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# Physicians Ought Not Kill

by

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Dying well or experiencing death with dignity and ease is the root understanding of the Greek word *euthanasia*. A pious Catholic could invoke the help of St. Joseph for such a death. But in the twentieth century, dying well has become a serious problem owing ironically and in no small part to the medically advanced and highly technologized treatment we have devised. To many sick and terminal patients, not only their illness but the prospect of such treatment is overwhelming and frightening. Facing their mortality has led some of them to propose suicide as a form of dying well, specifically, physician-assisted suicide. The proposal and, in the state of Oregon, the actual practice have stirred moral and public policy debates as the literature amply attests.<sup>1</sup> While this paper treats of some of those debates, its primary concern is the vital distinction between killing and letting die. The distinction all too easily escapes popular notice but nonetheless determines the debate about physician-assisted suicide and euthanasia.

Doctors and health care workers need no reminding about the mixed results which the union of medicine and technology has had in patient care. "The same technology which extends the life of one person may simply prolong the dying of another."<sup>2</sup> In cases where partial or full recovery is in doubt, images of sedated or comatose patients tethered to machines raise the question whether such treatment is worth it after all. The *Quinlan* case in 1976 and the *Cruzan* case in 1988, and a succession of cases between

them – Saikewicz [1977], Spring [1980], Eichner [1981], Barber [1983], Bartling [1984], Conroy [1985], Brophy [1986], and Jobes [1987] – served to instruct the public on its legal and moral right to decide for or against life-sustaining treatment including the use of ventilations, cardio-pulmonary resuscitation, dialysis and tube-feedings.

Recognition of the right culminated at the federal level with the *Patient Self-Determination Act* (PSAD) which went into effect December, 1991.<sup>3</sup> The PSAD obligates every health care facility receiving Medicare or Medicaid funding to inform its clients of their right to decline unwanted medical treatments, even those that prolong life. On the local level states also recognize that right, which has found articulation in so-called “advanced directives” “durable power of attorney”, and “living wills.”

As vehicles meant to enhance patient autonomy, advanced directives, living wills, etc., can be morally legitimated insofar as they accord with a principle which has informed Catholic medical ethics since the sixteenth century. That is, for the preservation of life, no one is obligated to choose extraordinary means where the benefits are disproportionate to the risk and burden incurred.

The 1980 Vatican *Declaration on Euthanasia* reiterated that principle and appealed to its sister principle, namely, the distinction between killing and letting die. While letting die is permitted, killing is not and stands condemned by the fifth commandment forbidding the intentional killing of an innocent life “whether a fetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease or a person who is dying.”<sup>4</sup>

While some moralists contend that between killing and letting die there is no real difference,<sup>5</sup> the distinction has nevertheless been useful at the level of common sense and practicality. Doctors generally recognize in their intention and action a difference between terminating futile treatment for a dying patient and terminating the patient by lethal injection.

The distinction between killing and letting die has until recently been crucial in maintaining the wall between death that is moral and legal and death that is not. Today that wall has been breached. The shaky consensus reached in society since *Quinlan* and *Cruzan* stands challenged by recent initiatives advocating direct interventions to bring about a patient’s death either with assistance (so-called *assisted suicide*) or by the direct action of another (so-called *active euthanasia*).

### **Killing Events**

We are all aware of the dramatic events that have so shaped public consciousness that, as a result, it now views end-of-life killing as



"compassionate killing", "death with dignity" and "managed dying". Four events easily come to mind, each of them eroding moral restraints on suicide and euthanasia.

Heading the list is Jack Kevorkian's lethal crusade to assist the suicides of what initially were terminal patients battling insufferable pain. He has since widened his dragnet to include the chronically ill, those with degenerative diseases, those with poor medical prognoses and, in one case, a woman afflicted with obesity and chronic fatigue syndrome. Until his much-publicized commission of an act of direct euthanasia<sup>6</sup> Kevorkian has assisted with legal impunity in the suicides of at least fifty individuals.

In 1991 Kevorkian articulated the goals of his crusade by publishing a book, the title of which speaks for itself: *Prescription: Medicide - The Goodness of Planned Death* (Prometheus Books). In that book and in a subsequent article, he advances assisted suicide and euthanasia "as an honorable medical service" which he laments has suffered a reversal in the course of western history. As to the culprit responsible for this reversal, Kevorkian is emphatic: "arbitrary laws to foist rules of conduct dictated by religion."<sup>7</sup> In campaigning to end those laws, Kevorkian finds preposterous whatever moral restraint the distinction between killing and letting die provides.

Another event played out in medical journals and books has been the open advocacy of doctors for assisted suicide. In 1989 the much respected *New England Journal of Medicine* featured from leading medical centers across the United States ten of twelve physicians who endorsed physician-assisted suicide. Going beyond support for terminating futile medical treatment, these doctors stated, "All but two of us ... believe in the rational suicide of a terminally ill patient."<sup>8</sup>

More shocking was the anonymous piece entitled "It's Over, Debbie", appearing in 1988 in the *Journal of the American Medical Association*. A resident gynecologist confesses to euthanizing a twenty-year-old patient dying of ovarian cancer. He relates:

It was a gallows scene, a cruel mockery of her youthful and unfulfilled potential. Her only words to me were, "Let's get this over with."

I retreated with my thoughts to the nurses's station ... I asked the nurse to draw 20 mg. of morphine sulphate into the syringe. Enough, I thought to do the job ...

Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world. I injected the morphine intravenously ... With clocklike certainty, within four minutes the breathing rate slowed even more, then became irregular, then ceased ... It's over, Debbie.<sup>9</sup>

Eschewing anonymity, Dr. Timothy Quill of the University of Rochester (NY) confesses in a 1991 issue of the *New England Journal of Medicine* to assisting his patient "Diane" in suicide.<sup>10</sup> Whereas the actions of Kevorkian and the anonymous resident provoked outcries and disapproval, Quill's action generally did not. His participation in a patient's suicide was lauded because of the comprehensive medical care and deep concern he accorded her.<sup>11</sup>

Incidentally, Quill alleges in his book *Death and Dignity: Making Choices and Taking Charge* that

Survey data that are flawed by low response rates and poor design suggest that from 3 to 37 percent of anonymously responding physicians admitted secretly taking active steps to hasten a patient's death.<sup>12</sup>

Before moving on to the third event which has undermined the moral prohibition against suicide and euthanasia, we must mention another publication, Derek Humphrey's suicide manual entitled *Final Exit*.<sup>13</sup> This how-to book was the cover story of *Newsweek* (26 Aug., 1991) and within weeks of publication made the *New York Times* best seller list.

A third event, which needs no lengthy commentary, is the 1994 Oregon ballot initiative which resulted in the state's "Death with Dignity Act." In 1995 the act became statute, allowing physicians under certain specified conditions to prescribe lethal drugs but not administer them. In a classic case of having it both ways, "The bill somewhat oddly stipulates that a death brought about in accordance with its measure 'shall not constitute suicide, assisted suicide, mercy killing or homicide' (*Measure 16*, 1994)."<sup>14</sup>

We may note in passing that five years ago, Oregon was "the first state in the nation to ration care for the poor based on a scale of cost-effectiveness. [And] Beginning this month [January, 1999], Oregon has added assisted suicide to its list of funded services."<sup>15</sup>

In line with the Oregon provision allowing physician-assisted suicide, fifteen other state legislatures saw bills introduced between 1995-96 to allow so-called "aid-in-dying." In 1996, two federal courts, one in Washington state, the other in New York, proclaimed physician-assisted suicide as a constitutionally protected right. The Washington case was filled by the euthanasia organization "Compassion in Dying" and the New York case by Dr. Timothy Quill. Both cases, [*Washington v. Gluckberg* and *Vacco V. Quill*], having made their way to the Supreme Court, invoked the Fourteenth Amendment to challenge the states' criminal ban on physician-assisted suicide. In a much-touted decision, the Supreme Court



on June 26, 1997 saw no amendment violations on the part of the states banning physician-assisted suicide.<sup>16</sup>

The legal aspects of these cases lie, of course, outside the competency of this paper. But it bears noting that the Court's finding against a constitutional right or liberty interest in "choosing the time and manner of one's death" in no way precludes the states from decriminalizing physician-assisted suicide or euthanasia. The point is understood by any American aware that the practice in Oregon remains unaffected by the Supreme Court decision.

Finally, we cite one last event which has served to undermine the check that morality has provided against suicide and euthanasia. We refer to the liberal policy of euthanasia in the Netherlands. While as of this writing not yet formally legalized, physician-assisted suicide and euthanasia have in practice existed there for over two decades. Of the 30,000 doctors in the Netherlands, 25,000 are members of the Royal Dutch Medical Association (RDMA) which subscribes to euthanasia and physician-assisted suicide, activities the Association regards as indistinguishable. If the opinion polls be accurate, in 1966, 40 percent of the Dutch population favored euthanasia, but by 1988, 81 percent.

With the concurrence of the Dutch courts the RDMA has drawn up guidelines for "permissible" euthanasia. With these as criteria, the Dutch Attorney General in 1990 chaired a commission which conducted three separate studies of physicians involved in hastening a patient's death. Of the 129,000 deaths per year in the Netherlands, 2,700 are directly caused or assisted by a physician. In addition to those deaths, the Commission reported 1,000 *nonvoluntary* deaths, that is, those occurring without an explicit and persistent request of the patient. Euthanized deaths, therefore accounted for nearly 3 percent of the total number in the Netherlands. We may add, incidentally, that with full universal health care there, physicians have no financial incentive for terminating their patient's life.<sup>17</sup>

We have cited Kevorkian, certain medical publications, the Oregon statute and the Netherlands as events which impinge on the American consciousness. What, we may ask, has been their practical effect? It may come as no surprise that

In polls of public opinion, a clear majority of Americans report that they favor making it legal for physicians to prescribe or administer lethal drugs to dying patients who want a quick and painless end to life.<sup>18</sup>

Most Americans, whether subscribing to that opinion or not, recognize that such practices affect us morally and socially at some

fundamental level. Doctors in particular sense that the ethic of medicine is once again at stake as it was in the Supreme Court decision regarding abortion.

### **Killing and Letting Die**

When it came before the House Judiciary, the American Medical Association cited its "Code of Medical Ethics"<sup>19</sup> and reiterated its opposition to physician-assisted suicide and euthanasia. At the same time over sixty *amicus curiae* pro and con were being filed at the Supreme Court relative to *Washington v. Gluckberg* and *Vacco v. Quill*. Testifying before the Judiciary, the president of the AMA cited as ethically cogent the distinction between killing and letting die, the distinction which the Supreme Court in its subsequent decision accepted as a basis for upholding the Washington and New York State laws.

The AMA noted the opposing view, which argues that since death is the result whether through killing or letting die, "the acts themselves carry equal moral status." The AMA disagreed, criticizing this view for failing to recognize that

Withholding or withdrawing treatment allows death to proceed naturally, with the underlying disease being the cause of death. Assisted suicide, on the other hand, requires action to cause death, independent from the disease process.<sup>20</sup>

In maintaining the distinction, the AMA could have bolstered its argument by introducing as morally relevant the principle governing the use of ordinary and extraordinary means. The distinction justifies the right of a person to refuse to initiate or to continue medical intervention once the treatment, in light of circumstances, is deemed "extraordinary" because of its risk, cost and burden. Perhaps, this was the allusion the AMA was making when, undoubtedly aware of *Cruzan, Quinlan et alii*, it mentioned "principles that underlie the right of patients to refuse the continuation of medical care."<sup>21</sup>

However, neither the principle of ordinary vs. extraordinary means nor that of killing vs. letting die informs the so-called *Philosophers' Brief*. One of the sixty *amici curiae*, this document is, as its authors point out, a first of its kind. While in the past, philosophers have been party to litigation before the Supreme Court, the *Philosophers' Brief* represents the first time that general moral philosophers have intervened solely and in their own name.<sup>22</sup>



Written by six of our nation's luminaries in the field of ethics, the Philosophers' Brief is an appeal for physician-assisted suicide. In constructing its case, the Brief ignores the ordinary/extraordinary distinction and dismisses as philosophically naïve the distinction between killing and letting die. In fact, the overall argument of the Brief relies on the denial of the distinction.

Attempting to give an ethical rationale to the challenges before the Supreme Court, the Brief interweaves moral argument with past legal cases. Of the many cases it cites in the interest of removing the Washington and New York ban on physician-assisted suicide, *Cruzan v. Missouri* and *Planned Parenthood v. Casey* figure prominently in the Brief.

With reference to *Cruzan*, the philosophers infer that implicit in the Court's recognition of a patient's right to refuse life-sustaining treatment is "the more profound right" the patient enjoys for determining the timing and manner of his/her death. In the reasoning of the Brief, the patient's choice or right to die renders irrelevant any moral distinction between killing and letting die. In light of *Cruzan* and this "profound right" the philosophers conclude with regard to physician involvement that

If it is permissible for a doctor deliberately to withdraw medical treatment in order to allow death to result from a natural process, then it is equally permissible for him to help his patient hasten his own death more actively, if that is the patient's express wish.<sup>23</sup>

The permissibility which the Brief claims for a doctor to assist his patient's suicide ignores one of the essential elements for determining a moral act, namely, intention. Overlooked is the fact that while the physicality of the act may be the same, e.g., the removal of a feeding tube from a terminal cancer patient, the doctor's intention may be either the patient's death through starvation or the patient's comfort by ceasing useless treatment. Even the muscular athlete senses a difference in his game when his intention to block a tackle becomes the intention to harm the tackler. In the language of traditional morality, there is a difference in moral object: one an act of sport, the other an act of battery.

Besides ignoring intention, the Brief not uncommonly elides the question that certain results may be foreseen into the conclusion that they are necessarily chosen. But foreseen results are not necessarily those that are chosen. That a doctor foresees death hastened through increased morphine does not mean that in administering the dosages he chooses the patient's death.

It is hard to account for the obfuscations and lapses of logic found in the Brief. Moreover, we may even wonder if the philosophers truly helped



their cause by favoring in their argument the case of *Planned Parenthood v. Casey*. In this 1992 decision, the Supreme Court reaffirmed the essential holding of *Roe v. Wade*. As we know, the Court articulated what has come to be called the "mystery passage." In limiting the ability of states to proscribe abortion, the Court claimed a sphere of autonomy wherein individuals experience that

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. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.<sup>24</sup>

Whether viewed as a statement of extreme subjectivism or muddled metaphysics, this mystery passage from *Casey* was one of the arguments which the Supreme Court heard in the *Washington* case. Quoting the passage twice verbatim, the philosophers merely accepted it as moral legitimation for patient autonomy that includes suicide.

There is much to criticize in the Philosophers' Brief.<sup>25</sup> Its failure to be philosophically persuasive is reflected in the fact that not a single opinion of the Court praises or criticizes the Brief. It is simply not cited.<sup>26</sup> Yet for purposes of this paper, the Brief serves to reveal the two key philosophical assumptions which have thus far justified events like Kevorkian, physician advocacy of suicide, and euthanasia in Oregon and the Netherlands. That is, physician-assisted suicide and euthanasia require, on the one hand, the denial of a distinction between killing and letting die, and on the other, the assertion of unbridled patient autonomy.

Of course, for advancing the case for physician-assisted suicide and euthanasia, other arguments exist. There are those appealing to mercy for relieving pain and to economics for relieving costs, those appealing to privacy and those to self-determination, a species of autonomy.<sup>27</sup> The sifting and evaluation of these arguments are far from over, their implications so great that the Supreme Court in its decision of 1997 effectively left the matter of physician-assisted suicide and euthanasia to be thrashed out by the people and their legislatures.<sup>28</sup>

### Physician Involvement

Of the arguments *against* physician-assisted suicide and euthanasia, one stands out with particular relevance for doctors intent on practicing their profession morally. That argument constructs its case from the simple premise that *physicians ought not kill*.

Of course, this *ought* emerges from a prior assessment of the nature of medicine against which the actions of its practitioners are to be measured. In this regard the venerable Hippocratic Oath has for over two thousand years been serviceable in defining medicine and proscribing the actions that violate it. Whether doctors subscribe to the Oath or not, they must at least wonder why its arcane wisdom singles out on the part of physicians three behaviors irreconcilable with patient healing: breach of confidentiality, sexual relations with the patient, and dispensing deadly drugs.

These restrictions are intelligible in terms of that one reality which doctors possess and their patients do not, namely, power.<sup>29</sup> In the physician-patient relationship, the power which doctors possess trumps any assumption of doctor-patient equality and, indeed, patient autonomy itself. After all, physicians hold the monopoly on medical information relative to prognosis, treatments, costs and burdens. With their technical expertise, physicians even lay out the therapeutic options from which the "autonomous patient" is to choose. Faced particularly with grave outcomes, the patient invariably feels daunted by such choices and tends to become more, not less, dependent on the doctor. How in the interest of patient autonomy can the influence of doctors be discounted when they are legally empowered to offer their patient the option of an "electable death?"

Contra Kevorkian, the proscriptions contained in the Hippocratic Oath are not those of a religious sect but of a profession cognizant of its power both to heal and to harm. Physicians should not take advantage of their patient's vulnerability and naked exposure. For physicians literally handle and investigate their patient's body and are privy to intimacies that few others are. Wielding such power, the ancient Pythagorean doctors merely articulated the norms to which all their colleagues subscribed for the practice of good medicine.

The ban on killing patients is the first of all the material norms laid out in the Hippocratic Oath. Couched in the language of a promise, the norm obligates its adherent in these terms: "I will neither give a deadly drug to anybody if I am asked for it, nor will I make a suggestion to this effect..." The logic is unassailable.

Can wholeness and healing ever be compatible with intentionally killing the patient? Can one benefit the patient as a whole by making him dead?...

To say it plainly, to bring nothingness is incompatible with serving wholeness: one cannot heal – or comfort – by making nil. The healer cannot annihilate if he is truly to heal.<sup>30</sup>



Medical wisdom reaching back two millennia would have those who practice healing recognize and hold in check the awesome power they wield. In treating their patients, physicians abuse that power when they use it to kill instead of to cure, to "make dead" instead of to make comfortable in dying.

To the argument that physicians ought not to kill, there is yet another facet involving power. It is the power synonymous with the inviolability of the person. Such power translates into the individual's right to possess and control his/her own person. It is, therefore, an affront to the power and dignity of a person to be possessed by another as in slavery or to be disposed of as in murder.

The gauge of a civilized society has been the enactment of laws reducing the occasions when the killing of persons is permitted.<sup>31</sup> Universally, societies governed by law have already outlawed all forms of private killing, irrespective of the motives (e.g., honor or revenge). Going beyond private killing, western society has traditionally sought to limit even legally sanctioned killing. Notwithstanding the relatively recent introduction of abortion, society has sanctioned only three occasions for killing: self-defense, a just war, and capital punishment. Europe and many countries have pared back those occasions by eliminating capital punishment. Thus, exempting abortion, the obvious evolution of society has been traditionally in the direction of curtailing killing, not increasing it.

How do we account for this restriction?

The most obvious reason is a reluctance to give one person absolute and irrevocable power over the life of another, whether there is consent or not. That prohibition is a way of saying that the social stakes in the legitimization of killing are extraordinarily high.<sup>32</sup>

In countenancing killing, a society erodes in its members the sense of personal power and sovereignty. To the degree that society permits killing, those attributes appear uncertain and all the more fragile for being transferred.

To allow another person to kill us is the most radical relinquishment of sovereignty imaginable, not just one more way of exercising it. Our life belongs no longer to us, but to the person into whose power we give it.<sup>33</sup>

Seen in this light, Oregon and the Netherlands symbolize an ominous and aberrant development in western society. Instead of restricting legalized killing, society is ready to introduce a new category (*Editor's*

*note: This address was given in 1999).* Where, in the interest of the common good, society traditionally sanctioned killing the assailant, the invader and the criminal, now society stands poised to kill the sick.

Notwithstanding its supposed legal restraints, the category represents a return to private killing justified, as we saw earlier, by arguments concerning pain and costs, privacy and autonomy. Dispatching the sick – a very elastic category as Kevorkian has shown – is, indeed, private since it occurs within the confidential relationship enjoyed by physician and patient. Herein lies the insidiousness of this category of killing. For the patient relinquishes the right and power of his/her own inviolability to the physician who arrogates to himself a lethal power forbidden by the very nature of medicine. From all indications in the Netherlands, such a deadly pact is inherently prone to escape legal control and surveillance.<sup>34</sup>

In this issue of power and physician-assisted suicide there are many ramifications which must remain unaddressed as we conclude this paper. However, one thing should be evident: the spectre of abuse is invariably present when power and killing come together. Medicine, for the sake of its own integrity, must stay out of the killing business. Physicians should seek to eliminate pain and suffering, not the patient.

For those dispensing and for those receiving medical treatment, the distinctions between killing and letting die and between extraordinary and ordinary means have been serviceable guideposts. Established by common sense and not by a surveyor's level, they mark out for doctors and patients alike moral perimeters not to be transgressed.

In an age quick to dismantle the traditional taboos against killing, the move to legitimize physician-assisted suicide and euthanasia has followed abortion in quick succession. This fast-moving death train expects physicians to climb on board. But they must resist and shout to their colleagues already on board, "*Physicians ought not kill!*"

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