid in dying in the United States will reveal three facts. First, there is a deep and abiding concern on the part of the public, state, and federal legislatures, and state and federal courts regarding all forms of physician-assisted death. Second, patients—those once competent as well as those who were never competent—have a right to refuse, through surrogates, life-sustaining therapies, and interventions. Third, the public, legislatures, and courts take seriously such concepts as autonomy, well-being, and dignity, and the application of these concepts to the patient-physician relationship, even with respect to matters at the end of life. We move now to the two most recent Supreme Court decisions regarding physician-assisted death.

On June 26, 1997, in its 9-0 decisions in *Washington v. Glucksberg* and *Vacco v. Quill*, the U. S. Supreme Court ruled that terminally ill patients have no right to medical help in committing suicide (Capron, 1997; Kaveny, 1997). In *Washington*, Chief Justice Rehnquist, writing for himself and four others, ruled that the liberty protected by the Due Process Clause does not include a right to commit suicide, nor does it include a right to assistance in doing so (Annas, 1998, p. 217). Rehnquist dismissed references to the 1992 decision in *Casey* and claimed that not all intimate choices about one's life qualify as protected rights. George Annas briefly gives Rehnquist's reasons for the decision:

Justice Rehnquist described the Court's established method of substantive due process analysis as having two features: (1) The fundamental right or liberty must be deeply rooted in this nation's history and tradition . . . or so fundamental to ordered liberty . . . that neither liberty nor justice would exit if it were sacrificed. (2) The asserted fundamental right or liberty interest must have a careful description. As to the first, the Court concluded there is no historic tradition of treating suicide as a fundamental right, noting that to find such a right the Court would instead have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every state. (1998, p. 218)

In *Vacco*, plaintiffs claimed that New York violated the Equal Protection Clause because the state allows a competent patient to refuse life-sustaining treatment but not to obtain physician-assistance in suicide, which they claimed is essentially the same thing. That is, plaintiffs asserted that in the "universe of terminally ill people near the end of life," the right to refuse treatment is the same as suicide (Annas, 1998, p. 221). The Court disagreed, citing first

the AMA's endorsement of the distinction between assisting suicide and withdrawing treatment. Second, the Court employed legal tradition that makes a distinction between causation and intent. This latter reason addresses not only assisted-suicide but also active voluntary euthanasia as well. The Court's reasoning was this:

[T]he Court agreed with previous legal rulings that when a patient refuses life-sustaining treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician he is killed by that medication. But since medications prescribed for legitimate medical purposes can kill as well, the real distinction in close cases is the physician's *intent* in prescribing the medications. The Court explained that when a physician provides aggressive palliative care, "in some cases, pain killing drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain." On the other hand, a doctor who assists a suicide necessarily intends that the patient die. Similarly, a patient who commits suicide with a doctor's aid "necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not." (Annas, 1998, pp. 221-222)

In both *Washington* and *Vacco* the Court affirms, as Kaveny has noted, that "the State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and social indifference" (1997, p. 30). These two decisions also affirm the doctrine of double effect, a doctrine that many medical ethicists find problematic (e.g., Beauchamp and Childress, 1994; Brock, 1992; Harris, 1995b). This doctrine holds that it is morally permissible to perform an action that has a morally objectionable effect if the action itself is morally neutral and the bad effect is unintended and unavoidable. Physicians must worry about charges of homicide or assisted-suicide if they prescribe drugs with the intent to kill their patients.

However, one might still wonder whether there exist circumstances under which active euthanasia and assisted-suicide would not threaten the equality of vulnerable people, or in which the requirements of double effect could be at least somewhat satisfied. Could these actions be found to meet constitutional requirements and hence become incorporated into social policy? Some Justices seemed quite troubled by the rulings and their impact on patients' quality of life and the relationship between patients and their physicians.

Consider the following observations from some of the Justices in their concurring opinions in *Washington* and *Vacco* (Capron, 1997; Annas, 1998):

- Footnote to the majority opinion: A situation could arise where it would be unconstitutional to apply prohibitions against assisted-suicide to particular patients and physicians.
- Justice Souter: The law may be setting up an “arbitrary imposition” or “purposeless restraint” in its legal regulation of care at the end of life.
- Justice Stevens: It may indeed be legal for individual patients and physicians to make decisions together about end-of-life care.
- Justice Breyer: There may, in certain cases, be a right to die with dignity.
- Justices O’Connor, Ginsburg, and Breyer: The desire to eliminate unremitting physical pain may belong in a special class of exceptions.

From opinion polls of the lay public, patients, and physicians about judicial decisions of circuit courts and the Supreme Court, we see a deep concern over what should be the correct moral and legal stance to take regarding voluntary and non-voluntary euthanasia and assisted-suicide. While passive euthanasia is morally and legally permitted in the United States, active euthanasia and assisted-suicide remain, for all practical purposes, morally suspect and certainly illegal. Nevertheless, various forms of physician-assisted death are practiced in the clinical setting; furthermore, there is no doubt that this aid is provided with the intent of directly hastening death. However, there is no constitutional protection or professional sanction for active forms of ending a person’s life. Thus patients continue to fear they will be subjected to a protracted, painful dying process that assaults their dignity and autonomy, and physicians continue to wonder if, by only letting patients die, they are abrogating their professional responsibility.

IV

Of course, the use of quality-of-life criteria, as well as specific notions of the patient-physician relationship, as a rationale for active forms of assisted death may very well be dangerous, or at least morally inept. As Walter Wright has already pointed out, Leo Alexander expresses this fear, and so powerful are his words that I shall not refrain from quoting them again. In 1949, with the world still coming to terms with the genocide committed in Germany, Alexander wrote in the *New England Journal of Medicine*:

The beginnings . . . were merely a subtle shift in emphasis in the basic

attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick. (1980, p. 584)

As Walter Wright observed, here we have the classic formulation of the slippery-slope argument. With regard to the issues surrounding the taking of human life—destroying human embryos, abortion, not treating severely defective newborns, voluntary and non-voluntary euthanasia, and physician-assisted suicide—slippery-slope arguments have been around for a long time and can be quite powerful. Frey has provided a straightforward definition of this type of argument:

The essential slippery slope argument moves in the following way: take step A, and we shall be led to take steps B and C. Step A takes us out onto the slope; steps B and C take us down it. In this form, a slippery slope argument is consequentialist in character: the consequences of taking step A are that we shall take steps B and C. This matter is one of probability, however, so that we need to believe it likely or probable that we shall take steps B and C. For if this probability is low, or remote, then fear of steps B and C may recede and step A may be taken; if, however, this probability is high, then the fear of steps B and C may well prevent us from granting the permissibility of step A, even if on other grounds it has passed moral muster. (1998, p. 45)

Alexander, Wright, and others are concerned that invoking specific notions of quality of life, of the patient-physician relationship, and of the proper goals of medicine in an attempt to defend assisted death will only lead to disaster. What does it mean to have an acceptable or unacceptable quality of life? What is the model for proper or improper interactions between patients and physicians? What exactly are the correct or incorrect goals of medicine? Perhaps the very act of asking these questions, especially in the context of end-of-life decision-making, is dangerous. The answers to such questions may become more expansive. The results may be more killing.

Forty years after Alexander expressed concern that the policies of Nazi Germany would be replicated in the United States unless we refused to place the “infinitely small wedged-in lever,” we learn from a story appearing in a prestigious medical journal that a gynecology-resident engaged in what at best can be described as an act of reckless mercy killing (Anonymous, 1988). A nurse awakened the resident to inform him that a 20-year-old woman (not his patient) dying of ovarian cancer was in great pain and experiencing unrelenting vomiting. After briefly examining the woman, the resident injected her with 20 milligrams of morphine sulfate. She died a few minutes later. Indeed, there is no doubt that Alexander would feel his prediction of a slide down the slippery slope had come true.

While this act first brought widespread condemnation from the medical community and ethicists, as time passed many physicians acknowledged that they were sympathetic with the resident and that they themselves had actively “helped” their terminally ill patients to die. As final evidence that America is on the slippery slope, Alexander could point to Binding’s and Hoche’s 1920 tract in which they claim:

Because gravely ill patients and trauma victims face present and certain death from their conditions, the interval between death from their condition and death caused by the interposed means is insignificant. Here, only a narrow pedant could speak of a palpable lessening of the patient’s lifespan. (1992, p. 240)

The specificity with which Binding and Hoche write can be quite disturbing and only adds support to those who see the slippery slope. Seventy years before the gynecology resident killed the young woman, Binding asserted: “I think particularly of terminal cancer, untreatable tuberculosis, and of the mortally wounded everywhere. It seems to me totally unnecessary that the demand for death arise from unbearable pain. Painless hopelessness deserves the same sympathy” (1992, p. 247).

Recall that Binding and Hoche argued for the medical killing of several different groups: competent patients who are seriously or terminally ill, incompetent people whether they are seriously ill or not, and unconscious patients who are seriously or terminally ill. They support their claims by appealing to and defending the notion of “life unworthy of life” and by invoking a very specific conception of physician responsibility. By the former, they mean a life that is a burden either to the individual, the government, or to society (1992, pp. 245-247). One is unworthy of living if one’s existence

results in great pain, hardship, and/or expense. By the latter, they mean that physicians have duties to cure, alleviate pain, and preserve life (1992, p. 256). However, physicians must remember that ethics in medicine is relative, and that perhaps the best guide for how to treat patients derives from peers (pp. 255-256).

When these two notions combine, the stage is set for medical killing on a grand scale. Doctors do have duties toward their patients, and there is even a duty to preserve life. Nevertheless, in the early German writings, any ethical obligations doctors have are relative, and any obligation to preserve life depends on whether that life has value. Morally and legally speaking, doctors should kill those whose lives are unworthy to be lived.

Are people in modern America, by advocating active forms of physician-aided death, adopting Binding's and Hoche's conception of "life unworthy of life"? When physicians actively "help" their patients (especially those who are incompetent) die, are they embracing a notion of the patient-doctor relationship that involves only relative duties and obligations? Are Alexander, Wright, and others correct when they claim America is sliding down the slope to mass medical killing? The answer is *no* to all these questions. A brief examination of quality of life and of the patient-physician relationship demonstrates why.

V

No doubt concerns over quality of life can be difficult to articulate and even more difficult to operationalize. For example, Jonsen, Siegler, and Winslade have noted that judgments regarding the quality of life of a particular patient can be classified as one of two types, personal evaluation and observer evaluation (1998). That is, judgments of poor quality of life can be made by the one living the life or by an observer. Add to this fact, that quality of life judgments can change over time and that they can reflect bias, prejudice, and socioeconomic conditions rather than the actual life experiences of the person experiencing the life. Because of these difficulties, are we to conclude that quality of life judgments are nothing more than the social worth of individuals? The answer is definitely not.

In discussing health-related quality of life, it seems feasible that we can take into account, and perhaps even measure, such factors as physical mobility, freedom from pain and distress, the capacity to perform the activities of daily life, and the capacity for social interaction. I would claim that, in considering these factors, we are not talking about the ingredients of a good life, but rather we are talking about a certain level of goods necessary for an

individual's fulfillment of his or her life plans. In looking at health-related quality of life, we are not interested in the burdens patients place on society but rather the burdens patients experience.

If this is so, then it seems not only ethically allowable but also morally necessary to admit that there is something we might call quality of life that is below minimal. A determination of a quality of life below minimal would mean that an individual is in a situation in which he or she suffers extreme physical debilitation as well as complete and irreversible loss of sensory and intellectual activity. If a patient is experiencing a quality of life that is below minimal, then we might invoke the patient's "best interests" standard as a decision-making tool.

The best interests standard, as Beauchamp and Childress (1994) have pointed out, is definitely a quality of life criterion. This criterion is most commonly used to assess appropriate options for incompetent patients. The obligation under this standard is to maximize benefit for the patient through a comparative assessment. All the options a patient has, if the patient were competent, are examined, assigning different weights to interests the patient has in each option. A surrogate decision maker would decide what counts as an interest by considering, to the extent this is possible, the viewpoint of the one for whom the judgment is being made. An example will make this clearer: Ms. Lane is a 70-year-old woman who has been institutionalized because of severe developmental disability since the age of four. Her mental age is estimated at less than the 5-year-old level, and she has an IQ of 20. She develops acute myelogenous leukemia. Treatment for this disease is quite painful and the possibility of success—success measured in terms of keeping Ms. Lane alive for six to eight months—is very small. Ms. Lane's guardian does not want treatment begun.

Medical ethicists and courts often make a distinction between quality of life of the patient with treatment and the quality of life of the patient without treatment. Reasonable people could certainly agree that with treatment, Ms. Lane's quality of life would diminish greatly. Certainly, it is morally permissible, perhaps even morally obligatory to let Ms. Lane die. Doing so would be in her best interest.

In making quality of life judgments and in employing the best interests standard, phrases such as "absolutely worthless" and "negative value" have no place. In arguing that in some limited cases, even active, non-voluntary euthanasia would be morally permissible, I am not claiming that it is permissible to kill a patient because, as Binding and Hoche have stated, "death would simultaneously free society and the state from carrying a burden which

serves no conceivable purpose” (1992, p. 246). What I in fact claim, is that ending the lives of some patients quickly and painlessly is in their best interest. Doing so does not lessen respect for life, but actually heightens it.

Even if we all admitted that there is no similarity between Binding’s and Hoche’s rationale of life unworthy of life and the best interests standard for judging quality of life, the issue would remain whether physicians should take part in helping their patients die. How are we to understand the proper role (morally speaking) of physicians with respect to issues at the end of life? May physicians engage in voluntary or non-voluntary euthanasia, and may they assist in the suicide of their terminally or chronically ill patients? If physicians kill, do they become “mere technicians of rehabilitation” (Alexander, 1980, p. 585)? If physicians help patients die, does this mean they have been “infected with Hegelian, cold-blooded, utilitarian philosophy” (p. 586)?

We need to be clear on two issues: the proper goals of medicine and what might be called the moral center of medicine. According to Jonsen, Siegler, and Winslade the goals of medicine are the following:

- promotion of health and prevention of disease;
- relief of symptoms, pain, and suffering;
- cure of disease;
- preventing untimely death;
- improving of functional status or maintenance of compromised status;
- education and counseling of patients; and
- avoiding harm. (1998, p. 16)

Even if one wishes to simplify the goals of medicine—thus shortening the list to something like curing disease and caring for and comforting patients—this simplification does not exclude participation in active forms of aid in dying. After all, there is nothing contradictory between carrying out these goals on the one hand, and respecting patient autonomy and well-being on the other (Brock, 1992). The achievement of these goals, whether there are several or only a few, is the benefit and purpose of medicine. Obviously, people may disagree over the meaning and scope of these goals. I maintain, however, that no contradiction exists between “avoiding harm” and “preventing untimely death” on the one hand, and “relief of pain and suffering,” even if this involves assisting in a patient’s death, on the other. Indeed, if a physician’s obligation to relieve suffering and avoid harm is taken as paramount, then there exists at least a *prima facie* duty to actively help some

patients die.

These goals or aims of medicine do not exist in a vacuum, but instead depend on their actualization in the context of the patient-physician relationship. Physicians and patients interact with one another, and within this interaction, we discover the moral center of medicine. At this center lies a commitment to the autonomy of patients and to their well-being. Physicians are not just healers; indeed, they are comforters and protectors of their patients as well. These values of respecting autonomy and of promoting well-being allow physicians to let patients die and even to assist actively in this process.

While there may be disagreement over the scope and meaning of respect for autonomy and promotion of well-being, there is nothing relative about this commitment. If Binding's and Hoche's characterization of physicians as "simply healers," as economists, and as calculators and evaluators of social worth were ever applicable (which I doubt) they are certainly not applicable to modern health care. Debate over the legal and moral status of active, voluntary, and non-voluntary euthanasia and assisted-suicide will continue; people of good will continue to disagree. This debate, however, is not furthered by concerns that we will fall into German rationales for mass killing.

VI

I believe that commentators like Alexander and Wright, who use Binding's and Hoche's ideas and arguments to justify a slippery slope in modern America, are certainly mistaken. On the other hand, I think Binding's and Hoche's rationale for mass medical killing, as well as the Nazi adoption of that rationale for the moral and legal implementation of that killing, have a great deal to teach us. I have tried to show, that at least sometimes there is no difference between letting die (omission) and killing (commission) in the medical context when such omissions or commissions are done in the best interest of the patient. However, there is one large-scale system of omission in the United States that reflects, perhaps unconsciously, the rationale of Binding and Hoche, and that is the American medical care system's treatment of underinsured and uninsured persons (Thomasma and Graber, 1990, p. 174).

The American health care system, all will agree, is in crisis. The U.S. Census Bureau tells us that there are currently 44 million underinsured or uninsured persons in this country. Health care is now so expensive that access to health care resources is becoming more limited. Those people who cannot afford health care are certainly a drain on society's resources. Perhaps letting 44 million people possibly die prematurely, which is the outcome if not the intent of American health care policy, is morally permissible. However, Loewy

has made the following, very powerful, observation:

[W]e have structured and we continue to structure our society so that many are hungry, poor, homeless, and without medical care while some live in opulent luxury. And deaths due to hunger, poverty, homelessness, and lack of medical care could, at least in our society, be largely prevented. To say that we always hold the killing of other humans to be unallowable is simply not true. (1998, p. 59)

Of course, perhaps Loewy's point is too strong. After all, as I have discussed in this paper, there is killing and then there is *killing*. People who die because they cannot afford access to medical services, or because such services are rationed, are not killed; they are simply allowed to die. This letting die constitutes passive, social euthanasia. This program of passive, social euthanasia is rather subtle. Thomasma and Graber eloquently express this notion and its subtlety when they note:

If a poor person needs an angioplasty to stay alive, and cannot receive it, while others who can pay are able to receive it, then we have socially euthanized that person. If the DRG [diagnosis related group] reimbursement system goes bankrupt in a state and hospitals that care for the poor in the inner city can no longer survive, they close. And access for the poor person covered by Medicaid, but who has a stroke while working in a shop in the inner city, is effectively denied. It takes the ambulance twice as long to get her to an emergency room as it might for a comparable person who suffers a stroke in an affluent suburb near a highly technical hospital. (1990, p. 175)

The Nazi experience and the concept of life not worthy to be lived are valuable and applicable to current developments in the United States. However, their value and application have nothing whatsoever to do with the debate over physician-assisted death. In fact, I suspect appeals to the Nazi experience and to slippery slope concerns only obscure and interfere with legitimate debate over the morality and legality of active, voluntary euthanasia; active, non-voluntary euthanasia; and physician-assisted suicide. The Nazi experience is most useful in critically examining and evaluating social institutions and attitudes that permit the denial of health care to those who need it and that allow so many people to die. Are people denied access because they are a burden to society? Does society let people die because they live lives

not worthy to be lived? Binding's and Hoche's characterizations and the Nazi horror can be instructive. History provides us with some incentive to examine our practices and the motives we employ to justify those practices. Maybe it is time we begin to care as much about keeping alive those who want to stay alive as we care about keeping alive those who wish to die.

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