Euthanasia

Historical, Ethical, and Empiric Perspectives

Ezekiel J. Emanuel, MD, PhD

Debates about the ethics of euthanasia date from ancient Greece and Rome. In 1870, S. D. Williams, a nonphysician, proposed that anesthetics be used to intentionally end the lives of patients. Between 1870 and 1936, a debate about the ethics of euthanasia raged in the United States and Britain. These debates predate and invoke different arguments than do debates about euthanasia in Germany. Recognizing the increased interest in euthanasia, this article reviews the definitions related to euthanasia, the historical record of debates concerning euthanasia, the arguments for and against euthanasia, the situation in the Netherlands, and the empirical data regarding euthanasia in the United States.

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During the last several years, euthanasia and physician-assisted suicide have again become prominent issues on the public agenda. Euthanasia is an emotionally charged issue, and much of the debate about it has occurred through slogans for referenda and in the mass media. The result has been the frequent disregard for subtle but fundamental distinctions; the omission of substantive arguments; and the failure to distinguish the areas of disagreement from areas of agreement. This review will attempt to clarify the issues surrounding euthanasia by delineating (1) the basic definitions of euthanasia and physician-assisted suicide, (2) the historical record on euthanasia and efforts to legalize it, (3) the theoretical arguments both for and against euthanasia, and (4) the experience of euthanasia in both the Netherlands and the United States. It should help clarify both the current debate over euthanasia and how we should proceed in considering the legalization of euthanasia and physician-assisted suicide. Furthermore, understanding the current interest in euthanasia by patients and the public and what concerns motivate this interest can help physicians and others develop programs for quality end-of-life care that address these concerns before we consider resorting to euthanasia.

From the Division of Cancer Control and Epidemiology, Dana-Farber Cancer Institute, and Division of Medical Ethics, Harvard Medical School, Boston, Mass.

BASIC DEFINITIONS RELATED TO EUTHANASIA

Table 1 delineates the essential definitions of euthanasia and physician-assisted suicide. These terms are distinguished on the basis of the intention of the physician, the nature of the critical action, and the consent of the patient. In voluntary active euthanasia, the physician and patient's intentions are to end the patient's life. In physician-assisted suicide, the physician provides patients with means to end their lives if they so choose. A most important point distinguishing voluntary active euthanasia from physician-assisted suicide is who actually administers the deadly medication or intervention. Conversely, what distinguishes voluntary active euthanasia from either passive or indirect euthanasia is the intention of the physician. In the former case, the physician intends to end the life of the patient, while in the latter two cases the phy

Table 1. Definitions of Euthanasia

Term	Definition
Voluntary active euthanasia	Intentionally administering medications or other interventions to cause the patient's death at the patient's explicit request and with full informed consent
Involuntary active euthanasia	Intentionally administering medications or other interventions to cause patient's death when patient was competent but without the patient's explicit request and/or full informed consent; eg, patient may not have been asked
Nonvoluntary active euthanasia	Intentionally administering medications or other interventions to cause patient's death when patient was incompetent and mentally incapable of explicitly requesting it; eg, patient might have been in a coma
Terminating life-sustaining treatments (passive euthanasia)	Withholding or withdrawing life-sustaining medical treatments from the patient to let him or her die
Indirect euthanasia	Administering narcotics or other medications to relieve pain with incidental consequence of causing sufficient respiratory depression to result in patient's death
Physician-assisted suicide	A physician providing medications or other interventions to a patient with understanding that the patient intends to use them to commit suicide

sician intends something else, such as relieving pain or withdrawing intrusive medical interventions. In nonvoluntary active euthanasia, the patient is mentally incapable of consenting, while in involuntary active euthanasia, the patient could consent and was either not asked or refused. Involuntary and nonvoluntary active euthanasia must be distinguished from the other actions in that the patients do not consent, while in the other acts the patient must consent.

The main reason for distinguishing these terms is differences in their ethical and legal status. It is widely agreed that so-called passive and indirect euthanasia are both ethical and legal in some situations.[1-4] Indeed, passive euthanasia is equivalent to the practice of withholding or withdrawing life-sustaining treatments. There has been a growing consensus supporting the ethics of the withdrawal and withholding of life-sustaining treatments, and legal rulings in almost all states and by the Supreme Court permit such practices at least under certain circumstances. Similarly, under the ethical principle of double effect, the use of morphine and other medications for pain relief, even if it shortens a patient's life, has long been deemed ethical by both physicians and nonphysicians.[1-4] For instance, in a reply to a physician who wondered about using morphine and chloroform to relieve the pain of a patient with ovarian cancer, the editors of the *Lancet* wrote in 1899 approving of so-called indirect euthanasia:

> [I]t would have been perfectly justifiable for [the physician] to have used morphia hypodermically and patients are frequently kept under chloroform cautiously administered for hours to mitigate the sufferings. . . . [W]e consider that a practitioner is perfectly justified in pushing such treatment to an extreme degree, if that is the only way of affording freedom from acute suffering. . . . If the risks be explained to the friends we are of opinion that even should death result the medical man has done the best he can for his patient.[5]

Conversely, there is great controversy about the ethics of voluntary active euthanasia, involuntary active euthanasia, and physician-assisted suicide. As will be noted below, it has recently been claimed that the active-passive distinction is ethically invalid and therefore the ethical principles that justify passive euthanasia can be extended to justify active euthanasia and/or physician-assisted suicide.

Because of this ethical controversy, referring to terminating life-sustaining treatments and the use of pain medications even when they shorten life—ie, passive and indirect euthanasia—with the emotionally charged term of *euthanasia* is likely to confuse our moral judgments and distort reasoned public discussion. In current public debate and political campaigns, when the term *euthanasia* is used without a qualifying term, it should refer to voluntary active euthanasia exclusively. To avoid any confusion, this is the way *euthanasia* will be used in this article unless explicitly noted.

HISTORICAL PERSPECTIVE ON EUTHANASIA

One of the first recorded references in the medical literature to euthanasia occurs in the Hippocratic Oath, where physicians are admonished against "giving a deadly drug to any patient." This opposition to euthanasia was a minority view and one of the fundamental points that distinguished the Hippocratic tradition from that of traditional Greek and classical physicians.[6-8] It was not until some time between the 12th and 15th centuries that the Hippocratic view of euthanasia became dominant.[7] But soon thereafter, different writers, such as Sir Thomas More and Francis Bacon, argued that physicians should practice euthanasia.[9]

During and after the Enlightenment, while suicide was a widely discussed topic, euthanasia was rarely mentioned.[10] This changed in 1870, when a nonphysician, S. D. Williams, gave a speech to the Birmingham (England) Speculative

Club suggesting that ether and chloroform be used to intentionally end patients' lives.[11] The latter portion of the 19th century was a time of great intellectual foment, with the development of the theory of evolution, the attempt to assimilate darwinism into all areas of humanistic study, and the widespread acceptance of a laissez-faire philosophy in politics and economics. Indeed, Williams appealed to both social darwinism and laissez-faire views to justify euthanasia. Because of this intellectual environment, Williams' speech did not sink into obscurity, but sparked interest in euthanasia in many London literary and political journals.[12-14] By the 1880s, euthanasia had become a topic of speeches at medical meetings and editorials in British and American medical journals.[15,16] In the 1890s, lawyers and social scientists joined the debate.[17-21] For instance, a New York (NY) lawyer argued at the World Medico-Legal Congress of 1894 that "physicians have the moral right to end life when the disease is incurable, painful and agonizing."[22]

In a process reminiscent of our current experience, debates about euthanasia moved from articles in medical journals and formal presentations at meetings of learned societies into politics. In Ohio in 1906 a bill was introduced to legalize euthanasia. The *New York Times* ran editorials and letters on the Ohio effort[23-27]; many, but not all, medical journals denounced the effort.[28-30] Ultimately the bill was defeated.

During the subsequent three decades, the intensity of the debates on euthanasia diminished in the United States and Britain.[31,32] But in 1920, euthanasia became a subject of interest in Germany when Hoche and Binding, a distinguished professor of psychiatry and lawyer, respectively, published *The Permission to Destroy Life Unworthy of Life*.[33-35] This book argued that certain people—those with incurable diseases, the mentally ill, and deformed children—lead "unworthy lives." For these people, Hoche and Binding argued, death could be a compassionate and "healing treatment" that was consistent with medical ethics.[33,34] In addition, the authors noted that these "unworthy lives" impose a financial drain on society and pollute the gene pool with defective genes. To protect itself, society should eliminate these "unworthy lives." Initially a minority view, Hoche and Binding's ideas became integral to the Nazi propaganda that co-opted physicians to practice mercy killing. As Lifton[34] wrote, "Binding and Hoche turned out to be the prophets of direct medical killing."

With the advent of the Depression, interest in euthanasia resurfaced in Britain. In 1931, C. K. Millard, a prominent physician and public health official, proposed legalizing euthanasia.[36-38] Again, interest flowed from the medical profession to the public with publication in the London *Daily Mail* of an article interviewing an unnamed "elderly country physician" who confessed to having committed euthanasia. After this article, newspapers and magazines in both Britain and the United States rivaled each other in printing requests for euthanasia from patients, testimonials on past incidents of euthanasia from physicians, and denunciations of the stories by physicians and medical organizations (**Figure**).[39-42] Millard's view prompted creation of the Voluntary Euthanasia Legislation Society by prominent British physicians to campaign for the legalization of euthanasia.[43,44] A bill to legalize euthanasia submitted to the British Parliament was defeated in the House of Lords 35 to 14 in December 1936 mainly because two lords who were also physicians argued that the safeguards were too bureaucratic and that physicians were already easing death, and so legalizing euthanasia was unnecessary to assure patients of a painless dying process.

This defeat, the outbreak of World War II, the discovery of the Nazi death camps, and the recognition of the role of German physicians in genocide muted, but did not completely eliminate, consideration of euthanasia.[45] In the late 1950s, Ganville Williams and Yale Kamisar revived the debate over the ethics of euthanasia in the legal literature.[46-48] In 1969, the first bill to legalize euthanasia since the 1936 defeat was introduced into the British Parliament. In the 1970s and early 1980s, legal cases brought euthanasia into the public forum in the Netherlands.[49] And in 1988, with the publication of "It's Over, Debbie" in *JAMA*,[50] the euthanasia debate significantly increased in intensity in the United States, Britain, and other countries.[51,52]

ARGUMENTS FOR EUTHANASIA

Since 1870, the arguments supporting euthanasia have remained remarkably constant. They rest on four major claims. First, it is claimed that autonomy justifies euthanasia.[53-59] We recognize that there is no single good life right for all individuals; there is a plurality of different kinds of lives that are good and valuable. Thus, individuals have different ideas about what is good and valuable in life and can lead different lives in realizing their vision. Society recognizes the autonomy of individuals by granting them the right to pursue their views about the good life and create their own lives. Protecting autonomy encompasses not just choices about the extent of education, marriage, careers, and avocational pursuits, but also the time and manner of death.[53-57,59] Indeed, the argument goes, our society recognizes that a proper death is as much a part of a vision of a good life as anything else because we recognize the right to refuse medical interventions and end one's life when such interventions seem to conflict with one's vision of the good life. According to the proponents of euthanasia, to respect the autonomy of individuals, we must permit them to

TIME, November 25, 1935

MEDICINE

The Right to Kill (Cont'd)

Fortnight ago the London *Daily Mail* published an anonymous confession by a "kind-eyed, elderly country doctor" stating that, for mercy's sake, he had done away with two defective newborns and three agonized adults (TIME, Nov. 18). Last week the storm of controversy and comment blown up by the *Mail's* story roared on in the world Press. In England famed William Ralph Inge, morose one-time dean of St. Paul's Cathedral, signed his name to an opinion that euthanasia

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ANNA BECKER

"For 749 horrible days. . . ."

(painless death) administered to incurables is "not contrary to Christian principles." This was also signed by three other churchmen including St. Paul's present dean, Very Rev. Walter Robert Matthews.

In Buffalo, N. Y. an alert newshawk turned up a willing candidate for euthanasia. She was Anna Becker, 34, a one-time nurse who was badly hurt in an automobile crash two years ago. Her teeth were knocked out. Her gums had failed to heal, she could eat no solid food and because of unhealed internal injuries even liquid food caused searing pain. Her legs swelled and hurt if she stood on them for a few minutes. She had been awarded damages of $6,000, of which she had collected nothing because of an insurance guarantor's bankruptcy. At the reporter's instigation she dictated a letter to the Erie County Medical Association. Excerpts:

"In the name of mercy, I ask you to appoint a doctor to take my life. I am constantly in pain. I want to die. A competent physician could certainly kill me with less pain than I endure in an hour.

"For 749 horrible days since the crash, I have thought of death and would have taken my own life long ago if I had the courage."

The medical society had an easy answer: the law forbade. Of three Buffalo clergymen of three different faiths, two expressed themselves in favor of euthanasia. In Washington, a U. S. Public Health surgeon declared that mercy killing was outlawed in this clause of the oath of Hippocrates: "If any shall ask of me a drug to produce death I will not give it nor will I suggest such counsel." In Kansas City, Mo., Dr. Logan Clendening (*The Human Body*), who likes to pooh-pooh the fears of hypochondriacs, said the question was outside the medical profession's province. In Chicago, Editor Morris Fishbein of the American Medical Association's *Journal* spoke his mind thus:

"Any dying person is irrational and not responsible for what he says. If he recovers, his attitude is entirely different. . . . I deplore the publicity that this [Miss Becker's] case has received and I feel that no editor would have featured this extremely morbid story if it had been in his own family. It is very unhealthy for American psychology."

Article recounting a patient's request for euthanasia and reaction to the request. Reprinted by permission of Time Warner Inc.[40]

end their lives through euthanasia. As the philosopher Dan Brock[53] put it: "If self-determination is a fundamental value, then the great variability among people on this question makes it especially important that individuals control the manner, circumstances, and timing of their dying and death." Or as Eugene Debs[60] put it in 1913: "Human life is sacred, but only to the extent that it contributes to the joy and happiness of the one possessing it, and to those about him, and it ought to be the privilege of every human being to cross the River Styx in the boat of his own choosing, when further human agony cannot be justified by the hope of future health and happiness."

Second, it is claimed that beneficence, furthering the well-being of individuals, also supports permitting euthanasia.[53-58,61-64] In some circumstances, continuing to live can inflict more pain and suffering than death: "There are also cases in which the ending of human life by physicians is not only morally right, but an act of humanity. I refer to cases of absolutely incurable, fatal and agonizing disease or condition, where death is certain and necessarily attended by excruciating pain [1896]."[22] Given that each individual has a different conception of what is good and valuable, there will be no single objective standard to define when life is burdensome enough to be ended. Only an individual can decide when continuing his or her life is more burdensome than death. Again, our society recognizes this by permitting individuals to refuse life-sustaining interventions on the grounds that continuing to live is more burdensome and painful than death. But, proponents of euthanasia contend, if life can be sufficiently burdensome to warrant stopping life-sustaining treatments, then, under some circumstances, individuals can deem it sufficiently burdensome to warrant ending it by euthanasia. Furthermore, permitting euthanasia can promote the well-being of individuals even if they ultimately never use it. Euthanasia can serve, in Brock's[53] words, as "psychological insurance" to relieve the anxiety of individuals who worry about having uncontrolled pain and suffering before death.

Third, proponents argue that from an ethical perspective, euthanasia is no different from withholding life-sustaining care.[53-55,59,63-67] In both cases, the final result is the same: the death of a patient. Similarly, by requesting euthanasia or the withholding of life-sustaining treatment, the patient consents to die. The physician's intention in both cases is the same: to end the patient's life. The main difference is that in the case of euthanasia the physician injects the patient with potassium or some other medication, while in withholding life-sustaining treatment the physician refrains from intervening. In these cases, the proponents argue, there is no moral difference between the final result, the patient's consent, and the physician's intention. Surely, the physician's different physical actions do not make a significant moral difference. Through such an analysis it is claimed that there is no ethical distinction between active or passive euthanasia, between an act and an omission, or equivalently between killing and letting die. Thus, advocates of euthanasia claim, if we find withholding life-sustaining treatments ethically justifiable, so too must be euthanasia.

Finally, it is claimed that the bad practical consequences of permitting euthanasia are remote and too speculative to inform the formulation of public policy. For instance, the claim that permitting euthanasia will undermine the trust essential to a physician-patient relationship is dismissed as neither inherent nor consistent with the experience of euthanasia in the Netherlands.[53,56,57,62,64] Indeed, the advocates claim that, if anything, permitting euthanasia should en-

hance patient trust in the sense that physicians will be permitted to do whatever is necessary for optimal care of the dying patient: "Patients' trust of their physicians could be increased, not eroded, by knowledge that physicians will provide aid in dying when patients seek it."[53]

Similarly, it is not clear that permitting euthanasia will undermine the core moral commitment of medicine, the physicians' care of sick patients.[68] Again, it is claimed that providing appropriate care to dying patients is expanded by recognizing that in some cases this means ending patients' lives at their own request because life is too burdensome. In this sense, euthanasia is not a separate class of interventions but should be viewed as an additional treatment enhancing the care that compassionate physicians can provide terminally ill patients.[52,53,56,57,64] It is claimed that Dutch physicians have not lost their moral commitment to care for patients even though euthanasia is permitted.

In addition, it is claimed that permitting euthanasia for competent patients who freely and consciously request it is not necessarily a slippery slope. There is a clear and easily recognized distinction between voluntary euthanasia and involuntary euthanasia, and it rests on patient consent. When a competent patient freely consents, then euthanasia is permitted, and in other cases it is not permitted. There is no necessary or inescapable slide from permitting one to permitting the other. As one journal in favor of euthanasia wrote in 1906:

> As regards any application of this principle to the elimination of the unfit or the degenerate, the imbecile, etc. as such, we find no such suggestion. . . . It would be entirely out of keeping with the consistently expressed individualism. . . . The fact that [euthanasia] may be justifiable, perhaps even a duty of humanity, under certain circumstances, exceptional circumstances, if you like—to yield to the pleas of the sufferer himself for "the end of pain," in no sense supports the idea that any person or persons may properly decide to eliminate the degenerate or the imbecile against or in the absence of his express consent and desire.[30]

Some advocates of voluntary active euthanasia contend that in some cases involuntary active euthanasia may be ethically permissible, but they note that there is no inevitable evolution from one to the other.[53]

Advocates of euthanasia also contend that tight procedural safeguards will inevitably accompany legalization of euthanasia and can prevent many potential ill effects. Different authors have suggested different safeguards.[53,57,59,68-70] Such safeguards might include (1) that the request for euthanasia be made by a competent patient and made several times and may even have to be made in writing; (2) that an examination of the patient ensure that depression or other psychological conditions are diagnosed and treated; (3) that euthanasia be restricted to specially certified physicians who cannot charge for the procedure; (4) that a case of euthanasia be documented in the medical record, including reference to alternative therapies offered the patient; and (5) that all cases of euthanasia be reported to an official body, such as the medical examiner's office, which investigates the incidents for potential abuse.

Finally, it should be noted that some commentators support permitting physician-assisted suicide but oppose permitting voluntary active euthanasia.[57,61,62] They contend that the critical difference is who administers the deadly medication. By leaving the final act to the competent patient, the risk of abuse and "subtle coercion from doctors, family members, institutions, or other social forces is greatly reduced"[71] compared with that of voluntary active euthanasia.

The arguments for euthanasia can be summarized in the idea that if the values of patient autonomy and beneficence justify terminating life-sustaining treatments, such as respirators, they also justify euthanasia because there is no ethical distinction between killing and letting die. It is worth noting that none of these arguments for euthanasia applies only to terminally ill patients. Autonomy justifies permitting euthanasia for anyone who consciously and persistently requests it, whether terminally ill or not. Similarly, some patients, such as Elizabeth Bouvia, who suffered from severe cerebral palsy, may have unremitting pain and suffering that can make life burdensome even without a terminal illness. Limiting euthanasia to terminally ill patients thus may be a policy decision to limit abuse or a political decision to win votes, but it is not required by the ethical arguments.

ARGUMENTS AGAINST EUTHANASIA

Paralleling these arguments for euthanasia are arguments against euthanasia. First, it is claimed that while autonomy is a fundamental value, it does not justify euthanasia.[72-74] Euthanasia advocates confuse satisfying preferences with autonomy. Autonomy requires that individuals live according to rationally conceived plans and that the conditions for conceiving and pursuing these plans must be preserved. Thus, not everything we want to do, even if it does not harm others, is permitted under the claim of autonomy. Individuals cannot voluntarily and irreversibly surrender the conditions necessary for autonomy. For instance, our society prohibits voluntary slavery and dueling because enslaving or killing competent individuals who consent is incompatible with the conditions necessary for people to pursue their idea of the good life.[72,73] John Stuart Mill argued that not all voluntary acts are justified by autonomy:

: by selling himself for a slave, he abates his liberty; he forgoes any fur- :r use of it beyond that single act. He :refore defeats, in his own case, the :y purpose which is the justification allowing him to dispose of himself. . The principle of freedom cannot re- ire that he should be free not to be free. is not freedom to be allowed to alien- : his freedom.[75]

pponents of euthanasia extend this ıalysis from slavery to euthana- a, arguing that death irreversibly ienates autonomy and cannot be)ndoned by appeal to autonomy.

Furthermore, while many states ave decriminalized suicide, recog- izing that people should not be riminally prosecuted if they want) kill themselves, and permitting pa- ents to refuse life-sustaining medi- al treatments, euthanasia is not the ame. Euthanasia and physician- ssisted suicide require the active)articipation of another person, the)hysician as either injector or pre- criber of the deadly medica- ion.[72,73] Prohibiting euthanasia and)hysician-assisted suicide does not)revent individuals who experi- :nce pain and suffering from com- nitting suicide by any number of)ther mechanisms. If an individual wants to end his or her life, it is pos- sible without legalizing euthanasia. In this sense, the autonomy to kill oneself does not extend "to have someone else's assistance."[72] Permitting euthanasia goes beyond providing a means for people to pursue their own ideas of what is good and valuable; it extends what Philli- ipe Aries called "the medicaliza- tion of death" by sanitizing suicide through physician involvement.[76] Thus, even if autonomy did justify letting people refuse life-sustaining treatments and end their own lives, it does not justify euthanasia. Another argument about social policy would be required to justify the legalization of euthanasia. The philosopher Francis Kamm put it this way: "[T]he person who requests it does not have a right to active euthanasia. . . . People, however, do often have a right to refuse treatment, and we have a duty not to interfere with this right.[77]

Second, it is not clear that beneficence can justify legalizing euthanasia. Many studies have demonstrated that physicians and the medical care system in general are not adequately treating the pain and suffering of terminally ill patients. Doubtlessly, it is argued, even with the finest management of pain medications and counseling, some patients would still have excruciating pain and suffering. We do not now know, however, the size of this remaining group. But, opponents claim, while these patients should receive compassionate care, it is unwise to base social policy on a few hard cases: "Changes in policy based on hard cases risks making bad policy decisions."[78] While euthanasia may be a compassionate act in a handful of extreme cases, this does not mean it should be legalized under the guise of promoting the well-being of patients in general.[74,79]

Third, it is argued that the ethical distinction between active and passive euthanasia, between killing and letting die, is reasonable and true.[72,73,79,80] The physical acts are significantly different. In euthanasia the physician invades the person's body with a medication to end the patient's life; in withholding or withdrawing medical treatments the physician refrains from introducing or removes an intruding medical intervention. More important, the intention of the physician is different in the two cases. In euthanasia, the intention is to kill the patient. In the case of terminating medical treatments, the intention is to remove the medical treatments; the patient's life may or may not end as a consequence because of the underlying disease mechanism. This difference is highlighted by the Quinlan case. Her respirator therapy was terminated, yet she did not die until 9 years later. As her parents have claimed, the aim was to remove the intrusive medical treatment, not to end her life.

Finally, opponents claim legalizing euthanasia is "perilous public policy."[74,79,81] One set of adverse effects may be on the physician-patient relationship and the practice of medicine.[73,74,79,82,83] Legalizing euthanasia, it is argued, will undermine the trust between physician and patient. And if one abuse is reported, patients everywhere will begin to question the motives of their personal physicians with whom they previously had good relationships. Also, legalizing euthanasia could undermine compassionate and humane care of the terminally ill. Faced with a suffering patient, physicians may find euthanasia easier and more efficient than the constant attention necessary for symptom control and counseling. The corrosive effect of such situations might alter physicians' understanding of the aims of medicine. Healing and the relief of suffering might be supplanted by a view of killing as healing. Indeed, commentators have noted that some Dutch physicians have begun to describe euthanasia as healing. The chair of the Dutch Health Council is quoted as having said: "There are situations in which the best way to heal the patient is to help him die peacefully and the doctor who in such a situation grants the patient's request acts as the healer *par excellence*."[84]

This, it has been noted by opponents of euthanasia, was precisely the way the Nazis justified mercy killing. While no one claims that the Netherlands is Nazi Germany, the thought process raises the question: if the acceptance of euthanasia can erode the commitments of a respected Dutch physician, then what can it do if legalized for any physician to do?

In addition, it is claimed, legalizing euthanasia could coerce patients to request euthanasia. "Chronically ill or dying patients may be pressured to choose euthanasia to spare their families finan-

cial or emotional strain."[74,78,79] The poor, the old, the disabled, members of minority groups, and other patients in disempowered groups are already discriminated against by the health care system. If it is legalized, these patients might become subjected to further coercion to consent to euthanasia.

Another adverse consequence of legalizing euthanasia, it is argued, would be the intrusion of courts, prosecutors, lawyers, and the police into medical practice.[85] Legalization of euthanasia would occur only if there were significant procedural safeguards and frequent oversight "checking for error and abuse."[85] But, it is argued, this event begins in the privacy of the physician-patient relationship. To guarantee that there is no abuse would require nothing short of monitoring all patient visits with a physician. Less assurance could be had with the requirement that all cases of euthanasia be reported to an investigative body. But even this level of oversight would cast all end-of-life decisions under the watchful eyes of the criminal law. Not only would this actually bring the criminal justice system into the hospital room for cases of euthanasia, it would make physicians who are finally accommodating themselves to withdrawing life-sustaining treatments reluctant to proceed. In this way, legalizing euthanasia could "roll back the clock" to make terminating life-sustaining treatments more difficult.[85]

Finally, the most discussed adverse consequence of legalizing euthanasia is the "slippery slope," the extension of euthanasia from competent patients to incompetent patients, the comatose, children, and the mentally defective.[72,74,80,84] Almost all medical interventions begin with a small, defined target population and then, once physicians are experienced and comfortable with the intervention, extend to other patient populations. Euthanasia, it is claimed, will be just the same. Once we recognize that death is more beneficial than a life of pain and suffering, we will be willing to admit that death is more beneficial than a life devoid of consciousness or higher mental functioning. Opponents of euthanasia note that American philosophers and Dutch physicians are already making these arguments to justify euthanasia for incompetent patients.[84] Indeed, advocates for patients' rights will soon come to view any set of restrictions on euthanasia as arbitrary and urge their repeal. For example, if voluntary active euthanasia were legalized, advocates would ask why a patient's mental incapacity should prevent ending a life filled with uncontrollable pain. Legalizing euthanasia for competent adults is, as one British physician put it in 1936, "only the thin end of a very big wedge."[86]

The arguments against euthanasia can be summarized first by noting that many people find intentionally ending the life of an innocent person wrong. But even if not everyone agrees to this and wants to accept that people can have the right to end their own lives, it must be distinguished from justifying a social policy permitting physicians to end patients' lives intentionally. And if in some cases extreme pain and suffering make euthanasia seem compassionate, this does not justify a change in social policy to make it generally available. Finally, there are many dangers with permitting euthanasia that may only make medical care of the terminally ill worse with oversight to prevent abuse.

EUTHANASIA IN THE NETHERLANDS

History

The Netherlands is the one advanced industrialized country in which euthanasia is permitted, although technically it remains illegal. Thus, it is useful to examine the Dutch experience with euthanasia to understand practice and actual consequences of permitting euthanasia.

The Dutch interest in euthanasia began in the early 1970s when a physician, Geertruida Postma, intentionally administered an overdose of morphine to a patient who was partially paralyzed, deaf, and mute, but had repeatedly requested to have her life ended. The patient, who was Dr Postma's mother, died. Dr Postma was convicted of murder but was given a suspended sentence of 1 week in jail and 1 year of probation.[49,87,88] In his decision, the judge specified conditions that must be fulfilled for a case of euthanasia to be permissible. As a result of this and another case, the Royal Dutch Medical Society issued a statement in 1973 arguing that euthanasia should remain criminalized but that physicians should be permitted to engage in euthanasia for dying and suffering patients as a *force majeure*, that is, a conflict between duties to preserve life and duties to relieve suffering.[89]

During the next decade, additional euthanasia cases came before the Dutch courts, and the public became more supportive of euthanasia.[49,87,88,90,91] There evolved some agreement that euthanasia would be permitted and not prosecuted if the case fulfilled three conditions. First, the patient must take the initiative in requesting euthanasia and has to request euthanasia repeatedly, consciously, and freely. Second, the patient must be experiencing suffering that cannot be relieved by any means except death. Third, the physician must consult with another physician who agrees that euthanasia is acceptable in the particular case.

In 1982, the Dutch government established a 15-member panel, the State Commission on Euthanasia, to investigate the legal aspects of euthanasia.[49,87,88,92] In 1984, the Royal Dutch Medical Association endorsed these three conditions for permitting euthanasia and expressed its concern that the existing legal circumstances did not ensure nonprosecution of physicians who followed the procedures. In November 1984, the Dutch Supreme Court ruled in the *Alkmaar* case, which involved the eu-

thanasia of a 95-year-old woman who suffered from a recent hip fracture, failing hearing and vision, and episodes of inability to speak and unconsciousness. The Dutch Supreme Court indicated that under the circumstances a responsible physician could have a legitimate conflict of duties and thus could provide euthanasia in good conscience.[90] Influenced by this decision, the State Commission on Euthanasia issued a report in August 1985 recommending that euthanasia by a physician who complies with the three conditions be a legal exception to murder in the criminal code. The two religious members of the commission dissented.

Legislation was introduced into the Dutch Parliament to adopt the State Commission's recommendation to legalize euthanasia. Opposition by the Christian Democratic Party prevented it from being enacted.[49,92] In 1987, the government introduced a new, more restrictive bill that would keep euthanasia criminal with no exceptions for physicians except under extreme cases. But before this bill could be debated, the Dutch government fell. In the formation of a new government, the Socialists and Christian Democrats agreed to establish a new commission, the Remmelink Commission, to collect empiric data on the actual practices of euthanasia to inform reconsideration of legislation legalizing euthanasia.

Article 293 of the Dutch Penal Code prohibits taking "another person's life even at his explicit and serious request" and is punishable by up to 12 years in prison or a fine of about $60 000.[49,88] Euthanasia remained a crime in the Netherlands, but, by agreement between the medical profession, the courts, and prosecutors, it was not prosecuted as long as the three requirements were fulfilled. In February 1993, the Dutch Parliament passed a bill that explicitly grants physicians immunity from prosecution if they adhere to the three conditions for a justifiable euthanasia and they notify the coroner about a euthanasia death.[93] The new law codifies the recognized exception, reassuring physicians that if they adhere to the three conditions and inform the authorities, they will not be prosecuted. In part this law is an effort to induce physicians to inform the authorities of euthanasia cases, thereby granting prosecutors formal and regular oversight to monitor for abuse. This law does not legalize euthanasia; Article 293 remains in effect, and physicians who do not fulfill the three conditions can be still prosecuted for homicide.

Empiric Data

Despite the fact that euthanasia has been tolerated in the Netherlands for almost 20 years, there had been little reliable data on the practice of euthanasia; before 1991 the information available was hearsay and anecdotal. Released in September 1991, the Remmelink Commission report provided the first rigorous empiric study of euthanasia in the Netherlands.[94,95] The study investigators interviewed 405 physicians, with prospective follow-up of them and their patients who died as well as completed questionnaires from anonymous physicians on 5197 deaths between August and December 1990. There is general agreement that the methods were rigorous and the data collected reliable, although the authors' interpretation of the data has been criticized.[96,97]

The authors of this study estimated that there were 9000 explicit requests for euthanasia in the Netherlands each year, with almost half including a written directive. Only 3000 or so of these requests resulted in euthanasia. In the Netherlands, 1.8% of all deaths were by euthanasia, 0.3% by physician-assisted suicide, and 17.5% by the withdrawal or withholding of life-sustaining technology (**Table 2**). The vast majority (68%) of patients who died by euthanasia were oncology patients, whereas fewer patients who died by the withdrawal of life-sustaining treatments had cancer; 27% of all deaths in the Netherlands are from cancer (Table 2). Of interest to those who have noted that most of the people put to death by Jack Kevorkian are women, Dutch women were not given euthanasia more frequently. Overall, 52% of patients given euthanasia were men, exactly the proportion of all deaths in the Netherlands. According to physicians' reports, the most common reason to request euthanasia was a loss of dignity (57%), while pain was the second most common reason (46%).

As regards the behavior of Dutch physicians, the Remmelink Commission study found that 84% had discussed euthanasia with at least one patient at some time. More importantly, 54% of Dutch physicians had participated in euthanasia, and a quarter had done so within the previous 2 years. Just 12% of Dutch physicians claimed that they would not commit euthanasia under any circumstances, and 35% claimed that they had never committed euthanasia but could conceive of circumstances in which they might. The investigators indicated that "many physicians who had practiced euthanasia mentioned that they would be most reluctant to do so again."[95] Unfortunately, this conclusion was based on the interviewers' impressions, without any quantification or explication.

According to the law, physicians are supposed to report their cases of euthanasia to the medical examiner and the prosecutor. The investigators found that in 75% of cases physicians listed a euthanasia death on the death certificate as a death "from natural causes." This "white lie" was done mainly to avoid the fuss and possibility of prosecution. Furthermore, less than 20% of euthanasia cases are ever properly reported to the state prosecutor.[98,99] Only 25% of Dutch physicians believe that euthanasia cases should be reported.

Finally and most important, the investigators found that in fully 0.8%

Table 2. Euthanasia in the Netherlands

	Euthanasia, %	Physician-Assisted Suicide, %	Withdrawal of Life-Sustaining Treatment, %
All deaths	1.8	0.3	17.5
Deaths involving patients with cancer	68	...	29

of all deaths, more than 40% of euthanasia cases, "drugs were administered with the explicit intention to shorten the patient's life, without the strict criteria for euthanasia being fulfilled."[95] In most of the cases, euthanasia had been discussed with the patient but the patient was not fully competent to request euthanasia when the drugs to end life were actually administered.[96] Not only are the strict criteria for permitting euthanasia being violated by extending euthanasia to incompetent patients who once expressed an interest in it, it appears that euthanasia is also being offered to minors in the Netherlands.[72,84,91]

These data suggest at least four important conclusions. First, most of the patients receiving euthanasia have cancer. Second, pain is not the primary reason for requesting euthanasia. Third, many requests for euthanasia are not fulfilled. In part this may be because physicians feel uncomfortable with euthanasia and find ways other than euthanasia to address the needs of dying patients. There are insufficient data to determine precisely what it is in the act of euthanasia that bothers physicians and how they cope with it. Finally, the criteria for permitting euthanasia are frequently violated. While many of the violations are minor, a significant number of breaches do appear serious, especially in the slide from voluntary to involuntary active euthanasia.

EUTHANASIA IN THE UNITED STATES

As the historical review indicates, before 1988 there had been some discussion of euthanasia in the United States by both physicians and the general public. With the publication of "It's Over, Debbie,"[50] however, interest in euthanasia revived, grew in intensity, and became a more common subject for articles in medical journals and the lay press. This interest has been further fomented by publication and enormous sales of *Final Exit* by Derek Humphrey, by pathologist Jack Kevorkian's publicized use of his suicide machine, and by the ballot initiatives to legalize euthanasia in Washington State and California. Indeed, efforts to legalize euthanasia or physician-assisted suicide are at various stages of development in other states. Besides the views of one pathologist, what do we know about the attitudes and practices of the American public and physicians regarding euthanasia?

The best study of the public's attitude toward euthanasia was a collaborative work between the *Boston Globe* and the Harvard School of Public Health (Boston, Mass) involving some 1004 people.[100,101] According to this survey, 64% of the public believe that a physician should be legally permitted to give a terminally ill patient in pain a lethal injection to aid in dying. Those who favored this tended to be young, Catholic, and white. By comparison, more than 75% of people thought the withdrawal of life-sustaining treatment should be legally permitted. Furthermore, if they had a terminal illness causing great pain, 20% would ask their physician for euthanasia and 19% would ask the physician to assist in suicide. Among those who would consider ending their lives if they had a terminal illness with pain, 47% would do so to avoid being a burden to their families, while only 20% would do so to avoid pain. Finally, only 11% would consider asking their families or friends to help them die if they had a terminal illness, and only 14% would be willing to help a terminally ill relative or friend commit suicide to end their suffering.

Some of the critical results of this *Boston Globe*/Harvard School of Public Health survey have been reported in surveys by organizations campaigning for the legalization of euthanasia.[102] For instance, Americans Against Human Suffering reported that 70% of adults agree that "a suffering person whose death is inevitable should be allowed to ask and receive his doctor's help to die."[103]

Despite these and similar public opinion poll results (including polls taken just before each vote), the initiatives in Washington State and California were both defeated by votes of 56% to 44%. This conflict between polling data and ballot results makes it unclear precisely how people are thinking about euthanasia. Is their favorable response to euthanasia in a poll genuine? Or does it reflect concerns about death that really are not addressed by legalizing euthanasia? Are the respondents confused by the terms and questions being asked? Clearly, additional research is needed to understand what motivates the public's interest in euthanasia.

What are the thoughts and actions of American physicians regarding euthanasia? Many American medical organizations, including the American Medical Association, the American College of Physicians, and the American Geriatrics Society, have issued statements against permitting active euthanasia.[104,105]

Table 3 summarizes surveys of American physicians on euthanasia.[106-112] They demonstrate that between 13.2% and 43.8% of physicians have been asked to commit euthanasia or physician-assisted suicide, and between 1.3% and 19.9% have committed some action that

Table 3. Physician Attitudes and Practices Regarding Euthanasia

Study	% Receiving Requests for Euthanasia	% Committing Euthanasia	% Willing to Commit Euthanasia	Date of Survey	Response Rate, %	Sample question
Washington State Medical Association[106]	39.1	...	29.7	Feb 1991	55.2	Has a terminal patient ever asked you to hasten his or her death?
Overmyer[107]	19	9.4	...	Feb 1991	24.9	Have you ever deliberately taken clinical action(s) that would directly cause a patient's death?
Crosby[108]	24.1	19.9	...	Oct 1991	40.2	Have you ever taken a deliberate action that would directly cause a patient's death?
Caralis and Hammond[109]	43.8	...	...	1988	66.0	...
Fried et al[110]	13.2	1.3	28.0	Jan 1991	65.3	Have you ever been approached by a patient to administer an injection that would result in his or her death?
Shapiro et al[111]	35.2	2.2	27.9	July 1991	33.0	...

might be considered euthanasia. In addition, 28% or so of physicians might be willing to commit euthanasia if it were legalized.

Unfortunately, most of these surveys have serious methodologic flaws that make the data suspect and their interpretation problematic. Except for the studies by Caralis and Hammond[109] and Fried et al,[110] the response rates are poor, as low as 25%. Also, the surveys concentrate on internists; none has concentrated on oncologists or physicians who primarily care for terminally ill patients. Most importantly, as Table 3 shows, the questions asked are ambiguous and are not restricted to active euthanasia. For instance, a physician who withdrew a respirator could legitimately indicate that he had "taken deliberate action that would directly cause a patient's death." Only the questions used in the survey by Fried et al were specific enough to ensure that the physicians' responses referred exclusively to euthanasia.[110] Interestingly, their data indicate that physicians receive requests for euthanasia and honor them much more infrequently than shown in the other surveys.

CONCLUSIONS

This review of the euthanasia issue suggests five conclusions. First, the preliminary historical review demonstrates that debates about the ethics and legality of euthanasia are not new. Controversy about euthanasia stretches back to the earliest recorded history of medical practice. Furthermore, in the modern era, interest in euthanasia arose even before physicians had efficacious, life-sustaining therapeutic interventions, let alone the high technology currently available. In the 1870s and 1880s, there were no antibiotics, much less respirators and artificial nutrition, and antiseptic technique and anesthesia had yet to make surgery safe; nevertheless, euthanasia was the topic of many orations at medical and medicolegal society meetings and editorials in medical journals. This suggests that while respirators and feeding tubes may intensify interest in euthanasia, they certainly do not *create* the interest in euthanasia. Furthermore, there does not seem to be a clear association between interest in euthanasia and the lack of effective pain treatments. During the last 120 years, pain management has dramatically and consistently improved, yet public interest in and discussion of legalizing euthanasia has fluctuated from nonexistent to intense. Thus, social and political forces besides the advance of technology and poor pain management seem to motivate interest in euthanasia.

Second, the ethical arguments for and against euthanasia are not finally determinative. There is agreement that it is ethical and legal to terminate medical treatments and give pain medications even if this shortens a patient's life. However, whether autonomy and beneficence justify voluntary active euthanasia and/or physician-assisted suicide remains controversial. There is a sense that the arguments pro and con will get more sophisticated and that some of the simplistic errors will be definitively exposed. For example, after several years of debate, it now seems clear that while there may be a right to refuse medical treatments and be left to die, there can be no ethical or legal *right* to active euthanasia. Also, it is clear that even if autonomy justifies wanting to die and being unhindered in taking actions to kill oneself, it cannot justify having a right to have a physician kill one. However, there is still disagreement about our intrepretation of autonomy and whether the irreversible relinquishment of being autonomous can be consistent with autonomy itself. Nevertheless, the conflicts do not seem ultimately resolvable simply on the basis of rigorous ethical arguments on the meaning of autonomy. What is at stake is a policy decision about whether it is a good policy, all things considered, to permit euthanasia.

Third, if the philosophical arguments are not definitive, then how our

society approaches the issue of euthanasia will depend on how we evaluate the consequences of permitting it. For this, the experience in the Netherlands is crucial as the only example of an industrialized country permitting euthanasia. As the review of the limited data available from the Netherlands indicates, there are some worrisome signs. A significant number of cases of euthanasia do not adhere to the agreed upon conditions for permitting euthanasia. Furthermore, until the new law passed in February 1993, physicians were most reluctant to report euthanasia cases, and therefore official oversight of the process was poor. In addition, committing euthanasia appears to take a toll on physicians. Many physicians do not like to engage in euthanasia. Greater experience with euthanasia seems to foster subtle but fundamental changes in the attitudes of some Dutch physicians toward the role and aims of medicine; killing seems to have become compatible with the goal of healing in the views of some. Finally, there is some evidence that the slippery slope is operative: as euthanasia has become generally accepted for competent adult patients, there have been moves to extend it to incompetent adult patients and children. All these worrisome signs are occurring in a comparatively small, culturally homogeneous country where respect for governmental authority and the law is strong. This raises concerns about the risks of permitting euthanasia in the United States, a larger, more culturally heterogeneous country with a long tradition of rebellion against governmental rules and the law.

Fourth, the data from the Netherlands confirm that the vast majority of euthanasia cases, nearly 70%, are likely to be in oncology patients. This means that if euthanasia is permitted in any state of the United States, oncologists will be the primary group of physicians facing the dilemma. Thus, there should be some professional interest in studying and addressing the concerns raised by public interest in euthanasia. To this end, it is important to note that the main reason for wanting euthanasia in both the Dutch data and the poll of the American public is *not* pain. The main concern of patients seems to be "being a burden." This suggests that much of euthanasia's attraction for patients could be addressed by interventions directed to reassuring patients that they will not become excessively burdensome. However, this hypothesis and policies that might follow need to be studied empirically.

Finally, all these conclusions are tentative. All we know about the practice of euthanasia in the Netherlands is based on one empiric study. What we know about the attitudes and practices regarding euthanasia in the United States is based on even thinner empiric studies: one rigorous survey of 1004 members of the public and a few hundred physicians. If we are to have more than the recounting of anecdotes and "sloganeering," if we are to have educated and informed policy discussions on euthanasia, if we are to have data to inform the design of alternative interventions to ensure compassionate and humane end-of-life care for terminally ill patients, then we will need much more empiric research both on the Dutch experience of euthanasia and on the attitudes and practices of American patients and physicians regarding euthanasia. As one British physician stated during the 1936 debate about euthanasia:

> So far as I can judge, the views hitherto expressed have been based mainly upon sentiment, and little real evidence has been adduced as to either the need for euthanasia or the actual dangers which might result from it. . . . It is probable, however, that most thoughtful persons would agree that the matter is one of sufficient importance to merit serious inquiry . . . [the proper course is] to examine all the relevant evidence and to investigate fully the whole question.[113]

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