

ACTIVE EUTHANASIA

Two recent proposals on medical decisions to end life, one defeated and the other passed, dominate and define the ongoing debate over killing and letting die. In a November 5, 1991 referendum in Washington State, Proposition 119,¹ which would have legalized physician-assisted suicide as well as active euthanasia, was defeated in a surprisingly close vote of 54 to 46 percent. Barely a month later, on December 1, 1991, the federal Patient Self-Determination Act (PSDA)² went into effect. That Act, passed by Congress as part of the Omnibus Budget Reconciliation Act of 1990, mandates that every health-care facility receiving Medicare or Medicaid funding—hospitals, nursing homes, health-maintenance organizations (HMOs) and home-health-care programs—must inform its patients or clients of their right to decline unwanted medical treatments, including those that potentially prolong life.

The PSDA is the culmination of nearly two decades of concern in the United States over the use of medical technology to maintain life when life itself has proven overly burdensome or painful to the patient. From the *Quinlan*³ case in New Jersey in 1976 to the U.S. Supreme Court's ruling in *Cruzan*,⁴ American courts have been challenged to recognize the right of patients—competent and incompetent—to decline unwanted and unwarranted medical interventions. That right is articulated in the Vatican's 1980 Declaration on Euthanasia, which states:

[O]ne cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide [or euthanasia]; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected.⁵

The Vatican Declaration, summarizing some four hundred years of church teaching on the right to decline extraordinary or disproportionate means of preserving life, makes a sharp distinction between refus-

¹ Proposition 119. An Amendment to Article 1, Section 2, Chapter 112, Laws of 1979; Susan M. Wolf et al., "Sources of Concern About the Patient Self-Determination Act," *New England Journal of Medicine* 325 (1991) 1666–71.

² 42 U.S.C. 1395 cc (a) (1) et seq. (as amended, Nov. 1990); see John J. Paris, S.J. and Kevin J. O'Connell, "The Patient Self-Determination Act of 1990," *Clinical Ethics Report* (May 5, 1991) 1–10.

³ *In re Quinlan*, 70 N.J. 10, 355 A. 2d 647 (1985).

⁴ *Cruzan v. Director Missouri Dept. of Health*, 110 S. Ct. 2841 (1990); Lisa Sowle Cahill, "Bioethical Decisions to End Life," *TS* 52 (1991) 107–27.

⁵ Sacred Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," *Origins* 10 (1980) 154–57.

ing measures that would serve "only [to sustain] a precarious and burdensome prolongation of life" and suicide or active euthanasia. The former is permitted; the latter is prohibited.

The word *euthanasia* ("a good death") is subject to widely differing understandings, and the distinction between active and passive euthanasia (killing and letting die) is frequently collapsed into the one term. James Rachaels' now famous essay on "Active and Passive Euthanasia"⁶ denies that there is any real difference between the two. For him, "if a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection." In fact, Rachaels argues that, since the latter action spares the patient from prolonged suffering, it is "actually preferable to passive euthanasia." Marcia Angell, Executive Editor of the *New England Journal of Medicine*, makes the same point in a recent editorial; after stating that "many of us believe that euthanasia is appropriate under certain circumstances and that, indeed, it should be legalized," she concludes that this should be done because "euthanasia is more humane than forcing a patient to continue a life of unmitigated suffering."⁷

To avoid confusion in the debate, it is imperative to distinguish euthanasia from termination of treatment. It is also imperative to have a clear definition of terms. For the purposes of this note, euthanasia is defined as the deliberate action by a physician to terminate the life of a patient. The clearest example is the act of lethal injection. Singer and Siegler's "Euthanasia—A Critique" provides the helpful distinction between such an action and such other acts as the decision to forego life-sustaining treatment (including the use of ventilations, cardio-pulmonary resuscitation, dialysis, or tube feedings—the issues raised in the *Cruzan* case); or the administration of analgesic agents to relieve pain; or "assisted suicide" in which the doctor prescribes but does not administer a lethal dose of medication; or "mercy killing" performed by a patient's family or friends.⁸

Church tradition, as the Vatican Declaration makes clear, opposes euthanasia or the direct intentional killing of innocent life, whether of "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." Furthermore, the Church holds that "no one is permitted to ask for this act

⁶ James Rachaels, "Active and Passive Euthanasia," *New England Journal of Medicine* 292 (1975) 78–80.

⁷ Marcia Angell, "Euthanasia," *New England Journal of Medicine* 319 (1990) 1348–50.

⁸ Peter A. Singer and Mark Siegler, "Euthanasia—A Critique," *New England Journal of Medicine* 322 (1991) 1881–83.

of killing for himself or herself," nor is it morally licit to consent to such an action for one entrusted to your care. The reason for these moral imperatives is clear: "Only the Creator of life has the right to take away the life of the innocent." To arrogate that right to ourselves, whether as patient, guardian, or caregiver would be a "violation of the divine law" and "an offense against the dignity of the human person".

Proposition 119 stood as a challenge to that tradition. In Washington State, for the first time anywhere in the world, voters were asked to approve what its proponents labeled "a new medical service": authorization for physicians actively to assist a terminally ill patient to die. Initiative 119, which was sponsored by the Hemlock Society, was circulated with the official ballot title, "Shall adult patients who are in a medically terminal condition be permitted to request and receive from a physician aid-in-dying?" Beneath that innocuously worded heading was the reality that "aid-in-dying" meant "aid in the form of a medical service, provided in person by a physician, that will end the life of a conscious and mentally qualified patient in a dignified, painless, and humane manner, when requested voluntarily by the patient through a written directive . . . at the time the medical service is to be provided."

Albert Jonsen, a medical ethicist at the University of Washington Medical School, noted that this was not just a simple amendment to earlier living-will legislation; it represented a radical change in medical practice.⁹ For the first time since the Hippocratic Tradition established prohibitions some 2,500 years ago against physicians directly taking the lives of their patients, physicians would be authorized to kill dying patients. Jonsen, who is no alarmist, wrote in *Commonweal* just prior to the vote: "The state of Washington is on the edge of a moral cataclysm." Public opinion polls suggested that he was right. A Louis Harris poll indicated that 67 percent of the voters in the state approved of the proposal. A more nuanced poll conducted by the Harvard School of Public Health¹⁰ revealed that 64 percent of Americans favor physician-assisted suicide and euthanasia for terminally ill patients who request it. Of adults under thirty-five, 79 percent supported the idea. The most startling finding of that poll was that, of the religious groups surveyed, Catholics were the greatest supporters of the proposition. Seventy-one percent said they would vote for the initiative if it were on their ballot.

The debate over euthanasia is not new. Only the emphasis has

⁹ Albert R. Jonsen, "What Is at Stake?" *Commonweal* 118 (August 9, 1991) 466-68.

¹⁰ Richard A. Knox, "Poll: Americans Favor Mercy Killing," *Boston Globe*, 3 Nov. 1991, A1.

shifted. In a thoughtful and thorough survey of the euthanasia movement, Humphry and Wickett¹¹ trace the issue from classical Athens, where magistrates kept a supply of poison for anyone who wished to die ("If your existence is hateful to you, die; if you are overwhelmed by fate, drink the hemlock"), through to the rise of Christianity, in which suicide was denounced as a violation of God's will.

In the U.S., the euthanasia movement gained prominence in the late 1930s with the founding of the Euthanasia Society of America. It had as its agenda "the belief that, with adequate safeguards, it should be made legal to allow incurable sufferers to choose immediate death rather than await it in agony."¹² A bill sponsored by the Euthanasia Society in the New York legislature in 1938 was defeated. But it generated interest and provoked the first article to appear in an American medical journal favoring euthanasia. Abraham Wolbarst in his "The Doctor Looks at Euthanasia," published in the May 19, 1939 issue of *Medical Record*, wrote: "The vast majority of thinking people favor euthanasia as a humanitarian principle. . . . The human mind revolts at the thought of unnecessary suffering . . . it is not how *long* we humans live, but *how* we live that is important."

The euthanasia movement took a dramatic turn in Germany in the 1920s and 30s which would prove its undoing for decades. With the prevalent notion of *Lebensunwerten* ("life not worthy of life"), it became standard practice beginning in the 20s for German physicians to terminate "useless" lives. That policy subsequently provided the rationale for the Nazi practice of murdering the mentally and physically handicapped which ultimately culminated in the Holocaust. The horror of that experience so dominated humanitarian thinking in the four decades following the Nuremberg war-crime trials that, as Derek Humphry put it, it "effectively hampered the intellectual and legal progress of the euthanasia movement" in the English-speaking world.

In a 1947 Gallup poll, for example, only 37 percent approved of a physician being authorized to end a patient's life by some painless means if the patient and family requested it. It was not until the 1960s, with Louis Kutner's proposal for a patient-instigated directive—a so-called "living will"—in which a patient stated he would not want medical measures utilized to prolong life, that the "death with dignity" movement revived.

One measure of the shift, particularly interesting in light of Washington State's Proposition 119, was the results of a 1971 survey of

¹¹ Derek Humphry and Ann Wickett, *The Right to Die: Understanding Euthanasia* (New York: Harper & Row, 1986).

¹² *New York Times*, 17 Jan. 1938 (reported in Humphry & Wickett 14).

medical students at the University of Washington School of Medicine.¹³ Ninety percent of fourth-year medical students and 69 percent of first year students said they would practice passive euthanasia with a signed statement of the patient. Half the students (46 percent in both cases) favored changes in permitting active euthanasia.

In the 1970s and 1980s, the movement took two directions, each of which is represented in the current debate and which culminated in the PSDA and Proposition 119. Legislation recognizing livings wills and health-care proxies and the court battles over the "right to die" were the vehicles used to protect individuals from unwanted medical treatment. At the same time, such groups as EXIT in England and its American counterpart, the Hemlock Society, pressed for active euthanasia. In 1979, a Scottish EXIT group published the first guide or "suicide recipe book." It gave detailed descriptions of how to end one's life. Derek Humphry soon followed with his guide on "self-deliverance," *Let Me Die Before I Wake*.

Support for physician-assisted suicide remained limited to fringe groups until the publication in 1989 in the prestigious *New England Journal of Medicine* of an article in which ten out of twelve physicians from the leading medical centers of the United States went beyond their earlier support for termination of unwanted medical treatment to endorse physician-assisted suicide. In an article entitled "The Physician's Responsibility Toward Hopelessly Ill Patients," these physicians wrote: "All but two of us . . . believe that it is not immoral for a physician to assist in the rational suicide of a terminally ill patient." The group, somewhat surprisingly, stopped short of a similar endorsement of active euthanasia. The reasoning is illuminating: "The social climate in this country is very litigious, and the likelihood of prosecution if a case of euthanasia were discovered is fairly high—much higher than the likelihood of prosecution after a suicide in which the physician has assisted."¹⁴

That report by distinguished clinicians from the most reputable institutions in the country followed by just one year the publication in *JAMA* of "It's All Over, Debbie,"¹⁵ an anonymous account of a gynecology resident's decision to inject a young cancer patient with a lethal dose of morphine. That action, done at 3:00 A.M. by a physician who had no prior knowledge of the patient on the basis of her request, "Let's

¹³ E. Harold Laws et al., "Views on Euthanasia," *Journal of Medical Education* 46 (1971) 540–42.

¹⁴ Sidney H. Wanzer, David D. Federman, S. James Edelstein, et al., "The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look," *New England Journal of Medicine* 320 (1984) 844–49, at 845.

¹⁵ Anonymous, "It's All Over, Debbie," *JAMA* 259 (1988) 272.

get this over with," provoked a storm of outrage. Willard Gayland and three of his physician colleagues, in a bluntly worded essay entitled "Doctors Must Not Kill,"¹⁶ expressed their horror at what had been done and their incomprehension at *JAMA's* having published the account. Their incredulity was expressed by their question: "What in the world is going on?" For them, the anonymous author of the "Debbie" essay broke the law, breached medical protocol, and violated the most deeply held and hallowed canon of medical ethics: Doctors must not kill. As they put it, "Generations of physicians and commentators on medical ethics had held fast to the distinction between ceasing useless treatments (or allowing to die) and active, willful taking of life." Since the time of Hippocrates until as recently as a 1989 statement of the Judicial Council of the American Medical Association, Western medicine has regarded the killing of patients, even on request, as a profound violation of the deepest meaning of the medical vocation. Leon Kass undertook to explain the reasons for this prohibition in a deeply probing essay in *The Public Interest*.¹⁷ There he argued that the basis for the shift in attitude, which has already led to some 5,000 cases of active euthanasia or assisted suicide a year in the Netherlands, is an overemphasis on freedom and personal autonomy, expressed in the view that each one has a right to control his or her body and life, including the end of it. In this view, physicians are bound to acquiesce not only to demands for termination of treatment, but also to intentional killing through poison, because the right to choose—freedom—must be respected even more than life itself. The second reason advanced for killing patients is not a concern for choice but the assessment by the patient or others that the patient's life is no longer deemed worth living. It is not autonomy but the miserable or pitiable condition of the body or mind that warrants, in Kass's words, "doing the patient in."

Kass's arguments against those positions constitute a commentary on the now classic essay written in the *Minnesota Law Review*¹⁸ by Yale Kamisar some thirty years earlier. Kamisar asked: Are not the risks and mistakes in authorizing medically assisted voluntary euthanasia too great and, more importantly, the possible radiations from the proposed change too overwhelming? How is one to establish that the

¹⁶ Willard Gayland, Leon R. Kass, Edmund D. Pellegrino and Mark Siegler, "Doctors Must Not Kill," *JAMA* 259 (1988) 2139–40.

¹⁷ Leon R. Kass, "Neither for Love Nor Money: Why Doctors Must Not Kill," *The Public Interest* 94 (1989) 24–45.

¹⁸ Yale Kamisar, "Some Non-Religious Views against Proposed Mercy Killing Legislation," *Minnesota Law Review* 42 (1958) 1042–71.

patient's choice is "voluntary"? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them? And how much freedom of choice does one really have if he does not want to die, but feels he should not live on because to do so, when there looms the legal alternative of euthanasia, is to be selfish or cowardly?

These realistic problems pale in comparison to the potential difficulties engendered in a society grown indifferent to the taking of life. That indifference would be compounded if the very segment of society committed to saving life were commissioned to destroy it. Once the euthanizing of a patient or two becomes but part of a routine day's work, the brutalization process so vividly described in Leo Alexander's classic essay on "Medical Science Under Dictatorship"¹⁹ (recounting the experience of Nazi Germany) becomes an all too real possibility. And once begun, who sets the limits on "a life not worth living," and how are the limits set?

That such fears are not far-fetched is seen in the actions of Dr. Jack Kevorkian, the Michigan pathologist who in three instances during the past year has used his self-designed "suicide machine" to assist non-dying individuals end their lives.²⁰ The first of those, Janet Atkins, was a functioning, lucid woman who feared that the debilitating consequences of the early onset of Alzheimer's disease would render her unable to end her life when she chose to. The others were a 43-year-old woman with multiple sclerosis and a 58-year-old woman with a severe, but treatable, pelvic inflammation.

Kevorkian's crude device, the primitive surroundings in which the assisted suicides occurred, and his intransigent attitude offended many. It also led to the Michigan Medical Society summarily revoking his medical license. No such penalty has been attached to the actions of Dr. Timothy Quill, a Rochester, New York physician, who reported in the *New England Journal of Medicine*²¹ how he had given instructions and provided adequate supplies of barbiturates so that Diane, a patient he had known and treated for years who was now dying of cervical cancer, could and did end her life. Unlike the outcry over the publication of "It's All Over, Debbie" and the negative reaction to Dr. Kevorkian, the response to Dr. Quill's participation in a patient's sui-

¹⁹ Leo Alexander, "Medical Science Under Dictatorship," *New England Journal of Medicine* 214 (1949) 39-47.

²⁰ Israel Wilkerson, "Opponents Weigh Action against Doctor Who Aided Suicides," *New York Times*, 25 Oct. 1991, National Edition, p. 1. See also George Annas, "Killing Machines," *Hastings Center Report* (March/April 1991) 33-35.

²¹ Timothy Quill, "Death and Dignity: A Case of Individualized Decision Making," *New England Journal of Medicine* 324 (1991) 691-94.

cide was mostly approval.²² Typical was the response of a physician who wrote: "Dr. Quill provided his patient with exactly what was lacking in the more notorious cases involving Dr. Jack Kevorkian and the anonymous author of 'It's All Over, Debbie,' comprehensive medical care, with deep concern for the patient's well being and respect for her choices."

Was the shift in response to these cases of euthanasia or physician-assisted suicide limited to the "mode of disposal"? Is aesthetic sensitivity the only barrier to euthanasia? Is our objection that guns and knives and crude homemade "killing machines" used in the back of rusted out vans or backwoods cabins are messy or offend our sense of propriety? Do we object to suicide or euthanasia "only if," in J. Roman's phrase, "[the victim] looks disgusting and not just dead?" And what of Roman's proposal in *Exit House*²³ that we should make suicide available to all over eighteen who request it? Derek Humphry's best selling *Final Exit*²⁴ likewise makes no distinction on who can partake in suicide. With his latest self-help text, all that is required is a desirous individual and a ready source of the lethal potion.

Critique of the Case for Euthanasia

Singer, Kass, and Callahan, as well as the bishops of the state of Washington,²⁵ use essentially the same public-policy arguments that Kamisar employed in opposition to euthanasia. A splendid special supplement of *Commonweal* devoted to euthanasia²⁶ contains an essay by Daniel Callahan which succinctly states those public-policy arguments. Callahan writes that the fear of dying is frequently surpassed today by the yet more powerful fear of being forced to endure destructive pain, or to live out a life of unrelieved, pointless suffering. The movement to legalize euthanasia and assisted suicide is a strong and, as he puts it, "historically inevitable response to that fear."²⁷ He traces

²² Correspondence: "Death and Dignity: The Case of Diane," *New England Journal of Medicine* 325 (1991) 658-60.

²³ Jo Roman, *Exit House* (New York: Seaview, 1980).

²⁴ Derek Humphry, *Final Exit* (Eugene, Oreg.: Hemlock Society, 1991).

²⁵ Archbishop Thomas Murphy, "Washington State's November Ballot: Euthanasia and Abortion," *Origins* 21 (1991) 298-302; Washington Bishops, "Initiative 119: The Real Choice," *Origins* 21 (1991) 302.

²⁶ *Commonweal* 118 (Aug. 9, 1991). This Special Supplement, entitled *Euthanasia: Washington State Initiative 119*, included articles by Albert R. Jonsen, "Initiative 119: What Is at Stake?" 466-68; Carlos F. Gomez, "Euthanasia: Consider the Dutch" 469-72; Leon R. Kass, "Why Doctors Must Not Kill" 472-76; Daniel Callahan, "'Aid-in-Dying': The Social Dimensions" 476-80.

²⁷ Callahan, "Aid-in-Dying" 476.

that response, as do Kass and Kamisar, in part to the failure of modern medicine to reassure us that it can manage our dying with dignity and comfort and to the fact that, as the Washington bishops put it, "the intense individualism of our culture" leads to the demand that we must be in control, that we be masters of our fate. We resent and reject any kind of dependence as incompatible with human dignity.

In the face of this powerful, almost relentless, dynamic, Callahan asks how we can regain and retain control. He admits that "for many the answer seems obvious and unavoidable, that of active euthanasia and assisted suicide."²⁸ Callahan rejects that solution, as the bishops do. Though it is ultimately their religious heritage and convictions that buttress that stand, the bishops realize that in a pluralistic secular society, it is public-policy implications and not religious beliefs that must be the basis for their political opposition to Proposition 119. It was Callahan's essay and a subsequent commentary on Proposition 119 by Richard A. McCormick, S.J.²⁷ that provided the policy arguments used by the bishops.

As Callahan put it, "We should not deceive ourselves into thinking of euthanasia or assisted suicide as merely personal acts, just a slight extension of the already-established right to control our bodies and to have medical treatment terminated . . . [Proposition 119] is a radical move into an entirely different realm of morality: that of the killing of one person by another."³⁰ As such, it would change the traditional role of the physician from healer to terminator. It would require intrusive regulation and oversight into the most private aspect of life, namely dying. It would also add substantially to the range of permissible killing in our society.

The most notable public-policy implication is the potential for abuse in the authorization of "private killings," i.e. those in which the agreement of one person to kill another "is ratified by the persons themselves, but not by public authorities."³¹ How do we control, regulate, or even oversee these killings? What assurance is there or can there be that the limitations enacted in the legislation will be strictly adhered to? The suffering of the person to be killed is, as Callahan notes, "subjective, unmeasurable by, and intangible to an outside observer." If freedom and suffering are to be the norms of euthanasia, there is no logical way in the future (1) to deny euthanasia to anyone who re-

²⁸ Ibid.

²⁹ Richard A. McCormick, S.J., "Biomedical Problems in the Nineties," *Catholic World* 234 (1991) 197-201; see also Leo Alexander, "Medical Science under Dictatorship," *New England Journal of Medicine* 241 (1949) 39-47.

³⁰ Callahan, "Aid-in-Dying" 477

³¹ Ibid.

quests it for whatever reason, terminal illness or not, or (2) to deny it to the suffering incompetent, even if they do not request it. The legal safeguards and procedures we specify to prevent that from happening are, as it were, written in smoke—difficult to discern and easily dissipated. Such barriers cannot provide protection over time.

The problem lies in the flawed logic of the moral premise of euthanasia: our right to self-determination and our claim upon the mercy of others, especially physicians, to end our suffering. Consider self-determination, Callahan suggests. If, as it is proposed, the competent adult has a right to euthanasia for the relief of suffering, is it not a restriction on self-determination to limit euthanasia to those who are terminally ill or profoundly pained? "How," he inquires, "can self-determination have any limits?" As for relief of suffering, why should relief be confined to competent patients? Isn't the suffering of the incompetent as great, if not greater? Doesn't it demand as much concern? Further, if the physician who acts to kill the patient does so in the belief that a life marked by some form of suffering is not worth living, how can the physician deny the same relief to a person who cannot request it, or who requests it but whose competence is in doubt?

Our duty to relieve suffering, Callahan notes, cannot justify the introduction of new evils into society. The risk of doing that is simply too great. It is too great because it would take a disproportionate social change to bring it about, one with implications that extend far beyond the sick and dying. It is too great because in Callahan's powerful words, the history of the twentieth century should demonstrate that "killing is a contagious disease, not easy to stop once unleashed in society."³²

The Washington bishops adopted those arguments and added the admonition of Richard McCormick that "those who insist that all life-support systems must be used at all times, even though the patient can no longer benefit from them, could well be unwittingly contributing to public acceptance of active euthanasia."³³ What the bishops had in mind is clear from the context in which their caution is placed: "People cringe at the prospect of a dying prolonged by tortuous, aggressive and isolating interventions. They are aware of the Nancy Cruzans of this world as they linger on hopelessly from year to year."³⁴

The Washington bishops, joined by their episcopal brethren in Oregon, address the question of the care of the irreversibly comatose or persistent vegetative patient in a pastoral entitled "Living and Dying

³² Ibid. 480.

³³ Richard A. McCormick, "Biomedical Problems" 199.

³⁴ Thomas H. Murphy, "Washington State's November Ballot" 300.

Well."³⁵ In language quite at odds with that used by the Massachusetts bishops, who insist "the authentic teaching of the Catholic Church" requires that "nutrition and hydration should always be provided [to irreversibly comatose patients] when they are capable of sustaining human life,"³⁶ the Catholic bishops of the Pacific Northwest acknowledge that "conscientious Catholic moral theologians and many others in our society have not achieved consensus about this point."³⁷ Given the lack of agreement on the issues, the Washington and Oregon bishops hold that "decisions regarding artificially administered nutrition and hydration must be made on a case-by-case basis, in light of the benefits and burdens they entail for the individual patient," and then conclude: "In appropriate circumstances, the decision to withhold these means of life support can be in accord with Catholic moral reasoning and ought to be respected by medical caregivers and the laws of the land."³⁸

The fears of the Washington bishops that restrictions on active euthanasia, once unleashed, could not be restrained are born out from studies of euthanasia as practiced in the Netherlands. Though technically illegal, active euthanasia is tolerated in the Netherlands where physicians end the lives of their patients under certain specified conditions: the patient's consent must be free, conscious, explicit and persistent; patient and physician must agree that suffering is intolerable; other measures for relief must have been exhausted; a second physician must concur; these facts must be recorded and the action must be reported to the state prosecutor.³⁹

³⁵ Oregon and Washington Bishops, "Living and Dying Well," *Origins* 21 (1991) 346–52.

³⁶ The Massachusetts Catholic Conference, *The Health Care Proxy Bill: A Catholic Guide* (Boston: Pilot Publishing Co., Dec. 1, 1990) 1–8, at 3.

³⁷ Oregon and Washington Bishops 349–50.

³⁸ Ibid. 350. Additional support for the Washington and Oregon Bishops' Statement on the moral option to withhold or withdraw nutrition and fluids from dying patients or those in a persistent vegetative condition are found in the Texas Bishops' Statement "On Withdrawing Artificial Nutrition and Hydration," *Origins* 21 (1990) 53 ff.; United States Bishops' Committee for Pro-Life Activities, "The Rights of the Terminally Ill," *Origins* 16 (1987) 222–26; Catholic Health Association of Wisconsin, "Guidelines on the Use of Nutrition and Fluids in Catholic Health Care Facilities" (1989); Richard A. McCormick, S.J., "Nutrition-Hydration: The New Euthanasia?" in *The Critical Calling* (Washington, D.C.: Georgetown Univ., 1989); John J. Paris, S.J., "The Catholic Tradition on the Use of Nutrition and Fluids," in Kevin Wildes, ed., *Birth, Suffering and Death* (Dordrecht: Kluwer, 1991). See also Lisa Sowle Cahill's coverage of the issue in *TS* 52 (1991) 110–19.

³⁹ M. A. M. de Wachter, "Active Euthanasia in the Netherlands," *JAMA* 262 (1989) 3316–19; A. M. J. Ten Have Henk, "Euthanasia in the Netherlands: The Legal Context and the Cases," *Hospital Ethics Committee Forum* 1 (1989) 412–45; R. Fenigsen, "Euthanasia in the Netherlands," *Issues in Law and Medicine* 6 (1990) 229–45; R. Fenigsen,

That actual practice in the Netherlands deviates widely from the agreed upon constraints is documented in two recent studies. Carlos F. Gomez reports that most acts of euthanasia in the Netherlands go unreported and uninvestigated by public authorities.⁴⁰ In his own survey of 26 cases of active euthanasia, only 15% had been reported to the prosecutor's office. Despite Proposition 119's assurance of codification into law, Gomez correctly notes that, had it passed, there would be no greater regulation of the private killings in the state of Washington than there is in the Netherlands. If, in instances of euthanasia, the official cause of death is listed as "respiratory arrest," and the massive overdose of narcotics that lead to that arrest is not even mentioned, then cases of physician killing would blend imperceptibly into the larger background of death from natural causes. Under such practice identification and oversight of euthanasia would prove impossible.

Though exact numbers are difficult to ascertain, a survey which was commissioned by the Dutch government and chaired by the attorney general of the Dutch Supreme Court indicates that "1.8% of deaths in the Netherlands are the result of physician assisted suicide."⁴¹ More revealing is the finding that 54% of physicians interviewed had participated in at least one case of active euthanasia and another 34% stated that, though they had not done so, they would be prepared to do so if asked. Of the 12% who said they would not participate in such an action, more than half said they would refer patients requesting euthanasia to a colleague with a more permissive attitude. In other words, the official Dutch study found that an overwhelming majority of physicians in the Netherlands see euthanasia, under certain circumstances, as an accepted element of medical practice. The circumstances mentioned in the study were "loss of dignity, pain, unworthy dying, being dependent on others, or tiredness of life." In only 10 of 107 cases was pain the only reason.

While most of the cases of euthanasia involved explicit patient requests, the attorney general's survey found that .8% of the deaths occurred without the patient's request. In these cases, it occurred "after consultation with the family, nurses, or one or more colleagues." The authors found that in the Netherlands there are over 25,000 pa-

"A Case Against Dutch Euthanasia," *Hastings Center Report* (Special Supplement, January/February, 1989) 22-30.

⁴⁰ Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (New York: Free Press, 1991). Gomez's findings are more readily available in "Euthanasia: Consider the Dutch" (n. 26 above).

⁴¹ Cf. the brief report of the survey, Paul J. Van der Maas et al., "Euthanasia and Other Medical Decisions concerning the End of Life," *Lancet* 338 (September 14, 1991) 669-74, at 672.

tients each year who seek assurance from their physician that they will assist them if life becomes unbearable. Each year about 9,000 explicit requests are made, of which less than one-third are agreed to by physicians.

The Dutch apologists for the practice suggest that euthanasia accounts for two to three percent, at most, of all deaths in the Netherlands. In a country with a published mortality rate of 120,000, this would imply from 2,400 to 3,600 cases of euthanasia a year. In the United States, with a rate of approximately two million deaths a year, this would translate into some 40,000 to 60,000 people killed each year by their physician. That not all of these would be voluntary is seen in Gomez's finding that, while most of the cases he studied fit the criteria established by the courts and Dutch medical profession, in four out of the twenty-six cases he investigated it was clear that the patient was incapable of giving consent, or it was doubtful that consent could have been obtained properly. He reports that in none of these cases was the public prosecutor notified.

The Dutch experience shows that to construct the argument for euthanasia in terms of autonomy is to misconstrue the reality of what happens to those who cannot be truly autonomous. If this is true in a nation with universal health-care coverage, how much greater the danger in a society in which 37 percent of the population is uninsured and concern for rising costs dominates the health-care agenda. And how much greater in a system in which there are no safeguards built into the legislation to protect the vulnerable. The practice of euthanasia, at least as envisioned in Proposition 119, would place patients, particularly the most vulnerable of patients, at intolerable risk. As the Washington bishops note, Proposition 119 contained no special requirements for the physicians who would administer lethal injections. There was no requirement for determining the mental state or competency of the patient. There was no waiting period required, no notification of family, no minimum residency, and no notification of euthanasia to public authorities.

The demand for active euthanasia is, in part, a response to the fear of entrapment in a technologically sophisticated, seemingly uncaring world of medicine. Unrestrained freedom to end one's life or to have it ended by a physician ought not to be the only response to that fear; nor is such a response without grave social implications. That legitimate fear does not call for state-sanctioned suicide or euthanasia; it calls for a rejection of the mindset that insists that we utilize *any* intervention capable of sustaining life—indifferent to the pain, suffering and burden to the individual whose life, or dying, is being prolonged.

The Roman Catholic bishops of the state of Washington spent some

\$1.5 million in their successful campaign against Proposition 119. But the movement for active euthanasia did not end with that ballot. The Hemlock Society has already begun a campaign to place similar initiatives on the Oregon and the California ballots. The success of the Washington bishops is a warning, not a victory. If we fail to be sensitive to people's fear of being trapped by medical technology, that fear will ultimately find its voice in an increased demand for active euthanasia. Unwittingly, then, Catholics, despite their well-developed moral teaching against euthanasia and their sophisticated tradition on the limitations of the moral obligation to prolong life, might contribute to public acceptance of active euthanasia.

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