

Physician-Assisted Suicide

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Keywords: aid-in-dying legislation, assisted suicide, autonomy, euthanasia, physician opinion re euthanasia.

I. INTRODUCTION

On election day, November 14, 1994, Oregon voters elected a physician, Dr. John Kitzhaber, as their governor and, simultaneously, granted physicians the legal authority to help people end their own lives. By passing Ballot Measure 16,¹ the voters decided that a physician may, at a patient's request, prescribe a medication "for the purpose of ending his or her life in a humane and dignified manner."²

The political power to govern a state and the moral power to collaborate in ending a life were conferred by the citizens in the same democratic election. Obviously, the citizens can bestow political power. It is not clear that they can or should bestow the legal authorization to terminate life by medical means. This is the debate over legalizing euthanasia.

This Article briefly summarizes the history of the euthanasia debate in the United States, describes the classical arguments for and against euthanasia, examines the terms of the current debate, and concludes that while society may want to recognize a competent patient's right to escape the suffering of a terminal illness, it should do so with humility—and with caution.

II. ASSISTED SUICIDE

"Assisted suicide" now appears to be the politically correct terminology. The word "euthanasia," first used by Francis Bacon in the sixteenth century to mean, literally, "good" or "happy death," has

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1. The text of this initiative is officially set forth in OREGON SECRETARY OF STATE, BALLOT MEASURE 16 WITH EXPLANATORY STATEMENT (Aug. 29, 1994).

2. *Voters in Oregon Allow Doctors To Help the Terminally Ill Die*, N.Y. TIMES, Nov. 11, 1994, at A28.

lost any precise meaning it ever had and has attracted some negative connotations. Therefore, those engaged in the debates often try defining "euthanasia" precisely for their own purposes or discarding the word in favor of new terminology that they consider more exact and less offensive. These various rhetorical tactics have, from time to time, employed the term "mercy killing;" distinguished between active and passive, voluntary and involuntary euthanasia; restricted euthanasia to those voluntary life-endings carried out by the physician; and, more recently, discarded the term "euthanasia" entirely in favor of "aid-in-dying," and "assisted suicide." The rhetorical tactics are not, however, entirely rhetorical: They reflect, at least in the minds of their more reflective proponents, genuine philosophical differences with different moral implications.

A. *The Classical Arguments*

I shall continue to use "euthanasia" as the general category of acts in which physicians act, in some way, to effect the deaths of patients. In this vein, it might be useful to rehearse rapidly the classical arguments against such activity. First, a prohibition against direct taking of human life, except in self-defense or defense of others, has been a central tenet of the Judeo-Christian tradition. Second, the ethics of medicine have always emphasized the restoration of health and have long repudiated killing the sick. The Hippocratic Oath states "I will give no deadly medicine to anyone if asked, nor suggest any such counsel."³ Third, the dedication of the medical profession to the welfare of patients and to the promotion of their health might be compromised by the complicity of physicians in the death of the very ill. Fourth, the slippery slope always threatens: An "angel of mercy" can become a fanatic, bringing the "comfort of death" to those who do not clearly request it, then to others who "would be better off dead," and finally to whole classes of "undesirable" persons. The "euthanasia" program initiated in Germany during the 1930's was first directed only to the incurably ill but gradually expanded into genocide.⁴

These classical arguments persuade many that physicians have an absolute obligation to refrain from active euthanasia; others are not so convinced. Some physicians are sympathetic toward active euthanasia and admit (privately to colleagues or anonymously in surveys) that they

3. AM. JUR. 3D, Proof of Facts: Taber's Cyclopedic Medical Dictionary 832 (16th ed. 1989).

4. See Andrew A. Skolnick, *Museum Scholars to Apply Holocaust Experience to 1990s Biomedical Issues*, 268 JAMA 575 (1992).

have practiced it. The Hemlock Society has reported that, to protect the respondents from legal liability, it destroyed questionnaires in which 118 doctors out of 588 questioned admitted they had committed mercy killing of a patient.⁵

Many contemporary philosophers are skeptical of the logic on which the classical arguments rest. They also question society's ability to draw the major classical distinctions: "killing" versus "allowing to die"; "direct" versus "indirect" killing; "active" versus "passive"; "ordinary" versus "extraordinary"; "omission" versus "commission." A challenge to the classical arguments by philosopher James Rachels was published in the *New England Journal of Medicine* several years ago.⁶ The somewhat cerebral argument of that essay led logically to the controversial conclusion that active euthanasia was ethically acceptable, but it stirred up nothing like the storm of protest aroused by a physician's much more visceral account, published in the *New England Journal of Medicine* and widely quoted, of helping a terminally-ill patient named "Debbie" end her life.⁷ Adding insult to injury, historians have cast doubt on the meaning and observance of the venerable Hippocratic injunction against giving poison to patients. Proponents of legalizing euthanasia have asserted that barriers of law and policy can prevent a slide down the slippery slope.

When the President's Commission for the Study of Ethical Problems in Medicine (1978-1983) examined the classical arguments about euthanasia, it generally shared its resident philosophers' skepticism about these arguments.⁸ It did not commend their use as the basis for ethical decision making. At the same time, it recognized that the classical arguments and distinctions are not without utility. The Commission reported that

The distinction between acting and omitting to act provides a useful rule-of-thumb by separating cases that probably deserve more scrutiny from those that are likely not to need it [T]he commonly accepted prohibition of active killing helps to produce the correct decision in the great majority of cases Thus the Commission concludes that the current interpretation of the legal prohibition of active killing should be sustained.⁹

5. *Group Burns Records on Euthanasia Survey*, N.Y. TIMES, Feb. 24, 1988, at A22.

6. James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975).

7. *It's Over, Debbie*, 259 JAMA 272 (1988).

8. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983) [HEREINAFTER PRESIDENT'S COMMISSION].

9. *Id.* at 61 (citation omitted).

B. The Current Debate

The debate over euthanasia has been carried on for more than a century in the United States, at least since a flurry of articles about euthanasia appeared in medical journals during the 1870s.¹⁰ Generally, it has taken place in a quiet undertone, although legal cases have leapt into the headlines from time to time, the most recent arising from Dr. Jack Kervorkian's campaign to force the issue by advertising his own participation in the suicides of some twenty persons.¹¹ The latest phase of this long debate has been the introduction of the issue into our most vocal and public forum, our electoral process. Votes on euthanasia are nothing new. Bills to authorize euthanasia were proposed and defeated in the Iowa and Ohio legislatures soon after the turn of the century.¹² But never before has the issue been debated so widely. In the early 1990s, Washington,¹³ California,¹⁴ and Oregon¹⁵ put the legalization of euthanasia before their voters. All three states have the initiative process that allows the signatures of a certain number of citizens to place a proposal on the ballot. If the proposal passes in a general election, it becomes law, without action by the elected legislature.

1. Oregon Initiative

Using the initiative process, Oregon voters have passed the first statute in American history that authorizes euthanasia.¹⁶ The voters were asked to approve only this very limited proposal:

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for

10. See Charles W. Triche III & Diane Samson Triche, *THE EUTHANASIA CONTROVERSY, 1812-1974: A BIBLIOGRAPHY WITH SELECT ANNOTATIONS* (1975).

11. Norm Mayfield, *Kervorkian Is No Killer*, *HOUS. CHRON.*, Dec. 5, 1993, at Outlook 3.

12. Stanley Joe Reiser, *The Dilemma of Euthanasia In Modern Medical History: The English and American Experience*, in *THE DILEMMA OF EUTHANASIA* 27, 36 (John A. Behnke & Sissela Bok eds., 1975).

13. Lori Olszewski, *Right-to-Die Advocate In S.F.; He's Promoting Ballot Initiative Allowing Physician-Assisted Suicide*, *S.F. CHRON.*, Aug. 28, 1992, at A25.

14. Paul Jacobs, *Emotions Run High Over Doctor-Aided Death Issue; Prop. 161; Proponents Say Patients Could "Die With Dignity;" Opponents Say There Are Not Enough Safeguards*, *LOS ANGELES TIMES*, Oct. 24, 1992, at A1.

15. *Oregon Voters Allow Assisted Suicide For The Terminally Ill*, *LOS ANGELES TIMES*, Nov. 11, 1994, at A34.

16. *Id.*

medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this act.¹⁷

This new law allows physicians to respond only to a patient's request for a prescription that will allow the patient to obtain a medication that the patient can use for suicide. It does not authorize the physician to administer the medication or to perform any other action, such as injecting potassium chloride or morphine or using carbon dioxide. The new law permits the most exact form of what is now called "assisted suicide," that is, a situation in which the patient determines to end his or her life and carries out the necessary actions him or herself. The physician merely assists by doing the two things he or she can do as physician: determining the medication that will most effectively, humanely and painlessly end the patient's life, and writing a prescription for the medication and dosage.

Despite these limitations, the Oregon legislation is historic, although it reveals no more about the nature of the debate than the Washington and California measures, which lost at the polls.¹⁸

2. The Washington Initiative

The Washington events, in which I was an active participant, are as instructive as any. In 1991, the citizens of the State of Washington voted on an initiative that would have authorized physicians to help their patients die "swiftly and painlessly." The results of the election were close: forty-six percent in favor, fifty-four percent against,¹⁹ after a vigorous campaign that ended with a very large voter turnout.²⁰ The ballot asked whether the existing Natural Death Act of the State of Washington should be amended to allow "a competent patient to request of a physician aid-in-dying." "Aid-in-dying" was defined as an act that would bring about the swift and painless death of the patient in a humane manner.²¹ Only a competent patient capable of making a voluntary request could receive this service from the physician at the time the request was made. At the same time, the ballot provided for two other revisions of the Natural Death Act.²² First, a persistent vegetative state was to be classified as a "terminal

17. George J. Annas, *Death By Prescription: The Oregon Initiative*, 331 NEW ENG. J. MED. 1240, 1241 (1994).

18. Olszewski, *supra* note 13, at A25; Jacobs, *supra* note 14, at A1.

19. *Results*, SEATTLE TIMES, Nov. 6, 1991, at D6.

20. *County's Voter Turnout Surpasses Previous High*, SEATTLE TIMES, Nov. 19, 1991, at C3.

21. *Group Crying Foul Over "Death With Dignity"—Some Signers of Petition Say It's Misrepresented*, SEATTLE TIMES, Sept. 6, 1990, at D4.

22. *Id.*

condition" for which life-support could be terminated and, second, nutrition and hydration were added to the life-supporting technologies that could be discontinued under provisions of the Directive to Physicians.²³

The last two provisions were not contested by the majority of those who debated the initiative. The provision that permitted aid-in-dying, however, generated heated debate. Proponents argued that it was a logical extension of our endorsement of individual autonomy. They argued for the ability of those who choose aid-in-dying to eliminate or avoid pain, suffering, and a diminished quality of life. Opponents replied that the initiative would be the first step down a slippery slope that would lead to involuntary euthanasia. The opponents pointed to the absence, in their view, of sufficient safeguards to detect and prevent: coercion of the ill and elderly to end burdensome and costly lives; the overly hasty choice of death by distressed persons; and, in the absence of any reporting requirement, the covert euthanasia of some who had not requested it. Opponents rested their argument less on principle than on the undesirable consequences that might follow. This argument, of course, rests on unverifiable predictions about the future.

Physicians were deeply divided over the Washington initiative. Polls showed an almost fifty-fifty split in opinion, although the official position of the State Medical Association was negative by an almost unanimous vote at its annual meeting. These opinions were verified in a study done one year after the election. About 1,000 Washington State physicians responded to a questionnaire about their opinions on euthanasia (defined as "deliberate administration of an overdose of medication to an ill patient at his or her request with the primary intent to end his or her life") and physician-assisted suicide (defined as "prescription of medication or counseling of an ill patient so he or she may use an overdose to end his or her own life"). Forty-eight percent agreed with the statement that euthanasia is never ethically justified and forty-two percent disagreed.²⁴ Fifty-four percent thought euthanasia should be legal in some situations, but only thirty-three percent said that they would be willing to participate.²⁵ Fifty-three percent thought assisted suicide should be legal in some situations, but only forty percent said they would be willing to help a

23. *Id.*

24. Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 *NEW ENG. J. MED.* 89, 91 (1994).

25. *Id.*

patient commit suicide.²⁶ These opinions represented strongly held views.²⁷ Obviously, a medical community that has been extensively exposed to the arguments about these issues remains deeply divided.

3. *Compassion in Dying v. Washington*

After the defeat of the Washington initiative, an organization called Compassion in Dying was formed to assist terminal patients who choose to die through rational suicide.²⁸ Assistance means "providing information, counseling, emotional support, and personal presence at the time of death."²⁹ The organization limits its attention to people who have been diagnosed with terminal illnesses and are competent to request assistance. It repudiates the use of active means, such as lethal injection or asphyxiation, advocating only self-administration by the patient of a medication that will effect death.

During 1993, Compassion in Dying, in concert with three terminally-ill patients, challenged the legality of Washington State's statute forbidding cooperation in suicide.³⁰ That statute provides that, "a person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."³¹ Violation of the statute constitutes a felony punishable by imprisonment for a maximum of five years and a ten-thousand dollar fine.³²

The plaintiffs claimed that this statute infringed upon their constitutional right to liberty under the Fourteenth Amendment.³³ Their plea was heard in Federal District Court, where Judge Barbara Rothstein issued an opinion that upheld their claim.³⁴ She agreed that the liberty interest reached the intimate personal decision involved in choosing to end one's life.³⁵ Judge Rothstein's decision represents a legal first: Never before has the legality of assisted suicide been argued as a constitutional issue in federal court and never before has it been endorsed as a constitutional right.

26. *Id.*

27. *Id.*

28. *Group Forms To Help the Dying Commit Suicide*, SEATTLE TIMES, May 4, 1993, at D1.

29. *Id.*

30. *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd* 49 F.3d 586 (9th Cir. 1995).

31. WASH. REV. CODE § 9A.36.060 (1994).

32. *Id.*

33. *Compassion in Dying*, 850 F. Supp. at 1455.

34. *Id.* at 1467.

35. *Id.*

III. THE EVOLUTION OF THE DEBATE

The Ninth Circuit recently reversed Rothstein,³⁶ but press reactions made it clear that her decision had struck a responsive chord. The *Seattle Post-Intelligencer* suggested that the Ninth Circuit had "miss[ed] the point."³⁷ When the case reaches the Supreme Court, the newspaper argued, "if reason prevails, it will be upheld."³⁸ In terms of public thinking on the issue, Rothstein may have let the genie out of the bottle.³⁹

Rothstein's decision forms part of the renewed debate about euthanasia, which erupted in the 1990s after several decades of discussion about the role of physicians and medical technology in sustaining life. As new life-sustaining technologies, such as ventilators and dialysis, became available in the 1960s, the awareness dawned that these technologies could not only save and sustain life but also support lives that some people considered "not worth living."

The case of Karen Ann Quinlan, a young woman sustained in a persistent vegetative state by a respirator, was widely publicized by the media in 1976 and became the first legal case in which a court authorized withdrawal of life support.⁴⁰ Broad discussions about foregoing life-supporting and life-extending treatment ensued in legal, medical, and public policy circles, as well as in the popular media. These discussions have led to consensus within the profession and the public that certain treatments may ethically be omitted by physician, patient and family, even if death ensues. "Orders not to resuscitate" and decisions not to initiate critical care or to discontinue such care once begun have gained wide acceptance as ethical practices in medicine. Debate continues at the margins about such issues as discontinuing nutrition or hydration. This has been a reasonable and beneficial response to an exaggerated use of technology and to a deplorable neglect of patients' preferences.

Now, however, the premonitions of some early critics of this evolution seem to have come true: If we permit omission of treatment, they warned, we will soon tolerate commission of lethal acts. If the strong injunction to save and prolong life is relaxed even in the least, the stronger prohibition against killing will begin to weaken. So,

36. *Compassion in Dying*, 49 F.3d 586 (9th Cir. 1995).

37. *Right To Die Form of Privacy*, SEATTLE POST-INTELLIGENCER, Mar. 15, 1995, at A14.

38. *Id.*

39. *Id.*

40. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

despite the President's Commission's endorsement of the legal prohibition against active killing, the words of the philosopher Rachels may become the common wisdom: "[I]f my contention is right, it follows that active euthanasia is not any worse than passive euthanasia . . . and the difference in some cases in their consequences . . . may make active and not passive euthanasia, the morally preferable option."⁴¹

Thus, in only a few years, the debate over euthanasia has moved from acceptance of "foregoing life-support" to serious consideration of lethal acts. In the face of this apparent confirmation that we are starting down the slippery slope, many physicians may begin to worry. Most physicians, it seems, find euthanasia repugnant. Yet, if the classical arguments are philosophically and historically indefensible, how can that repugnance be rationally justified? What "arguments for the faith that is in them" can those physicians who are reluctant to become accomplices in aid-in-dying offer? The President's Commission urges, "health care professionals, individually and through their professional associations must become more active in creating, explaining and justifying their standards regarding appropriate professional rules."⁴² Yet, if the classical arguments seem so unconvincing to the ethicists, how can health care professionals accomplish this task?

The philosophers had concentrated on the logic of arguments for and against euthanasia. As mentioned above, arguments formerly considered logically impregnable have yielded to closer logical scrutiny and many of them, such as the distinctions between "action" and "omission" are now standing, if they stand at all, on shaky logical ground. Many people have turned from the logical and philosophical arguments to the pragmatic and consequentialist ones. They ask not whether euthanasia is right or wrong in itself, but whether its tolerated practice in a society will bring about positive or negative consequences. This is an argument in which non-philosophers have as much right to participate as philosophers, and in which physicians, who live very close to the problem of dealing with death, have a particular right to join.

IV. THE PRINCIPLE BEHIND EUTHANASIA

Determining whether the consequences of euthanasia will be positive or negative depends upon the principle on which we choose to

41. Rachels, *supra* note 6, at 80.

42. PRESIDENT'S COMMISSION, *supra* note 8, at 89.

base the ethics of euthanasia. Traditionally, that principle has been the moral obligation to relieve pain and suffering. In the long history of the debates over active euthanasia, the earliest arguments concentrated on bringing merciful deaths to those who were suffering great pain. Euthanasia was an act of beneficence or mercy, hence the common term "mercy killing."

The voluntary choice of the patient was mentioned but not considered central or even necessary. In these earlier discussions, it was not unusual for a proponent to slip easily from advocating euthanasia for those requesting it to advocating it for those whose lives were, in the eyes of others, terrible. For example, a physician wrote in 1944:

"To end a life that is useless, helpless and hopeless seems merciful The useless, helpless and hopeless are of many kinds. They either always have been or have become unfit in the struggle of life idiots and the insane, imbeciles and morons, psychopaths both mild and severe, criminals and delinquents, monsters and defectives, incurables and the worn out senile."⁴³

A leading medical ethicist, Joseph Fletcher, who centered his moral philosophy on the freedom of individuals, advocated voluntary euthanasia, but seemed to tolerate what he called a "partly eugenic position," involuntary euthanasia for "monstrosities at birth and mental defectives"⁴⁴

Arguments based on beneficence were vulnerable to a strong counterargument, namely, that the opinion that some persons might hold about "the useless, helpless and hopeless," might be seriously discriminatory. The meaning of those terms is colored by ideology, prejudice and bias. "Useless" depends on what some individuals or a whole society counts as a contribution, and estimates of this can differ dramatically according to culture, economic status, education, race, and so forth.

In the current arguments, the focus shifts from escaping a "useless" existence or relieving pain to the freedom and autonomy of the patient. This shift puts the responsibility for evaluating quality of life into the hands of the terminal patient who wants his or her life ended. Other people are only the implementers, not the evaluators. Thus, in principle, the "slippery slope" is avoided: The level ground of autonomy—persons making competent judgments in their own

43. Frank Hinman, *Euthanasia*, 99 J. NERVOUS & MENTAL DISEASE 640 (1944).

44. Joseph F. Fletcher, *MORALS AND MEDICINE* 207 (1954).

behalf—becomes the basis for legalizing euthanasia or, more accurately, assisted suicide. This is the argument that Judge Rothstein accepted and termed a “liberty interest” protected by the Fourteenth Amendment.⁴⁵

However, it is not easy to stay within the bounds of that “liberty interest.” Emotionally, logically, and even legally, the principle of beneficence creeps back into the argument. Some persons may feel that, should they have an early diagnosis of a deteriorating condition that would compromise mental status, such as Alzheimer’s disease, they should be allowed to give an advance directive covering aid-in-dying as well as abatement of life support. An advance directive implies that someone other than the patient will make the decision at the appropriate time. That other person will be bound to honor the patient’s wishes, apparently acting on the principle of the patient’s autonomy, but will inevitably have to make a personal judgment about the welfare of the patient under the current conditions. This reintroduces the principle of beneficence and the value judgments of people other than the patient.

In addition, the conditions of certain patients, such as those severely damaged by trauma or congenital conditions, call for alleviation. Such patients have never had the opportunity to make a request for aid-in-dying; but, should they not have the right to that service when it is reasonable? Again, the principle of beneficence appears even more forcefully.

The argument that aid-in-dying should extend to such patients can appeal to the commonly accepted legal principle that the incompetent have not lost their fundamental rights. This principle has been recognized in important judicial decisions about foregoing life support; why should it not be recognized when the question is aid-in-dying, proponents may ask.

V. DO SAFEGUARDS INFRINGE UPON PERSONAL AUTONOMY?

Although legal and ethical toleration of euthanasia is based upon the principle of personal autonomy, the social practice of euthanasia must be surrounded, as all serious commentators note, with strong safeguards to prevent abuse. Oregon’s statute and the other proposed statutes hedge the act of requesting aid-in-dying with many barriers: Persons requesting such aid must be diagnosed by several physicians as terminally-ill; they must express themselves multiple times and in

45. *Compassion in Dying*, 850 F. Supp. at 1455.

writing; they must be assessed for mental competence; they must wait certain time periods; they must obtain witnesses who will attest to the validity of their requests. These safeguards are intended to prevent the slide down the slippery slope that could otherwise sweep up the unwilling, the incompetent, the depressed. At the same time, each of them infringes on the patient's autonomy. Indeed, each safeguard puts into the hands of others, principally physicians, the right to veto a request. Thus, ironically, an attempt to honor personal autonomy may become another prison. Although many who seek to escape the prison of a suffering life will succeed, some will still be restrained by these procedural safeguards from doing so.

VI. CONCLUSION

Clearly, the adoption of statutes such as Oregon's Measure 16 will be seen by many as a major humanitarian advance. When technological medicine, so beneficial in many respects, can save lives but doom patients to great suffering for the remainder of their time, those who face such dreadful and diminished lives should have the power to demand that medicine, which has enabled these lives to exist, also be empowered to end them. The proponents of humane and dignified death make this claim and often illustrate it with two typical vignettes: the patient trapped in the coils of medical machinery and the patient agonized by intractable pain. Both were prominent images in the political campaigns in Washington, Oregon, and California.

It is true, of course, that modern medicine saves lives that it cannot otherwise improve. It is also true that life is prolonged today by the drugs that cure a pneumonia in a fifty-year-old or leukemia in a twelve-year-old. Life is prolonged by nutrition, by immunization, by clean water, and by safer work places. Still, many proponents of a humane "death with dignity" seem to suggest that active euthanasia will abolish the terminal indignity of death itself. Unfortunately, it will not. Even with this "humane" legislation, we must struggle with the ineradicable human problem of finitude. The old often become old without being subjected to intensive care, and they deteriorate in body and mind despite what medicine can do. Many persons die miserably outside and apart from the world of health care. Many of these will not have the opportunity to request aid-in-dying, and many, even if they had the opportunity, might choose not to do so.

Euthanasia for the voluntary and competent patient seems plausible and liberal. However, it can be criticized as yet another facile technological solution to a perennial human problem. We can efficiently abolish dying—that is, the process that leads to death—but

we cannot abolish death itself. We can hide the misery but not the ultimate fact. If we can ethically and legally do that for someone who requests it, why not for each and every sufferer of terminal misery? The possibility of swift and painless death will inevitably become the necessity. The privilege granted to the competent will be seen as a right of which others, less fortunate than the competent, should not be deprived. In the end, banishing the misery of dying may not be the undiluted benefit that it appears from a distance.

We may pass laws that tolerate euthanasia and protect those decent people who request and help perform it. But we must never become comfortable with the practice.