Five years ago a patient with moderately advanced idiopathic pulmonary fibrosis offered me $10,000 if I would give him a lethal injection to end his life. His offer was unusual, but I suspect his request for euthanasia is not. The recent Washington State Initiative 119, coupled with interest in California and other states, suggests a growing public interest in euthanasia. Derek Humphry’s best-selling book *Final Exit* has given instructions on how patients can “do it themselves,” and Drs. Kevorkian and Quill have gained widespread notoriety by showing us part of the spectrum of physician-assisted suicide. Furthermore, some thoughtful American physicians believe that physician-assisted suicide should be available to members of our pluralistic society. In one survey, 59 percent of Colorado physicians were willing to give a lethal drug to a patient in certain circumstances. In another survey, 70 percent of San Francisco physicians polled thought patients should have the option of active euthanasia with an incurable terminal illness. This contrasts with the American College of Chest Physicians statement, which does not endorse euthanasia, and the American Thoracic Society position paper, which states that the practice of euthanasia is unacceptable.

The primary purpose of this article is to outline the historical evolution of the concept of euthanasia and the ethical arguments for and against its practice and that of assisted suicide. An additional but no less important purpose is to point out that the question of euthanasia and assisted suicide has two separate parts. What will society’s decision be concerning the legalization or acceptance of these practices, and, more important to physicians, will medicine choose to act in concert with society’s decision? In keeping with this second purpose, I have divided the ethical arguments into societal and medical arguments for and against these practices. Finally, there is speculation about the politics and possible outcomes of the debate.

**HISTORICAL ASPECTS**

The original meaning of euthanasia evolved before there were ways to end patients’ lives in a painless fashion, and encompassed a far broader and more humane conceptualization than is found in contemporary society. Euthanasia (“a good death”) was defined by the spiritual state of mind of the dying patient, not as a method of dying. Physicians focused on ensuring the psychological well-being of their patients, with less concern for the manner of their physical demise. The development of hemlock in the 5th century BC allowed some patients to die in a way that was consistent with the original conceptualization of euthanasia (ie, in a peaceful state of mind). The meaning of euthanasia has evolved over the centuries to focus on a “good way” of ending the life of a suffering patient, with less emphasis on the patient’s psychological state of well-being. While all physicians would agree that the original meaning of euthanasia is something that we should strive for with dying patients, it is the contemporary meaning, an intent to end life and a method of dying, that is in dispute.

**DEFINITIONS**

For the purpose of this discussion, I will assume that euthanasia means the direct killing of a patient at the patient’s request and that physician-assisted suicide means the intentional killing of oneself with the indirect aid of a physician. These definitions exclude the concept of allowing death to occur by the withdrawing or withholding of life-supporting treatment. Physician-assisted suicide includes the physician who *knowingly* writes a prescription for, orders, or secures the medication, or puts it in the intravenous line or assists in any other indirect manner. From an ethical point of view, an argument can be made that euthanasia and physician-assisted suicide are morally inseparable acts because in both instances the physician’s intent is the same; the physician is a necessary element in the causal chain of actions, although perhaps not always the immediate cause, and the consequences are the same. In one instance the patient acts last (assisted

*From the Division of Pulmonary and Critical Care Medicine, The Johns Hopkins Asthma and Allergy Center, Johns Hopkins University, Baltimore.*
suicide), and in the other the physician acts last (euthanasia), but in both the patient is in control of his or her life and death until the fatal moment.7 From a legal point of view, some physicians may be less reluctant to order a medicine (assisted suicide) than to actually inject the medicine (euthanasia), because they feel that they are less a direct cause and intent is more difficult to determine.

**Philosophical Foundations**

All social movements, including euthanasia, must have philosophical or religious underpinnings if they are to sustain long-term societal support. In the past two centuries, the two dominant philosophical theories of what determines right and wrong have been the deontologic and consequentialist theories. Simply put, consequentialists believe that outcomes determine the value of actions, while deontologists believe that principles based not exclusively on outcomes determine right and wrong. Medical ethics is generally considered a deontologic enterprise. The guiding principles of medicine—autonomy, beneficence, nonmaleficence, and justice—are less concerned with consequences. Philosophers who adhere to one or the other of these theories are unwilling to use the rival theory to justify their positions. As we shall see however, proponents and opponents of euthanasia ignore pure philosophical discourse and use arguments derived from both theories to justify their positions.

**Societal Arguments for and Against Euthanasia and Assisted Suicide**

**Pro**

The primary ethical argument for euthanasia and assisted suicide from the point of view of contemporary American society is a deontologic one. It states that each person has the right to autonomously determine his or her own life plan, to seek his or her own destiny. It is argued legally that to prevent persons from exercising this right restricts their freedoms as guaranteed by the Bill of Rights.

A second argument frequently heard is that individuals have the right to engage in euthanasia or assisted suicide because they have the right to determine that which represents their well-being.7 In the case of suffering terminally ill patients, euthanasia or assisted suicide may represent their best interest and thus their well-being.

It is also argued that if our society in general approves of euthanasia and assisted suicide, then it is right to carry out the practice based on the tenet that what is right or wrong is determined by the norms of a society at any point in time. An Associated Press Poll in 1985 showed that 68 percent of persons interviewed felt that a patient with an incurable disease ought to be able to end his or her life by active means.8 Some philosophers, critical of this approach to ethics dismiss it as nothing more than "ethics by consensus" and point to historical examples of democracies making morally wrong decisions.9

Brock7 has argued that a good consequence of legalization of euthanasia would be the increased availability of this practice to all consenting, competent adults, thus increasing further the options for end-of-life decision making.

Another argument, both conceptual and semantic, is that in fact we are already practicing euthanasia and simply calling it by another name.7 Supporters frequently use the example of the withdrawal of life-supporting treatment which results in a patient's death. The physician has, with the patient's or family's approval, taken an action that has resulted in the death of the patient. By intentionally ending the life of the patient through withdrawal of life supports, the physician has done nothing different from the physician who uses other active means to end a patient's life. Since these other active means are called euthanasia, then withdrawal of life-supporting therapy should also be called euthanasia. It is argued that we should acknowledge our present involvement in euthanasia and spend more time talking about justifiable and unjustifiable euthanasia, rather than denying that we already engage in the practice. A complex counterargument, stated below, has been put forth to refute this argument.10

The counterargument states that the above position is wrong because it confuses the distinction between causing something to occur and the moral responsibility for its outcome. The following two points are made to support this argument. First, those who hold that euthanasia and withholding treatment are the same confuse withdrawal of treatment with causing death. A physician's withdrawal of treatment can lead to death only when the underlying disease would kill the patient in the absence of treatment. Disease is the cause of death, not the removal of the ventilator. Withdrawing ventilatory support from a normal person does not lead to his death. This contrasts with direct killing by lethal injection (euthanasia), which will cause the death of a healthy or diseased person. To argue that lethal injection is the same as omission of treatment (withdrawal of a ventilator) is to confuse causalities.

The second argument is that we fail to recognize that morality and blameworthiness are human inventions. Before there were ever medical treatments, physicians were not held morally responsible for patients' deaths due to disease. With the development of medicines and technology and the power to delay the time of death, moral rules were devised to guide physicians. Moral responsibility enters the picture when physicians omit or withdraw treatments that should have been provided because they could have been of benefit. If a chest physician withdraws venti-
latory support from a young person with a potentially reversible cause of adult respiratory distress syndrome, the patient dies of the naturally occurring underlying disease, but we would hold the physician morally responsible and say that he or she had "killed" the patient. The word kill implies a derogatory moral judgment about the action of the physician, because the physician did not actually kill the patient—the disease did. It follows then that it is a misuse of the term kill when we speak of a physician who withdraws treatment that is not benefiting a patient. To summarize, whether or not the physician's action is morally right or wrong has more to do with what the physician "ought" to do in particular circumstances than with the cause-and-effect relationship of the action.

Con

The principal philosophical argument offered against euthanasia and assisted suicide is a deontologic one. The claim is made that it is simply wrong to kill or be involved in the suicide of innocent human beings. This principle, rooted in Judeo-Christian tradition, holds that human life is of great value and that persons do not have the right to end their own lives, much less aid in the intentional death of someone else.12,13 This principle has found further support since the beginning of the "age of reason" in the theory of Immanuel Kant, who argued for the concept of "respect for persons" and against suicide.14

Further, those who argue against euthanasia and assisted suicide point out that these acts are not an expression of pure autonomy, that is, conceived and carried out exclusively by the person wishing to die. They are communal acts requiring the participation of others in society—the physicians.11 The question is asked: in the name of autonomy, can patients demand that others in society carry out acts that satisfy the patients' desires?

Several consequentialist arguments have been presented by those arguing against euthanasia and assisted suicide. The first holds that by euthanizing patients, we demean the concept of the sanctity of life, leading to a gradual erosion of its value, with subsequent liberalization of criteria for euthanasia and the eventual euthanization of the demented, the deformed, and even the nonproductive. They cite the German experience and more recently the Remmelink Committee report of 1991, which reviews the recent Dutch experience with euthanasia and reports that about 1,000 patients are now being "euthanized" each year without their unequivocal consent.15,16 Further, the argument is made that those unable to pay for adequate care, or those who are a financial burden on their families or third-party payers, would be more likely to be coerced into considering the possibility of euthanasia or assisted suicide for themselves.

Those who oppose euthanasia and assisted suicide point out that legalization of these practices might jeopardize the advances already made in patient and surrogate rights to make decisions about other forms of end-of-life decisions.17 Legalization of euthanasia and assisted suicide by the courts with clear safeguards to ensure against abuses may cause the courts to scrutinize the broader issue of end-of-life decisions, and possibly impose unwanted restrictions on other end-of-life decisions to ensure against abuses.

A final argument is that legalization of euthanasia may reduce societal abhorrence of homicide and thus lead to a general devaluation of life.7

Medical Ethics Arguments For and Against Euthanasia and Assisted Suicide

Pro

The principles of autonomy and beneficence in medicine are the foundations put forth by those who support physician involvement in euthanasia. The argument is made that patients have the autonomous right to make decisions concerning the ends of their lives. Physicians have an obligation to act in the patient's best interest as determined by the patient in concert with the advice of the physician. Since death may be the last "good" in a person's life, physicians have an obligation to seek that good when other traditional forms of therapy do not bring about a greater good as represented by the alleviation of pain and suffering.

A consequentialist argument put forth by both physicians and patients states that our continued disregard for patient wishes to be euthanized coupled with our seduction by medical technology have led to untold, unnecessary suffering on the part of countless patients near the end of life. This is exemplified in pulmonary medicine by the prolonged dying of some patients inappropriately maintained on life-support systems. Therefore, practices that limit suffering (euthanasia and assisted suicide) would result in the greatest net good for society. The deontologic corollary of this argument is that physicians have an obligation not to do harm by perpetuating their patients' continued suffering.

Further, it is argued that physicians have an obligation to promote a trusting physician-patient relationship. If a patient asks the physician to participate in a suicide or perform euthanasia and the physician objects, a trusting relationship cannot be realized because the patient may feel abandoned or without control at what may be the most dependent, stressful time of his or her life.

Con

The primary argument for the refusal of physicians to participate in euthanasia and assisted suicide is that
these practices are antithetical to the concept of being a physician, the protector and champion of human life. To engage in killing patients destroys the essence of what it means to be a physician. The Hippocratic Oath proscribes the use of deadly drugs or the suggestion of their use. The World Medical Association International Code of Ethics states that the "physician shall always bear in mind the obligation of preserving human life." The deontological expression of this concept is that it is wrong for physicians to kill or assist in the suicide of patients.

Several consequentialist arguments have also been presented. The first is that legalized euthanasia and assisted suicide will lead to patient mistrust of physicians born of fear that external forces (family, third-party payers) will cause physicians to have divided loyalties and prematurely coerce patients to ask for euthanasia or assisted suicide. This mistrust will result in further deterioration of the physician-patient relationship. A second argument is that once physicians begin to euthanize patients, they will no longer view as before their broader roles as comfort and caregivers and consequently may try less vigorously to develop and promote more effective comfort and care measures near the end of life in all patients.

Practical Strategies in the Euthanasia Debate

It is not surprising that the two sides of the euthanasia and assisted suicide debate use both deontologic and consequentialist arguments to support their positions. Both sides seem to begin from deontologic positions, but arguments based on consequences seem, to practically minded Americans, more persuasive than those which say that we should or should not do something based on principle. Supporters of euthanasia and assisted suicide raise the specter of unnecessary suffering and loss of trust, rather than arguing exclusively that the principle of autonomy demands that patients have the right to determine how and when to end their lives. Those against euthanasia and assisted suicide, instead of focusing exclusively on the argument that it is wrong to kill or assist in the suicide of innocent humans, cite the potential for moral decay and the apparent abuse of the practice as described in the Remmelink report as justification for rejecting the practice. It has been suggested that, like the abortion debate, the euthanasia and assisted suicide debate will ultimately pit those considered to be "pro-choice" against those who are "pro-life." If this occurs, a consensus may never be reached in our society since both sides base their positions on fundamental beliefs not grounded in logic and, therefore, not subject to logical discussion.

Possible Outcomes of the Debate

Growing support for euthanasia and assisted sui-
pendency, or “unworthy dying.” This suggests that
attention to relief of psychological suffering in dying
patients is often ignored or minimized by the harried
modern physician or relegated to the territory of
family and clerical support. We would do well to
remember and resurrect the ancient meaning and
practice of euthanasia. Were we as physicians to
address the psychological suffering of patients as
vigorously as we do the scientific aspects of care, the
public’s sense of desperation, loss of control, and sense
of abandonment might diminish and public interest in
euthanasia might well dissipate.

When the patient mentioned at the beginning of
this discussion offered me the money to end his life,
I realized I had been insensitive to his needs. By
speaking at length with him, I recognized that it was
not his physical limitations that were so distressing,
but rather his loss of sense of independence that led
to depression. After trying to help him deal with these
feelings for a number of weeks, I realized that he was
feeling no better, and asked if he would be willing to
see a psychiatrist. He agreed, spent the remainder of
his life periodically having therapeutic sessions, and
died several years later. He never again mentioned
euthanasia. The resolution of this patient’s suffering is
consistent with the findings in the Remmelink report.15
Of all Dutch patients wanting assurance that physi-
cians would actively assist in their dying, two thirds
never made a serious request, and of those who did,
two thirds were not euthanized because alternative
forms of treatment were found.

CONCLUSION

The purpose of this communication has been to lay
out in a disinterested fashion the ethical arguments
for and against euthanasia and assisted suicide and to
suggest the possible outcomes of the debate. None of
us who have taken care of dying patients is a disinter-
ested observer; each will have strong feelings about
the debate. It is important that each of us understands
that society’s choice does not determine medicine’s
position in this matter. In the end, we would be wise
to follow the advice of Edmund Burke:16 “It is not,
what a lawyer tells me I may do; but what humanity,
reason, and justice tell me I ought to do.”

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