

ISSUE 4

*Permitting Physician-Assisted Suicide
would/would not result in a “slippery slope”
ending in involuntary termination of our
most vulnerable and powerless citizens*



The Slippery Slope Phenomenon



ENTER THE PHYSICIAN ACCOMPANIED BY THE
ARGUMENT THAT PHYSICIAN-ASSISTED SUICIDE
CANNOT BE CONFINED TO THE WILLING AND
COMPETENT BECAUSE OF THE “SLIPPERY SLOPE”
PHENOMENON

We never broached Dad’s request for assisted suicide with his oncologist or any of the other physicians involved, although I would later give a great deal of thought to employment of the medical profession as facilitators of assisted suicide. While a deep exploration of the morality of suicide and assisted suicide without the addition of physicians was necessary before coming to this discussion, the fact is that when people discuss the issue of assisted suicide they generally are talking about the morality of physician-assisted suicide (PAS). There are a number of reasons for this. The current debate, as it focuses on assistance, almost by definition deals with those too ill or disabled to kill themselves. Those are people who fall within the province of medicine. Probably many of these very ill people could blow out their own brains with a gun, which could easily be obtained for them if they didn’t have their own, but this presents a picture that likely strikes most as brutal and unfair. They are ill and suffering. Nothing could be more discordant with the narratives of finding peace, of the good death, than the violent explosion of a weapon, leaving blood and brain matter on the walls for their loved ones to find. In

fact, a powerful rhetorical strategy employed by those who favor assisted suicide is to tell grisly tales of the terminally ill who are forced to end their suffering by violent means.¹ Assisted suicide needs to be clean, calm, and tidy, that is, medical.² Perhaps, as opponents of assisted suicide might claim, this keeps people from facing up to what they are really doing. I think, rather, that they know what they are doing. This is just an acceptable form. What they focus on is someone who has a license to obtain the type of drugs that can cause a peaceful death, who knows how to properly administer the drugs, and who can move easily in both the institutions where most people die (hospitals and nursing homes) and their private homes. That person, of course, is a doctor. And with doctors and the medical profession there comes the argument of the “slippery slope.”

In this argument, something awful awaits us if we slide all the way to the bottom of the slope. The essence of the argument is that once you embark down the slippery slope you will not be able to stop until you reach the dreaded bottom.³ In the realm of assisted suicide, involuntary killing of the most vulnerable in society (the elderly, sick, disabled, or disadvantaged minorities) lies at the bottom of the slope,⁴ from which no set of guidelines or rules can prevent the inevitable fall.⁵

Philosophically, the slippery slope argument provides a method of supporting and justifying an absolute utilitarian rule. It differs, however, in the normal method of support for such a rule. Rule utilitarianism is generally based on the notion that at a certain numerical threshold an act that is part of a general practice (such as walking across a public lawn) will do harm. In contrast, the slippery slope argument is not concerned with numerical thresholds as such but with the idea that the initial practice will inevitably lead to a different and far more morally abhorrent practice.⁶ As such, I find the analysis as much or more akin to the type of social policy analysis one associates with law than with moral philosophy.⁷ Although I am aware that this distinction between “social policy” and “morality” can be deconstructed, I believe the general contexts in which the two are applied in our common experience are sufficiently distinct so as to be useful for this portion of the analysis. (Perhaps the policy argument differs from the moral one we are considering here in that the former can be a nuanced position of comparative risk while the latter requires a much greater sense of certainty.) Regardless of how one classifies the slippery slope argument, however, it is a pivotal one in the debate over assisted suicide.

Central to any consideration of this form of argument is the issue of burdens of proof. Who has the burden here and what is the nature of that

burden? Must those proposing physician assisted suicide (or voluntary euthanasia) prove to some standard of certainty that this doomsday result will *not* happen or does the duty of proof rest with the opposition? On either side, how does one prove this?

In order to sift through this crucial notion of burdens, I found that the following hypothetical helped to shape and clarify my thoughts. You are on a hike with a companion when your friend comes upon a patch of mushrooms. He starts to pick some, saying that they will taste great with the sandwich he brought for lunch. When you say that you think they may be deadly, he asks if you are sure. When you answer no, he responds, "If you can't prove to me they're poisonous, I'll eat them." I think most of us would find that the friend's attitude crosses the threshold of idiocy. If instead you had the same dialogue about a package of mushrooms from a grocery store, or even an apple plucked from an apple tree (assuming you wash off the pesticides), the friend's decision to eat the mushrooms or the apple would seem reasonable. In fact, your opposition would seem extremely odd. It is true that literally every food on the planet will cause a life-threatening allergic response in some small percentage of the population, but unless someone provides us with specific information that convinces us otherwise, we happily gorge on our food. So why is the mushroom example different and what does it tell us about burdens?

It tells us that there is no single burden of proof, such as the prosecution's burden in a criminal case, but a sequence of shifting burdens. First, the party objecting to the practice must show that there is such risk and that it is of a sufficient magnitude to be of concern. Magnitude, in turn, will be a function of two interacting concepts, frequency and seriousness. Eight out of 10 should get our attention if that's the established frequency of a particular risk. If we engage in the conduct, we know the chances are pretty good that the risk will come to fruition. One out of a 100 seems like a fairly low frequency. But if the one out of a 100 risk is that we'll accidentally set off a nuclear explosion then the risk grows in magnitude. This is what the mushroom scenario is all about. We know that many mushrooms are poisonous. If the friend guesses wrong, he may die. That's serious magnitude. In light of this, his claim that I must prove to him that this mushroom is unsafe appears deeply stupid.

Having established a real risk of significant magnitude, the burden now shifts to the person proposing the practice to bring forth evidence either that in this particular case the risk will not come to fruition (he knows that the mushroom is safe or he knows it's poisonous but he has an immunity

to that poison) or that he can create safeguards that avoid the risk (he has a test kit that will tell him if the mushroom is safe).

I would, however, place the ultimate burden of proof on the person who relies on this particular slippery slope analysis.⁸ Recall that the starting point of this moral argument against assisted suicide is that the initial action of participating in it might be seen in isolation as not immoral. The immorality comes from the consequences of permitting this action: an inevitable and inexorable slide to the horrific narratives of unconstrained, involuntary euthanasia of vulnerable populations, which will be the equivalent of geriatric genocide, mass murder. It would seem that if people are to be labeled as immoral under this slippery slope scenario, those providing this theory must put forth a convincing position that people like my father are (or at least should be) aware that their actions carry a realistic risk that this scenario will come to be. After all, it is in the willingness to take that risk that any claim of immorality must find its source.

How heavy should this burden be? That depends on the particular society's view of risk aversion and thus on what level of risk taking could be considered "acceptable" or "unacceptable" in that culture. While there may well be risk-averse societies, America would seem to be quite the opposite. Risk taking lies at the core of our cultural mythology—a small group of Puritans in search of religious freedom crossing the Atlantic in a small wooden craft named the *Mayflower*; English subjects risking certain execution for treason in fomenting a revolution to gain independence; pioneer families making the dangerous trek west on the Oregon Trail to build a new life, thereby becoming the embodiment of our "pioneer spirit"; and, of course, the American entrepreneur, risk taker par excellence. In fact, the very structure of our society under the Constitution bespeaks of our willingness to accept great risk as a necessary cost of providing each citizen the space for full human realization free of government interference. Thus, we accept the risks accompanying almost limitlessly unconstrained freedom of speech and expression, the risks of a politics based on majority rule, and the risks of criminality due to constraints on police that make detection and prosecution of crime more difficult.

Under this ethos of extreme risk taking, it would seem that we would not label someone as "bad" (and in fact partially responsible for the killing of countless innocents) for performing an otherwise moral act unless it is demonstrated that the otherwise moral action carried a clear and likely risk of the substantial harm envisioned at the bottom of the slippery slope. Of

course, a legislature could prove to be extremely risk averse in the PAS arena and ban the initial conduct based on the fear that it could conceivably lead to the slippery slope scenario, but that would be a statement of pragmatic policy, the result of balancing risks, consequences, futures studies, conflicts among constituencies, costs and realities of effective supervision and regulation, and such. It would not turn on the sources of moral labeling we are investigating.

In the domain of the slippery slope and assisted suicide I do not doubt that the risk is real in the sense that if you condone physician-assisted suicide (and euthanasia) at some point there will be a case of killing without the patient's consent. Nor could anyone dispute the seriousness of such a consequence. Rather, the debate is over frequency. Will this happen so frequently as to become an all but routine aspect of future medical practice?

In attempting to meet their burden, the opponents of physician-assisted suicide rely on two sources for their proof: assumptions about likely human behavior within the social, cultural, and economic world of medicine and illness;⁹ and empirical analyses of actual programs that permit physician-assisted suicide (the Netherlands and the state of Oregon).

A CLOSER LOOK AT THE SLIPPERY SLOPE

The Paradigm Case: The Nazi Eugenics Program

We have already touched on the Nazi eugenics (selective breeding) program,¹⁰ which was ostensibly pursued in the quest for a master race. A fuller exploration of the progressive steps through which the program devolved will give a sense of an apparent slippery slope in action and provide a vivid image of what those opposed to physician-assisted suicide most fear. As I said before, I am not neutral when it comes to the Nazis. Most of my relatives from my father's family were among the six million murdered. Six million. That's mind-boggling. Kill 100,000 people in a giant football stadium. Then do it again and again and again, 60 times. That is more people than the entire population of the state of Maryland. And this wasn't done by dropping some horrific bomb. In effect, it was done one person at a time, face-to-face, six million times. My father had a cousin who lived in Lithuania. In the late 1930s, she wrote to him asking for money so she could come to America. He was young and full of himself and thought that if she wanted to come to America she could earn her

own passage. He never wrote back and never heard from her again. She died in the camps. Dad lived with the guilt until the day he died, knowing that he could have saved her.

The eugenics program began with the forced sterilization of 350,000 people with “genetically determined” diseases (feeble-mindedness, insanity, etc.).¹¹ Next followed the Nuremberg Laws, which forbade sex or marriage between Jews and gentiles. In 1939, a mercy-killing panel was established. Beginning with so-called disabled children at birth, the panel expanded its scope to the mentally ill, retarded, and epileptics.¹² By 1941, 70,000 had been killed under the program. It has been documented that half of all the doctors were members of the Nazi party prior to Hitler’s rise to power.¹³ It is still discomfiting to know that regular doctors who were committed healers could so easily shift their focus from the good of the patient to the “good of the state.” This shift was so dramatic, in fact, that killing “useless eaters”¹⁴ to free up hospital beds for wounded soldiers became a routine part of medical practice.¹⁵ World-renowned humanist psychiatrists willingly took on the task of killing mental patients,¹⁶ their eagerness going beyond even what the government requested of them. One of the doctors on the mercy-killing panel for disabled children was the inventor of the ultimate lifesaver of the newborn, the incubator.¹⁷ The extermination of the Jews then followed through a rhetorical play on medical terminology. The Jews carried “dangerous genes” and “racial poison.”¹⁸ They had to be eliminated.

With this history of doctors so readily switching from their role as healers to that of killers, it is hardly surprising that opponents of physician-assisted suicide would see the risk of a similar tragedy if we begin to let doctors in America participate in killing their patients.

But this analogy can only be taken so far, supporters of physician-assisted suicide will say. It is, to be sure, a cautionary tale of which we must never lose sight. Rather than providing a glimpse into the future, however, it will serve as a brake on slipping down the slope, just as the shameful image of the interment of Japanese Americans in World War II likely constrained the actions of the government against persons of Middle Eastern descent after 9/11. Anyway, Nazi Germany was totally different. That was a society in which all allegiances were to the state. It was the fatherland, not the individual, that counted.¹⁹ In such a society, sacrificing the individual for whatever the government perceives is the greater good was inevitable (particularly in an all-out war). America could not be more different. It is a government of the people, by the people, and for the people.

The state exists to serve the people. The individual is guaranteed civil rights against the state, which are enshrined in the Constitution. We believe in patriotism, but its purpose is to defend the “Land of the Free.” The slide down the German Alps simply is not replicable on the freedom-bathed American Rockies.

I, too, believe that it can’t happen here, at least not anything that monstrous. But, on the other hand, I know that when our nation is under stress bad enough things can happen (e.g., the suspension of habeas corpus and the ban on criticizing the government during the Civil War, the criminalization of dissent during World War I, the interment of Japanese during World War II, McCarthyism, the illegal conduct of the FBI in attempting to undermine the antiwar movement during the Vietnam War, and the government’s attempt to broaden police powers at the expense of civil liberties after 9/11). Also the Nazi eugenics program did not function in an intellectual vacuum. The Nazis had a theory, which was subsequently mirrored in a 1927 opinion of the U.S. Supreme Court. In 1920, the preeminent legal expert Karl Binding and noted humanitarian Alfred Hoche published an article entitled “Permitting the Destruction of a Life Not Worthy of Life.”²⁰ Seven years later, in the case of *Buck v. Bell*, the Supreme Court approved an involuntary sterilization law. In that case, Justice Holmes declared what could have been the slogan for the first stages of the German eugenics program when he wrote, “Three generations of imbeciles is enough!”²¹

The Physician-Assisted Suicide Slippery Slope

The slippery slope that leads from physician-assisted suicide to involuntary killing of the vulnerable goes approximately like this.

- The psychology of doctors will begin to subtly change as they become comfortable with the idea that they can kill as well as heal within their concept of being a medical professional.
- Initially, their historical focus on healing, with an accompanying sense of failure if they cannot heal, combined with the new possibility of killing, will lead some doctors to hide their failures through assisted suicide.
- Next they will avoid failure all together by using assisted suicide to solve the problem of tough cases.

- Doctors are not well trained in, and thus not very good at, palliative care (comfort care focusing on pain control and support for the spiritual, psychological, and emotional needs of the dying). Yet, most desires for suicide in the terminally ill can be attributed to suffering that could be alleviated by means of palliative care. The availability of assisted suicide, however, will take away incentives to increase physicians' knowledge of and patients' access to palliative care. Thus, a vicious cycle will take place in which the less palliative care is available to treat the common causes of suicide requests the more people will seek assisted suicide. The more patients resort to assisted suicide the less will be the incentive to develop a quality system of palliative care, and so on.
- At the same time, the psychology of the dying will begin to change. Not only will they be subject to coercion from family members to whom they have become an emotional and financial burden, but incrementally they will begin to believe that because they can die (have a right to die) they should die (have a duty to die).
- Run by huge bureaucracies focused on the bottom line, medicine will increasingly have an incentive to cut costs by terminating persons nearing the end of life (especially given that the final month of care is by far the most expensive). The easiest targets will be the most vulnerable (the isolated, elderly, poor, sick, and mentally diminished).
- Finally, the medical bureaucracy will receive the tacit support of the wider society. As medical resources become scarcer and scarcer, society will have to find methods of allocation (i.e., triage). Euthanizing old, very ill people near the end of their lives will be condoned as a partial solution to this resource crisis both because it will be perceived that, as a group, these old people have already had their fair share of health and life and because, as a practical matter, old sick people are incapable of acting collectively as a countervailing political force.

All in all, this is a pretty scary scenario.

Is this scenario of institutionalized, involuntary euthanasia a realistic one? Will acceptance of physician-assisted suicide lead us to insulate ourselves from moral realities to the extent that everything is so cloaked in sterile medical technology that we are no longer capable of distinguishing between medicine and murder? Those terrifying questions led me to carefully examine each premise in the preceding behavioral scenario.

The Psychology of Doctors

The first major slide down the slippery slope is based on an implicit argument that goes something like this.²² Doctors are trained to be healers.²³ When they no longer can heal, they are at a loss. They face the limitations and failures of their craft and their exercise of that craft. In the past, they dealt with the inability to treat by throwing up their hands and saying, "There's no more I can do for this patient," leaving what remained to family members and nurses. If you add the notion that they can kill their patients as well as treat them, this additional dimension of their role will gradually be used to fill the uncomfortable void left when their medical arts no longer can perform medical miracles.²⁴ They do not have to be confronted with their failures. They do not have to agonize over cases so close to hopeless that failure is all but certain. They can employ their medical knowledge to make that failure disappear; they can utilize their authority to convince the patient that he or she should die.²⁵

I, too, think of doctors as healers. Incredible advances in medical technology (bypass surgery, transplants, chemotherapy, CAT scans, MRIs, laser surgery) have expanded the doctor's healing arts toward the miraculous. Of course, doctors know that they cannot conquer death, that death defines us as human. Yet it is not so simple. While doctors know this, they also know that the immediate cause of death is always some disease or system failure (heart failure, kidney failure). Since they believe that they can combat any disease or system failure on some level, doctors do believe that they can cheat death.²⁶

No doubt it is painful personally and professionally not to be able to save a patient in spite of all your knowledge, skill, and access to technological resources. Yet to move from that to the conclusion that "once they taste blood" in assisting a suicide doctors will so lose feelings for the human value of their dying patients that, in order to not face their failure, they will kill them (like someone would throw away a clay bowl they made because it did not turn out right) is quite a leap. When we imagine that doctors would conduct nonvoluntary (though not involuntary) euthanasia by killing people who are not even dying but are demented or semiconscious, that leap is greater still.

To make that leap, one must make a number of assumptions. First, we must assume that doctors are problem-solving virtuosos who only see the medical problem (heart murmur, flu, facial burn, sprained ankle, pregnancy, cancer) as unconnected to the human being whose problem it is.

Second, doctors have no respect for the value of human life in general, only valuing life to the extent they personally can save or improve it. Third, the current consciousness, perspective, and training of doctors at this date will continue unchanged even if the medical profession accepts physician-assisted suicide as a tool (albeit an extreme tool) in end of life care. Fourth, the role of the doctor has always been limited to mechanical healing without concern for patient suffering or the need for compassion.

As to the first two assumptions, I have certainly encountered a few doctors in my life about whom these assumptions would hold. They are not encounters one easily forgets, and they were not individuals I thought were good doctors or would ever wish to see again. In my experience, the vast majority of doctors do see their patients as people and value their lives individually and as part of a network of family and friends. They do their best to fight for the patient in tough cases but know that they can only do their best. I cannot imagine these doctors killing patients to avoid failing or facing failure. Admittedly, my perspective was formed as an educated, upper-middle-class, Caucasian male patient who has the support of a broad, similarly situated group. I am not a sick person in his nineties lying alone in a bed in an understaffed state nursing facility.

As to the third assumption about training and perspective, I will address it next when I discuss palliative care. At this point, I can say that with the significant focus on end of life care over the past decade, and as the baby boomers care for their aging parents and face their own mortality, recognition of end of life care as a part of medical practice is an evolving reality.

As to the fourth assumption, the idea that, for doctors, it is either heal or nothing, this seems vastly overstated. Relief of suffering and compassion have always been part of the doctor's role.²⁷ It was at the center of the school of Hippocrates. I recognize that opponents of PAS point to the Hippocratic oath as an argument against a physician ever aiding a patient in committing suicide.²⁸ And it is correct that the oath specifically bars giving a patient poison and thus bars assisted suicide.²⁹ The oath, however, also forbids surgery, abortion, and fees for teaching.³⁰ Thus, no one particular portion of the oath can be taken as more than a function of the particular historical context. The broader sweep of the oath, however, transcends its particulars. The oath provides a vision of medicine as nonintrusively aligned with nature as the real healer.³¹ The medical philosophy is one of restraint. It also offers a school of healing that pledges to act

with less self-interest than competing schools of healing and other trades in general.³² The hope, then, was that patients would avoid seeking extreme self-remedies and, when they chose healers, would choose the school of Hippocrates. In fact, Hippocrates believed in trying to do away with suffering, lessening the violation of the disease, and refusing to treat those who were “over mastered by the disease.”³³ In other words, he believed in compassionate care.

Patient Mistrust of Doctors

A related argument against physician-assisted suicide focuses on the projected effect on the psyche of patients. As doctors become willing to assist in suicides, and perhaps euthanasia, more vulnerable patients will gradually become less trustful of doctors and may in fact even grow to fear that the doctor will kill them.³⁴ With this loss of trust, doctors will become less able to care for patients. After all, patients must have confidence in both doctors' competence *and* motives if they are to make the wholehearted commitment to their treatment that is often required. Patients who, as a result, become sicker and more vulnerable will fear involuntary euthanasia even more and will trust doctors even less, and so the downward cycle will spiral. Surveys conducted on this issue come to contradictory conclusions.³⁵

Now, if I were old, sick, and alone, I certainly would not want to think that my doctor might creep through the hospital or nursing home at night and inject me with some lethal drug. But it is difficult for me to see how I might come to this conclusion merely from the fact that I am aware that my doctor was willing to assist in the suicide of a suffering, terminally ill patient or even carry out voluntary euthanasia under the same circumstances. It seems as likely that my trust will actually be greater knowing that my doctor will do everything possible to relieve my suffering, including (as a last resort) assisted suicide. (In fact, many patients, once they know assisted suicide is available, relax and never use it.)³⁶

To the extent that I perceive my doctor not as *my* doctor but as a foot soldier in a profit-obsessed medical bureaucracy, however, my feelings may well be otherwise.³⁷ But the problem then is not so much that there is a lack of trust because of some issue with the appropriate parameters of the physician's role (saving versus taking life). It is a lack of trust based on what I perceive as a conflict in loyalties. This, not the doctor in the role of killer, is the real issue. The fear accompanying the sanctioning of assisted

suicide and euthanasia, then, is that we are placing a lethal weapon in the hands of someone we cannot trust. I will discuss this later when we consider bureaucratic medicine and the slippery slope.

The Vicious Cycle of Palliative Care

Palliative care³⁸ is concerned with bringing comfort not a cure.³⁹ As such, it provides all the technologies available to alleviate, or at least control, pain. Since suffering is composed of more than raw, physical pain, palliative care attends to the emotional, psychological, and spiritual aspects of suffering as well.⁴⁰ The angels from hospice obtained whatever pain medication my father required at whatever hour it was needed. They also offered to arrange for massages, spiritual or psychological counseling for my father and our family, special mattress pads, storytellers, and more. They dealt with the whole man as situated within his full world.

Most people who seek assisted suicide do not do so because of uncontrollable pain.⁴¹ They may fear such pain, but in fact most pain (though not all,⁴² as appeared to be the case with my father) can be brought under control.⁴³ They wish to die for other reasons such as not wanting to be a burden on others or having difficulty accepting their increasing dependence, which they associate with a lack of worth.

On the other hand, most doctors historically have not been well trained in pain control⁴⁴ and certainly not in dealing with what appears to be the less scientific (emotional, spiritual, psychological) aspects of suffering.⁴⁵ Doctors, after all, are there to diagnose and heal. Medicine is a heroic enterprise, not one that provides comfort once the battle is lost. And there surely is something to this position. Traditionally, little of medical school training dealt with pain relief and almost none with end of life cases. Further, the fear of addiction led doctors to ration the most powerful painkilling drugs (such as opiates) until absolutely necessary,⁴⁶ that is, when the pain is rampaging out of control. Also doctors do not want to bring themselves up against state licensing boards or Drug Enforcement Administration investigations.⁴⁷ Thus, even as late as 1994, studies found the quality of palliative care, including pain control, to be deplorably poor in American hospitals.⁴⁸

Admittedly, from my own experience I know that there is a generation of doctors that holds onto old notions of pain control and drugs (“Let’s see if aspirin works before we give you aspirin with codeine for that abdominal surgery”). But, also from my experience, I’ve seen modern ideas about pain control becoming more the norm. Act before it begins to get out of

hand. And forget this fear of addiction.⁴⁹ You're dealing with very sick and dying people. My father did not get high on the drugs; they just got him to the place where he was not writhing in pain, where he could interact on some normal, human level.⁵⁰ Also there appears to be an expanding awareness of the role of palliative medicine and end of life care in the medical practice.⁵¹ After all, for well over a decade the American medical profession has been bombarded with book after book, article after article, and talk show after talk show about their deficiencies in these areas. At some point, some of that seeps through.

Enter the slippery slope. Whatever admirable progress we might be making in palliative care will come to a halt. With assisted suicide and voluntary euthanasia as options, there will be no incentive to invest in learning about and expanding facilities for palliative care. After all, people who are dead do not suffer.⁵² Since palliative care addresses many of the motives patients have for seeking to end their lives, however, lessening availability of palliative care will lead to more patient requests for death, which, in turn, will further reduce incentives for palliative care, and so on,⁵³ a vicious cycle in which more and more patients are driven to death by what increasingly is unrelieved suffering.⁵⁴

I can see that this could happen, but I do not see why these consequences are any more likely than their opposites. Imagine widespread acceptance of physician-assisted suicide. In that world, I would know that as a physician I could be called on to assist in, or even carry out, a patient's death. I would also be aware of the relationship between good palliative and end of life care and requests for death. Rather than a disincentive for learning more about pain control and general palliative care, it would seem to be quite the opposite. Physician-assisted suicide would only be part of a continuum of care. Ending the life of a patient is a professionally and emotionally difficult thing, as narratives of doctors who have participated in such a death (other than Doctor Kevorkian) reveal.⁵⁵ I would not want to carry that burden if there was another reasonable alternative. I certainly could not imagine having to face the fact that because I did not apply principles of palliative care a patient needlessly committed suicide with my assistance (or that I actually killed him or her).

Enter Bureaucratic Medicine

In truth, the bureaucratic nature of current medical practice is the most frightening aspect of the slippery slope argument because all baby boomers

know that the practice of medicine has completely changed since we were young.⁵⁶ We grew up in a time when our family doctor would come to our homes when we had the measles or mumps. There were no bypasses, MRIs, or sophisticated antibiotics. Science has plainly moved far forward. But there were people we considered *our* doctors. For most of us, that is no longer the world in which we live. We have someone called a primary care physician who we see, often as a prerequisite to being sent to a fragmented array of specialists and subspecialists. If and when some loved one must go to a hospital for surgery or some serious illness, in my experience, the lack of a sense of being watched over by an identifiable, responsible physician is even greater. You cannot leave a friend or family member alone in a medical facility.⁵⁷ Information does not always pass accurately from person to person or shift to shift. Let me tell a short story, one that ten years later is still vivid.



We were increasingly having problems with controlling Dad's pain, and controlling his pain was literally the number one focus of all of our lives. After weeks of trips back and forth to the hospital and changes and additions to medications and dosages, we all agreed that the best solution would be to hook Dad up to a morphine pump at home. That way my father could push a button whenever he wanted more pain medication. The hospice nurses, of course, were responsible for calibrating the machine for the appropriate time (which increasingly was set at shorter intervals) and dosage (which was increasingly set higher).

To hook up the pump, however, first required a short and simple surgical procedure in which a shunt was inserted into Dad's chest.

When we went in for the procedure, the surgeon approached us with an additional surgery that could be done at the same time—a sort of two for one. Tumors were obstructing the passage into Dad's stomach, blocking what little food he ate. Why not remove these as long as Dad would already be in surgery?

We were, if anything, a proactive group. What will this accomplish? A bit more comfort and a bit more nutrition, which might lead to the patient living longer. How much longer? Hard to tell. Days, maybe a week or more. This sounds like major surgery. Won't he be in pain and have a significant period of recuperation? That's possible. But he's dying. Won't this diminish his quality of life during the little time he has left? I guess so. Forget it! Just put in the shunt. (In fact, within a week, Dad decided to stop eating and drinking any-

way in order to move things along as quickly as his body was willing to cooperate.) Later that afternoon Dad was back from surgery with a brand new shunt and feeling all right. We left later that evening, planning to bring him home the next day.

We were home the next morning arranging for something the exact nature of which now escapes me, regarding Dad's final stay. The phone rang, and I answered. "John, you know this is wrong. This is so very wrong. How can a son do this to his father? You will have to live the rest of your life with this on your conscience." What?! Dad sounded calm and clear. He also sounded totally delusional. I told him I loved him and that we were coming right over, and we all jumped into the car and rushed to the hospital.

When we got there, Dad was strapped to the bed with the type of restraints they use in mental hospitals. My dad, strapped down. It was unimaginable. It took a while to piece it all together.

The night before, Dad had become restless. He wanted to walk around and yak with the nurses. That was Dad; he talked everywhere to everyone. But they had work to do. They couldn't watch Dad in order to ensure he wouldn't fall while he walked around, and they thought he needed rest before what they mistakenly believed was "upcoming surgery." So, they gave him a sedative, and he had what is termed an adverse reaction. More specifically, the pills triggered a temporary psychotic break—Dad was just nuts when we arrived that morning and had apparently been even crazier the night before. So they had strapped him down "for everybody's safety." "Fine, we're here now. Unstrap him!" But here the insanity was not Dad's alone.

Early in the morning, hospital attendants had come to prep him for the major surgery we had rejected the day before. Somehow it had been written on his chart, and, though crazy, Dad had maintained enough awareness to tell them that the surgery had been rejected. Why believe him? He was insane, in restraints, and "the chart had no notation other than the surgery was a go." Somehow, Dad convinced them to call us. "Sorry, your conversation with the surgeon rejecting the procedure was not put on your dad's chart." Okay. Again, do you want to discuss insanity? We all immediately agreed that if Dad ever had to go back to the hospital one of us would be there with him around the clock.



For most geriatric residents of nursing homes, state hospital wards, and even state mental institutions (where, as in a facility near me, they ware-

house elderly dementia patients who cannot afford a nursing facility), no one is watching. The residents comprise some combination of the sick, weak, confused, and demented. Many of these individuals are poor, and many are people of color. All are powerless. From what I saw during Mom's odyssey through a series of assisted living and nursing facilities following Dad's death, even the vast majority of somewhat affluent residents are alone, totally vulnerable. For many, family members live far away. For others, the family took heart that the patient was receiving expensive care but took little time to visit.

Back to the slippery slope. High-priced private assisted living facilities and nursing homes have little economic incentive to shorten the lives of their clients. That would be killing the goose that laid the golden egg. Stays of geriatric patients in hospital and nursing home facilities that are funded by insurance or state funds or are part of a health management organization (HMO) may well be a different story. In 2000, the average life expectancy for Americans was 76.1 years old, and those over 85 were the fastest-growing segment of the population.⁵⁸ With this increase in longevity, however, has come a parallel increase in people suffering from chronic illnesses. By 2030, one in five people will be over 65⁵⁹ (i.e., 64 million people),⁶⁰ placing great strain on the health care system. By far the greatest cost in caring for an individual suffering from such a chronic illness is during the last month of his or her life.⁶¹ Thus, when you add in the increasing Medicare enrollment in HMOs, and the fact that 40 percent of total Medicare expenses come in the last few months of life,⁶² the economic pressures to shorten those last few months only increase.

The slide down the slippery slope thus becomes clear. Permitting assisted suicide has two interrelated effects. Regularizing the taking of life of the suffering begins to instill in the physician the notion that, for some, death is a "blessing." Once doctors begin to accept their role as one of delivering this blessing, it will be natural to gradually analogize from the terminal cancer patient begging for more morphine to the shriveled, perhaps a bit confused or even demented, all but helpless hospital or nursing home resident. What could their life mean? Wouldn't death be a blessing? At the same time, when this perspective is melded with physicians' increasing loyalty to a medical bureaucracy that is centered on the bottom line and profits for shareholders,⁶³ the physician has an incentive to try to encourage these powerless, vulnerable, yet expensive individuals to agree to kill themselves.⁶⁴ We've already discussed coercion from family members. Think of the power of doctors.⁶⁵ They are the primary, and authori-

tative, source on the patient's health. They can provide information in ways that encourage or discourage patients to continue their lives. They are the ones who will decide whether a request for PAS is "reasonable," and their judgment will ultimately be powerfully influenced by their own subjective views of the "quality" of the life of the patient. To an extent, they can encourage hope or despair. They can look for possible depression-laden underpinnings of requests to die or take the request at face value. Again, this likely will be influenced by their sense as to whether "if it was me, I'd rather be dead" or not.

In nursing homes, doctors may visit, but generally nurses provide day-to-day treatment for the patient. In this domain, from what I've seen, the nurse has a professional and moral authority comparable to that which the doctor carries in the hospital.

Add euthanasia to the equation and you only make it easier to kill and increase the bottom line by providing a mechanism through which doctors can claim consent but which does not require any substantiation (as would be the case if patients must take the lethal pills themselves) outside of the doctor's word.

How realistic is this scenario? Some of the elements certainly are. Hospitals and nursing homes are filled with extremely vulnerable geriatric patients and residents. Managed care companies, and health insurance firms in general, care about profits. They are, after all, businesses. State budgets, on the other hand, are almost always strained. The expense of providing decent health care for our population is increasing, costing more than we as a society are willing to allocate. It is likely we will eventually confront making resource allocation decisions, whether those are done by categories of treatment options (routine procedures, such as physical exams and flu shots, versus more costly procedures such as heart transplants), treatment populations, and such.⁶⁶ Finally, physicians working in managed care are constrained somewhat by the economic interests of the HMO. But is that enough?

Already 80 percent of us die in hospitals and nursing homes, and 70 percent of those will have their lives ended by withdrawal of some form of lifesaving support.⁶⁷ All of one's concerns about coercion and preemptive medical decision making resulting in death are surely present here (remember, in order to pull the plug, the doctor does not even need consent if he finds the care to be medically "futile"). The question is what assisted suicide, and even voluntary euthanasia, adds to the mix. It seems to add two things. First, there will be patients who are not on life-sustain-

ing machines, so there will be no plug to pull. Most patients in nursing homes, for example, are not on respirators and such. In fact, many resident facilities for the elderly will not even accept people who require medical care beyond dispensing prescribed pills. Therefore, assisted suicide could potentially reach a far larger population. Second, withdrawal of treatment generally takes place during the last days of the patient's life. Assisted suicide could shorten the life of a geriatric patient in a hospital by weeks and one in a nursing home by months or even years. Could it happen here? Possibly it could, but I don't think so.

Admittedly, extreme scarcity could change that, not by making doctors secret killers but through a cultural understanding that, under some circumstances, one has an altruistic "duty to die." This was, after all, part of Eskimo, Norse, Samoan, and Crow Indian culture. From my current perspective, putting my grandmother or mother on some ice floe to perish is incomprehensible. And I believe that it is not a place we can arrive at incrementally, small step by small step, without noticing along the way. I believe it would take something far beyond inconvenience and scarcity of medical resources.

The behavioral underpinnings of a slippery slope rationale for an absolute utilitarian rule banning physician-assisted suicide paint a troubling picture, which I think must be taken very seriously. On the other hand, we are not considering the wisdom of assisted suicide as a social policy, though the means of inquiry may appear similar to such an analysis. We are deciding whether the slippery slope argument justifies a position in which it is always *morally* wrong for a doctor to assist in a suicide. The arguments resting on assumptions about the behavior and psychology of doctors and those in the medical field do not persuade me. While the projected ride down the slope would be a frightening abnegation of the most basic values of our society, there are far too many speculations and contingencies to conclude that, if we permit doctors to help people like my father end their suffering, the end of the ride to the bottom is "a clear and likely risk." At the same time, the decision to protect the vulnerable from a coerced or involuntary death by deterring assisted suicide through labeling it as immoral impedes the choice of people like my father (rational and supported by a strong family network) to end their extreme suffering in the face of an imminent and certain death.

Interestingly, some have made a slippery slope argument in favor of assisted suicide: if we do not legalize and regulate assisted suicide, then it will happen anyway, Kevorkian style, with the type of abuses accompany-

ing any such underground practice.⁶⁸ I do not find what is in effect a lesser of two evils argument to be a very compelling one from a moral perspective. After all, those who believe assisted suicide is otherwise morally supportable do not need this argument. Such a stance is only needed if one is implicitly saying that assisted suicide is wrong but it's going to happen whether we like it or not, and, given that, we're far better off if it's out in the open and regulated. Again, this might be acceptable as real politics, but it is hardly inspiring morally. Plus I disagree with the factual premise. While I believe that there are instances when doctors or nurses surreptitiously assist in patient suicides, or even perform euthanasia, these happen in medical facilities or private homes, not in a Kevorkian van or any other setting comparable to the image of the back alley abortionist that added so much moral force to the pro-abortion movement. Many such incidents, in fact, happen under the medically sterile guise of PDE. Also most of those seeking to end their lives with medical assistance are very sick, often in hospitals, under home care, or in nursing homes. They are not likely to jump into their cars and go into the night searching for some dark angel of death.

THE NETHERLANDS AND THE DUTCH STANCE

Sooner or later anyone discussing assisted suicide and euthanasia will focus on the Netherlands. Generally, it will be those opposing assisted suicide and euthanasia who will cite the Dutch experience. They will treat it as a laboratory experiment that has produced data verifying the slippery slope hypothesis. To place these claims in context, it is best to first appreciate the legal structure within which physician-conducted euthanasia was first tolerated and subsequently legalized in the Netherlands.

The Legal Evolution

In 1973, a Dutch court convened over the murder prosecution of a physician who had intentionally injected a lethal narcotic dose into her seriously ill and suffering mother.⁶⁹ What happened in this case would not be comprehensible in a similar trial in the United States. We have a strong commitment to a true adversary system, and, at least in a case involving such a serious charge, the prosecutor's only concern would be to ethically obtain a conviction that is legally sustainable on appeal. In the Netherlands, however, adversariness takes a backseat to the "principle of expediency and

advisability.⁷⁰ Under this principle, good “public policy” is more significant than individual guilt. To this end, the court trying the physician listened to expert testimony about the prevailing ethical standards of Dutch medical practice and found that euthanasia is acceptable to the medical community, assuming a given set of circumstances.⁷¹ Although legislation declared the physician’s admitted conduct to be homicide, the court created something hovering between law and social policy that was intended to rationalize the discrepancy between legal norms, on one hand, and societal morality on the other. The judge thus found the defendant guilty of murder and then, finding that she had followed the protocol for euthanasia in the Dutch medical profession, sentenced her to *one week* of incarceration (suspended) and a year’s probation.⁷²

Subsequently, cases in 1984 and 1986 created an actual defense to a homicide charge in the context of physician-conducted euthanasia.⁷³ The law had long recognized a defense of *necessity* (force majeure)⁷⁴ wherein one can violate a law to avoid a far greater evil (e.g., tearing down someone’s house as a firebreak to save an entire neighborhood or speeding to rush a child who has swallowed poison to the hospital).⁷⁵ The Dutch courts applied this concept of necessity to what they found was an irreconcilable “conflict” between two duties incumbent upon the physician: the duty to preserve life and the duty to avoid suffering.⁷⁶ Euthanasia was found to be an acceptable choice under this necessity theory. That defense, of course, required adherence to the type of criteria for carrying out euthanasia followed in the general medical community.

In 1993, this medical protocol was enacted into law, though not through amendment of the penal code.⁷⁷ Rather, the protocol was appended to an act dealing with coroners, death certificates, and burial.⁷⁸ If physicians followed the protocol, reporting their compliance to the prosecutor, they would not be prosecuted, though their act of intentionally taking a life was still considered murder under the law.⁷⁹ In theory, of course, the prosecutor could determine that the guidelines had not been met and file murder charges. The specific guidelines were:

- The request must be made entirely of the patient’s own free will and not under pressure from others.
- The patient must have a lasting longing for death: the request must be made repeatedly over a period of time.
- The patient must be experiencing unbearable suffering.

- The patient must be given alternatives to euthanasia and time to consider these alternatives.
- There must be no reasonable alternatives to relieve suffering other than euthanasia.
- Doctors must consult with at least one colleague who has faced the question of euthanasia before.
- The patient's death cannot inflict unnecessary suffering on others.
- Only a doctor can euthanize a patient.
- The euthanasia must be reported to a coroner, who is to be supplied with a case history and an affidavit stating that the guidelines have been followed.

THE DUTCH NOTION OF "PRAGMATIC TOLERANCE"

The Dutch approach to euthanasia is a product of the social upheavals of the 1960s, of the rise of a "secular morality" focused on individual choice,⁸⁰ and of the uniquely Dutch form of compromise between existing legal norms and the realities of the prevailing morality in the society known as "pragmatic tolerance."⁸¹ The treatment of possession of a recreational amount of hashish or marijuana is a well-known example of this concept. The Dutch maintain the prohibition against possession of those drugs under their penal law, but they tolerate open violation of the law if a particular protocol is followed (e.g., smoke in designated "coffee shops" or private residences and only possess that amount determined by the government to be appropriate for personal consumption).

The point of these compromises is to avoid serious social fragmentation and dissent, while maintaining an open public dialogue on important social issues.⁸² This tradition of pragmatic tolerance is deeply embedded in Dutch culture.⁸³ From the nation's inception, the Dutch needed cooperation across a range of different constituencies without the possibility of a strong central framework to coerce it. In a nation comprised of a confederation of culturally different provinces, the Dutch had to live and let live if they were to work together in national self-defense, carry out the extraordinary task of reclaiming and protecting their land from the sea, and create a commercial empire from which this tiny nation once (incredibly) dominated the globe.⁸⁴

Admittedly, American law enforcement has its own variant of prag-

matic tolerance, which we term “discretion.”⁸⁵ It is said that our society would be intolerable if the police enforced every law on the books in every situation (e.g., when I pass a police car parked on the shoulder of a freeway and I’m going 58 miles per hour in a 55 zone, I’d be both shocked and incensed if I were stopped and given a ticket, though I’d clearly violated the literal letter of the law). Also police must ration resources. They simply cannot enforce all the laws on the books. Therefore, they may decide to concentrate on heroin, cocaine, or PCP, leaving enforcement of marijuana possession to informal warnings and confiscation should they happen to come across an offender in the course of their other priorities. As such, the motivation in America for actions akin to pragmatic tolerance are not based on fears of cultural fragmentation but concerns about freedom in the sense of having some “breathing space” and the constraints of limited resources.

Problems with Self-Reporting Euthanasia in the Netherlands

Initially, one can imagine a number of reasons why a physician in the Dutch system might choose not to self-report a death by euthanasia instead violating the protocol by listing the cause of death as “natural causes” on the death certificate.⁸⁶ First, the entire process, leading up to and including the actual death, would tend to be a private matter between family, patient, and physician.⁸⁷ Reporting risks bringing government officials into the center of this intensely personal world at the very time when the family is likely to be emotionally spent and seeking acceptance and closure for what has happened. Understandably, a physician may hesitate to put a family through this. Second, reporting involves forms, interviews, and time spent away from the physician’s practice.⁸⁸ The tendency to avoid all this time, effort, and unpleasantness by simply not reporting, thus, also would seem to be a motivation.

But reporting is a requirement of a protocol that assures the Dutch physician he or she will not be charged with murder. This would seem to offer a powerful incentive to follow the protocol. Perhaps it does, but there is a third, powerful, countervailing force. Reporting *guarantees* that the physician’s action will draw the attention of a prosecutor. The doctor will then be at risk that the prosecutor will find, under his or her interpretation of the statutory guidelines, that the physician has not met the requirements of the protocol and therefore could be subject to a murder charge.⁸⁹

In fact, in the United States this entire process would likely violate the Fifth Amendment protection against self-incrimination (and possibly the roughly analogous international law principle of *nemo tenetur*).

In the Netherlands, the real risk if one does not report is that someone in the family will say something and this will be communicated to the police. Family members, however, generally understand that they should not say anything (especially knowing that this will bring the government into their lives and get the doctor in trouble). Even if something inadvertently drops, unless the person receiving the information is a police officer, that person, too, will be unlikely to breach the circle of privacy and secrecy. Even if word does leak out, moreover, the physician is not in a much worse position than if he or she had reported. As long as physicians can establish that they followed the guidelines (and it will generally be their word and characterization of the events backed up by supportive family members), all they'll get is a slap on the wrist for not reporting.⁹⁰

Under these circumstances, one would predict that only a minority of physicians performing euthanasia would self-report. In the Netherlands, this prediction proved correct, with 18 percent reporting in 1990⁹¹ and 41 percent in 1995⁹² (as established by surveys that guaranteed anonymity). In 1998, the reporting system was altered to lessen the disincentive for self-reporting. Under this system, the physician now reports to the medical examiner.⁹³ The medical examiner then sends his or her report to the prosecutor, not for a charging decision but only to decide if the body may be released for burial or cremation. The medical examiner then sends the report and that of the physician to an interdisciplinary regional committee composed of a physician, a lawyer, and an ethicist who will make the decision whether the case should even be referred to a prosecutor. Available statistics to date vary on the percentage of cases referred for prosecutorial inquiry by these regional committees: 2, 6, and 2 to 4 percent.⁹⁴ In any event, the numbers are low, which is what one would expect given that euthanasia by doctors has widespread cultural support and the treating physician basically controls the evidence.⁹⁵ Under this regime, reporting by 1999 had jumped to 60 percent.⁹⁶ That still means that 40 percent are not taking the initial step of reporting, which leaves a rather large hole in the system. On the other hand, we are seeing a tremendous increase in reporting over less than a decade (from 18 to 60 percent), which, in the life of a nation involved in somewhat radical experimentation, is not very long. There is no reason to believe that this upswing will not continue.

In 2001, the Dutch moved from pragmatic tolerance to legality.⁹⁷ The legislature amended the penal code to exempt intentional killing by means of physician-conducted euthanasia, called voluntary assisted euthanasia (VAE), from the definition of murder as long as the physician followed criteria roughly paralleling the previous legislative guidelines.

VAE must be performed in accordance with “careful medical practice.” Requests must be voluntary, well considered, persistent, and emanate from patients who are experiencing unbearable suffering without hope of improvement, and the doctor and the patient must agree that VAE is the only reasonable option. At least one independent physician must be consulted, who must see the patient and give a written opinion on the case.

Under this new law, the process using the regional committee as the screen for determining whether a case would be referred for prosecution was retained.⁹⁸ Individuals were also given the ability to include the desire for VAE in their living wills (e.g., “If I live past 80 and am demented, please euthanize me”).⁹⁹

Problems with the Guidelines

It is fair to contend that, in supporting the guidelines, the Dutch medical community sought sufficient clarity to protect it from criminal prosecution. After all, physicians didn’t want to live in fear that, although they were attempting to follow the rules in good faith, they nonetheless were constantly at risk of inadvertently violating some interpretively unclear boundary and facing murder charges. On the other hand, they sought sufficient flexibility to give fair play to their professional judgment.¹⁰⁰ Arguably, the guidelines meet both goals but only if seen in the context of actual practice.

Phrases such as “reasonable options,” “intolerable suffering,” “well-considered request,” and “without hope of improvement” surely offer flexibility for the exercise of professional judgment. The lack of clarity in those terms, on the other hand, initially might seem to put even the most well-meaning physician at risk of misinterpretation by officials and, with that, possible prosecution.

In fact, this is not a problem. Since the doctor writes the report, and thus has the opportunity to rhetorically fill and shape the narrative of each

case as fulfilling each of these *subjective* terms (although the physician's statements still must conform to and reflect some form of material reality), he or she should generally feel safe, having made a good faith attempt to follow the guidelines. I would also anticipate that, over time, the regional committees will act like our administrative regulatory agencies and promulgate (formally or informally) some concrete consensus about the permissible interpretive range available to the physician when trying to follow the rules. The greater problem is the extent to which the guidelines protect the basic interests of the patient in not being wrongly and/or unnecessarily killed and the interests of the broader society that VAE not become a routine tool for interpersonal problem solving.¹⁰¹

Opponents of VAE argue that the Dutch guidelines are so vague,¹⁰² flexible, and incomplete that, though championed under the flag of personal autonomy of the patient, they actually position the physician as the ultimate arbiter of the worth of the patient's life and the desirability of his or her death.¹⁰³ Let's look at a few examples. To begin with, the guidelines mandate that the patient be enduring intolerable suffering.¹⁰⁴ If this means physical pain beyond the human capacity to endure that no medical technique can bring under control, *intolerable* has a medical context. When you go beyond that to recognize the complex, individual nature of suffering as a brew of physical, psychological, emotional, existential, and spiritual ingredients, the word *intolerable* becomes contextual, with the context ultimately likely being the doctor's evaluation of the quality and worth of the patient's current existence.

In fact, the Dutch have even cut the moorings of physical pain from suffering and have interpreted suffering to include extreme psychological pain. That obviously greatly expands the pool for VAE. Now it's not just extremely ill (generally elderly and dying) patients who can be euthanized. The net can pull in far younger, physically healthy individuals who are suffering in mental anguish. Further, in addition to this multiplication of potential numbers, there are other problems as well.

The suffering must be "without hope of improvement." What can this mean when considering a mentally suffering 52 year old? Perhaps there are literally untreatable mental illnesses, although I am not aware of that being the case. In any event, such cases would seem to be relatively rare and not something that a family practitioner would have the expertise to determine in a case in which a life is literally at stake. Yet the act does not require the involvement of a psychiatrist.¹⁰⁵

Also the request must be voluntary. But what does this mean, and how

is it to be determined? There are no criteria in the guidelines for what constitutes voluntariness and no requirement of any kind of investigation or, again, expertise in the form of a consulting psychiatrist.¹⁰⁶ The patient in mental agony raises additional problems. The question of how someone could be competent to agree to VAE when he or she is so mentally damaged that the only apparently viable choice is death is a challenging one to say the least.¹⁰⁷ Surely, the guidelines do not envision VAE for persons whose mental illness makes them suicidal. After all, in most cases suicide is connected to some form of severe mental suffering (i.e., clinical depression).

Also what would it mean in this context to say that there are no other “reasonable” options for this person? Can the fact that the patient refuses to take antipsychotic medication, for example, make this option any less reasonable? It wouldn’t seem so under Dutch law, which stipulates that VAE is not appropriate when there is a reasonable treatment option even if the patient refuses to accept the treatment (although there is some indication that Dutch physicians do not always follow this rule). So, again, what is the basis of a conclusion that this psychiatric patient has no reasonable options other than suicide? When all is said and done, it would appear that the physician’s determination that the person who is living in mental anguish qualifies for euthanasia entails a subjective judgment that this terribly depressed person is doomed to a miserable life and it isn’t worth the effort to try to change things. Again, over time, the regional committee may clarify these ambiguities.

Problems in Application

Research in the Netherlands from 1990 and 1995 indicates that,¹⁰⁸ under any reasonable interpretation, the protections afforded patients by the guidelines have been significantly circumvented.¹⁰⁹ No major studies have appeared since the formation of the regional committees in 1998 and legalization in 2001. We therefore need to remember that we are dealing with a small window of time in an evolving practice played out on a national scale. Nonetheless, the data merit very serious consideration.

The finality of VAE requires the type of caution reflected in the requirements of consultation with a second physician and exploration of alternative, less drastic methodologies to curb suffering. Available data indicate that physicians have not regularly followed this requirement of consultation (only 50 percent of the time)¹¹⁰ and that those who did con-

sult tended to choose a close colleague for a brief discussion in which the decision of the treating physician effectively was “rubber stamped” in almost all (93 percent) of such consultations.¹¹¹ Matters, however, are changing rapidly. The guidelines were revised in 1995, making clear that the consultation must be both “formal” and “independent.”¹¹² Recently, a commission of 10 experts created a protocol for consultation in the VAE setting, including the requirement that the consulting physician be truly “independent” of the treating physician and have knowledge of and expertise in palliative care.¹¹³ This likely will elevate the quality and effectiveness of these consultations as a safeguard for the patient. In fact, panels of trained, independent consultants are now available.¹¹⁴

Requiring the presentation and evaluation of alternatives presupposes both that the physician be aware of pain control and other palliative care possibilities and that there exist facilities, expertise, and resources to deliver these alternatives to VAE.¹¹⁵ In the mid-1990s, knowledge of palliative care in the Netherlands was in its infancy, with little expertise and few facilities. It was predicted that the acceptance of euthanasia would stunt the emergence of quality palliative care in the country¹¹⁶ and that the vicious cycle we’ve discussed between lack of palliative care and requests for suicide would gain momentum.

In fact, that does not appear to have happened. Policymakers gradually are becoming convinced that the Netherlands can only have a well-considered euthanasia policy if it has a well-developed system of palliative care.¹¹⁷ Accordingly, in 2000, centers of national health care policy announced that it would be national policy that palliative care be used to prevent euthanasia in order to rule out the possibility that future requests for euthanasia could be the result of inadequate palliative care. To that end, significant funds were provided to establish six centers for academic study and physician education on palliative care and to integrate hospices into the formal health care system.¹¹⁸ At the same time, grassroots movements for palliative care education have sprung up and are being eagerly sought out by practicing physicians.¹¹⁹ Thus, the situation on the palliative care front appears to be improving and rapidly so. Even critics of the Dutch system acknowledge that palliative care in the Netherlands has improved.¹²⁰

A Specific Request by the Patient

The source of greatest concern based on the data, however, comes from what is a breach of the cornerstone of medical euthanasia: you do not kill

people without their request. The source of these disturbing data is two government surveys (in which anonymity from the prosecutor's office was assured)—a 1990 survey (the so-called Rummelink Report) and a 1995 follow-up study.

The 1990 survey established that 1,000 patients had been euthanized without any request on their part.¹²¹ The response to this violation of the basic tenet of the guidelines was that most had previously indicated their wish for euthanasia, or had at least discussed euthanasia with the physician,¹²² but had subsequently become unconscious or incompetent.¹²³ Saying that “most” had had such a conversation with the physician, however, is not the same as saying “all.” As to those who had asked for euthanasia, moreover, there is no indication that this was a persistent request over time. It is not uncommon for very sick patients to say they want to die one day and feel very different a week later. Finally, as for the group that had “discussed” euthanasia, a discussion is a long way from a specific request.

Some of my concern would be assuaged by the claim that in 94 percent of these cases the family was consulted and in 84 percent the counsel of a colleague was sought (one can't tell from these data if there were cases in which no one was consulted)¹²⁴ if it were not for one other piece of data. Fourteen percent of those euthanized were fully competent and 11 percent partially competent.¹²⁵ Those who conducted the survey, perhaps wishing to foster an atmosphere of harmony, never asked these physicians the tough question: why did you kill a competent patient without his or her explicit request?¹²⁶

The answer may be that they were close to dying anyway and in agony. Some statistics indicate that 87 percent of the “Rummelink 1,000” (as they have become known)¹²⁷ would have died within a week.¹²⁸ Yet that still leaves 13 percent, 130 human beings. Other data indicate that the percentage predicted to die within a week was 70 percent, with 21 percent (210 people) predicted to die in one to four weeks¹²⁹ and 7 percent (70 people) in one to six weeks.¹³⁰

In 1995, the number of patients euthanized without a specific request dropped to 900.¹³¹ I found no data indicating whether any of these patients were competent or what their projected life expectancy was.

Another category of data in these reports covers the use of pain medication administered with *the specific intent* or *partial intent* to cause death.¹³² On its surface, this would also seem to constitute some form of euthanasia as opposed to PDE. In 1990, physicians employed painkillers to intentionally kill 1,350 patients, 450 without a request.¹³³ In that same year,

physicians administered painkillers when it was “partially” their intent to kill the patient, resulting in 6,750 patients killed, 5,050 without a specific request. The numbers in 1995 were (approximately) 2,000 as the result of the physician’s specific intention, 1,600 of those without a specific request and 2,850 the result of partial intent (there are no data on the percentage of specific requests in this category).¹³⁴

What does this mean? The partial intent data are not very compelling to me. This seems like an exploration of the physician’s psych rather than a clear indication of what he or she was really doing. The complexity of human motivations is such that the responses may reflect no more, for example, than “He was in such agony that I guess deep down, somewhere in my soul, I was hoping he would die, hoping this was the end.” I just don’t know.

The explicit intent to kill is far more troubling. Yet even there ambiguities exist. The physicians were not asked if the dosage of pain medication they administered was any more than what was necessary for pain control. If it was no more than the dose needed for pain control, their intent may have been no more than an honest expression of hope within an otherwise legitimate regime of PDE. One has to wonder: do most cases in America involving PDE, DNR (do not resuscitate) codes, and such really reflect an intent to kill and the Dutch are simply more honest about it? Again I do not know. It may be important to note, however, that the Dutch consider PDE, pulling the plug, and so on to be forms of “involuntary euthanasia.”¹³⁵

For those attempting to use any of these Dutch data to carry the burden of establishing the slippery slope (as opposed to giving some support to the position), a simple fact stands in the way: There are no pre-1990 data on the practices of the Dutch medical profession with regard to VAE.¹³⁶ So one has no hilltop from which to judge whether there has been a slide or if matters have even improved.¹³⁷ The Dutch experience does confirm what one would expect in the implementation of any policy permitting VAE: there will be a tendency to broaden the meaning of the term *suffering*.¹³⁸ some physicians will intentionally violate the guidelines and/or hold onto unreasonable interpretations,¹³⁹ and sometimes euthanasia will be practiced without a request. That is not sufficient to carry the burden of the slippery slope as the basis for an absolute moral prohibition of assisted suicide.

Yet the Dutch experience hardly provides one with a basis for contending that the slippery slope argument is all unrealistic speculation. Doctors killed 1,000 people without their consent, a quarter of which were compe-

tent or partially competent. It is also difficult to ignore a survey of senior citizens in the Netherlands in which 66 percent of those living independently and 95 percent of those living in nursing homes said they opposed the legalization of euthanasia. Similarly, in a survey of senior citizens on general health care issues (in which euthanasia was not mentioned in any form), 10 percent expressed the fear that they would be killed against their will.¹⁴⁰ Seeing as they live there, maybe these Dutch senior citizens know something.

THE UNITED STATES AND THE NETHERLANDS: A CULTURAL DIVIDE

In assessing the Dutch experience with VAE for purposes of making decisions about the implications (if any) of that experience for America, we have to recognize differences in our respective cultures that are relevant to the likely impact of legalizing VAE. Initially, there are differences that might lead one to think that any problems in the Netherlands will be magnified in the United States.¹⁴¹ The Dutch have family doctors who they know and who know them.¹⁴² Few Americans have any such relationship with a physician.¹⁴³ Many of us have no doctor, relying on the emergency rooms of county hospitals in times of medical necessity. Others, like me, have a new “primary care” physician every few years whose principle role seems to be to serve as a procedural prerequisite under my insurance policy for referrals to specialists. The Dutch doctor, thus, may be in a far better position to assess a suicide request since he or she will have a much fuller appreciation of the patient’s history, personality, family, and social network.

All Dutch citizens have free and full medical coverage.¹⁴⁴ Forty-two million Americans have no form of health insurance.¹⁴⁵ Financial costs, therefore, will not play a part in the decision of a Dutch patient regarding treatment options. For Americans, the specter of using up life savings and family resources (sometimes encompassed by the concern characterized as “being a burden”) can influence such choices given that VAE ensures that no more money will be expended.

The Dutch are basically nonviolent and tolerant.¹⁴⁶ They do not carry handguns or have a death penalty. Killing as a response to a problem is not in their consciousness, nor is racism. In America, well . . .

There are some forces in the two cultures, however, that push in the

opposite direction. The Dutch trust their doctors.¹⁴⁷ We are far more wary and can be very proactive in questioning a physician when a loved one is under his or her care. The Dutch unwillingness to cause conflict and fragmentation by means of criticism, which underlies the notion of pragmatic tolerance, also leads them to try to ignore or make excuses for doctors who violate the euthanasia guidelines.¹⁴⁸ Americans do not have this fear of division and dissent; in fact, we encourage it in our culture and Constitution. As such, we would not be shy about criticizing a professional who had plainly stepped over the line.

OREGON

In 1994, the citizens of Oregon passed the Death with Dignity Act by a margin of 51¹⁴⁹ to 49 percent.¹⁵⁰ The act legalized physician-assisted suicide but prohibited voluntary euthanasia. Implementation was delayed by a federal court injunction until 1997 when the injunction was lifted by the Federal Court of Appeals for the Ninth Circuit.¹⁵¹ In November 1997, voters rejected a proposal to repeal the Act by a margin of 60 to 40 percent,¹⁵² although this may have been a mandate reflecting sensitivity to their state's rights as much as PAS.¹⁵³

The Terms of the Act

The act is described in a 2001 Oregon Health Department (OHD) report as follows.

The Death with Dignity Act allows terminally-ill Oregon residents to obtain and use prescriptions from their physicians for self-administered, lethal medications. Under the Act, ending one's life in accordance with the law does not constitute suicide. However, we use the term "physician-assisted suicide" because it is used in the medical literature to describe ending life through the voluntary self-administration of lethal medications prescribed by a physician for that purpose. The Death with Dignity Act legalizes PAS, but specifically prohibits euthanasia, where a physician or other person directly administers a medication to end another's life.

To request a prescription for lethal medications, the Death with Dignity Act requires that a patient must be:

- an adult (18 years of age or older)
- a resident of Oregon
- capable (defined as able to make and communicate health care decisions)
- diagnosed with a terminal illness that will lead to death within 6 months

Patients meeting these requirements are eligible to request a prescription for lethal medication from a licensed Oregon physician. To receive a prescription for lethal medications, the following steps must be fulfilled.

- The patient must make two oral requests to his or her physician separated by at least 15 days.
- The patient must provide a written, witnessed request to his or her physician (two witnesses).
- The prescribing physician and a consulting physician must confirm the diagnosis and prognosis.
- The prescribing physician and a consulting physician must determine whether the patient is capable.
- If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination.
- The prescribing physician must inform the patient of feasible alternatives to assisted suicide, including comfort care, hospice care, and pain control.
- The prescribing physician must request, but may not require, the patient to notify his or her next of kin of the prescription request.

Implementation of the Act

The implementation of the act is very recent, with the primary data on it coming from the 1999, 2000, and 2001 reports of the OHD, which assessed the practice of PAS in Oregon from 1998 to 2000, respectively.¹⁵⁴ (Subsequent yearly reports have been consistent with these initial reports in all relevant respects.) Reviewing the reports, one is left with the impression that, unlike in the Netherlands, there is no real problem in Oregon.

The number of instances of PAS, while rising, are still relatively small:

23 requests for lethal pills granted in 1998 with 15 acts of suicide as a result, 33 requests granted in 1999 with 26 suicides as a result, and 39 requests granted in 2000 with 26 suicides as a result.¹⁵⁵ The 2002 statistics reveal 38 suicides,¹⁵⁶ a number that has basically remained stable to date.¹⁵⁷ Throughout the operation of the act to date, most of the patients who requested suicide were suffering from cancer or ALS (amyotrophic lateral sclerosis, commonly known as Lou Gehrig's disease);¹⁵⁸ they had a median age of 69 in 1998 and 71 in 2000.¹⁵⁹ Physicians in Oregon, moreover, do not appear to be indiscriminately dispensing lethal medication, granting only one in six requests, out of which one in 10 patients actually took the pills.¹⁶⁰

Concerns that good palliative care will not develop if PAS is an option, and, in fact, will lead to the vicious cycle created by poor palliative care coupled with PAS, also appear to be overstated.¹⁶¹ Seventy to 80 percent of patients choosing PAS were already in a hospice,¹⁶² the epitome of palliative care. Moreover, Oregon physicians appear to be eager to learn about palliative care,¹⁶³ with the result that palliative care in Oregon has improved since passage of the act.¹⁶⁴ In fact, doctors commonly respond to requests for PAS by referring the patient for palliative care.¹⁶⁵ Recently, nurses from the Oregon Hospice Association, an organization that strongly opposed the act, stated that they were relieved that their fears about PAS had not been realized.¹⁶⁶ The patients these hospice nurses saw who chose PAS (and these nurses attended to 70 to 80 percent of this group) did not do so because of finances, depression, or lack of social support.

In addition, the patients requesting PAS were not poor, uneducated, or vulnerable. They were 12 times more likely to have a college or graduate degree than to have failed to finish high school. They generally were white, middle class, and increasingly married.¹⁶⁷ They were not in physical agony. Their decision to seek PAS was instead a product of multiple factors: loss of autonomy, inability to control bodily functions, inability to participate in pursuits from which they had once gained enjoyment, and the desire not to be a burden on others.¹⁶⁸

Critics of PAS in Oregon counsel caution and skepticism.

The Perspective of Critics of the Act

Critics raise a number of thoughtful points that draw into question the capacity of the act to provide clear boundaries that will protect patients over time. Does the standard "terminal" mean that the patient will die

within six months even with treatment?¹⁶⁹ If not, serious diabetics would qualify since six months without insulin would lead to their demise. Also predicting the life expectancy of a terminal patient is far from an exact science. Fifty percent of doctors in Oregon indicated that they were incapable of accurately predicting whether a particular patient with an illness such as cancer, AIDS, or ALS would or would not die within six months.¹⁷⁰

Of equal concern is what the act does *not* require. Unlike the Netherlands, patients in Oregon do not need to be “suffering.”¹⁷¹ Further, even if they are suffering, and that suffering is at the root of their requests for death, while the physician must consider and inform the patient of “feasible alternatives” to ameliorate the suffering, he or she is not required to have any knowledge of or training in pain control and palliative care.¹⁷² So what protection for the patient does this requirement *meaningfully* add? It becomes no more than a perfunctory step along a mechanical checklist of statutory requirements for conducting PAS without risk of liability to the physician.

The same can be said of the requirements of consultation¹⁷³ and referral to a mental health professional if either the physician or consulting physician “believes the patient’s judgment is impaired by a psychiatric or psychological disorder.”¹⁷⁴ Not only does the consultant not need to be “independent” (i.e., not a colleague, member of the Hemlock Society, etc.),¹⁷⁵ but neither of the doctors need have any expertise or training in palliative care, psychiatry, or psychology.¹⁷⁶ So how can the consultant serve as a check on the crucial determination of the physician that there is no “feasible” alternative other than death?

And how can either physician determine if the patient should be referred to a mental health professional? Even trained psychiatrists have difficulty assessing a patient’s competence. In fact, only 6 percent of Oregon psychiatrists surveyed felt that they could reliably determine in a single session a particular patient’s competence to choose PAS,¹⁷⁷ while 57 percent doubted that they could make the assessment at all.¹⁷⁸ This leads to two additional problematic possibilities under the act. If experts have difficulty determining in a short amount of time whether a patient’s “judgment is impaired” by mental problems, one might question how general physicians can effectively determine when to refer a patient to a psychiatrist or psychologist. Granted, having the ability to sense that there *may* be a problem so as to justify a referral is different than having to determine that in fact there is one. Yet even the first judgment would seem to require

some amount of training and a degree of expertise. Assuming that such a referral takes place, even the mental health expert will have difficulty assessing competence in what will almost assuredly be a single appointment.

Further concern as to overall safeguards under the act regarding this central issue of patient competence comes from data, which show that, although national studies indicate that two-thirds of patients requesting PAS are depressed,¹⁷⁹ referrals from physicians to psychiatrists and psychologists under the act *dropped* from 31 percent in 1998 to 19 percent in 2000.¹⁸⁰ We are, of course, dealing with very small numbers, so this may have little statistical significance. But it does lead one to pause before giving the act unqualified praise. Additionally, critics have provided a few anecdotal reports of cases of PAS in which the physician's conduct seemed questionable under the terms of the act. Proponents, on the other hand, cite other anecdotal reports that show how well the act functions, as well as the tragedy of individuals and their families who, having no access to PAS, were forced to kill themselves by some violent means.

Problems with the OHD Reports

Critics allege that, far from acting as a watchdog, the OHD has become an advocate and apologist for PAS in Oregon. In fact, they contend there is pressure throughout the entire Oregon medical community not to question the efficacy of the act or speak out about troubling individual cases.

As for data collection, the physician merely fills out a short form, which is basically in a check-the-boxes format. Only a line or two is left to discuss the basis of the diagnosis, the patient's reasons for desiring PAS, the grounds for determining patient competency, and such. While the OHD then conducts a telephone interview with each physician, in which these and other topics can be explored in more depth, the results of those conversations, as well as the forms themselves, are maintained as confidential by the OHD. Thus, there can be no real study of the data or the process. Also the OHD has no idea as to the number of physicians who did not send in a report (although this is likely to be a relatively small number, if any, given that nothing will happen to physicians if they turn in the form while they risk attracting the attention of the police and prosecutors if they fail to report).

The OHD report, moreover, is based almost entirely on the postevent reports of the interested physicians. The OHD never seeks information

from patients prior to PAS (by having them fill out a questionnaire or filling one out for them), never talks to hospice nurses or social workers, never contacts the doctors who refused to grant the patient's request for PAS in order to find out why, and obtains information from families only on limited topics (e.g., in gathering information for one of the annual reports, interviewers were instructed that the family was not to be asked about the patient's symptoms).¹⁸¹

Some other data are worth considering. Forty percent of the patients were rejected by at least one doctor before finding a physician who would provide PAS.¹⁸² This may have been a function of the first physician's religious beliefs, a consequence of the fact that the patient was not yet "terminal," or perhaps due to the fact that the physician thought there were less drastic options that the patient had not yet tried (and subsequently tried without success). It may speak to the persistence and determination of these patients, evidence that this was truly their committed choice, and of the stability of their choice over time. On the other hand, it may mean that the standards are hopelessly subjective and subject to manipulation. In this case, one only has to "shop around" for a pro-PAS doctor, who will be able to justify the decision as long as the patient has a life-threatening disease.

The data included in the three OHD reports concerning patients' motives for desiring PAS indicate that concern that the patient would become a "burden to others" influenced 12 percent of all decisions in 1998, 26 percent in 1999, and 63 percent in 2000.¹⁸³ What does this mean? Again we are dealing with very small numbers. Also becoming a burden is stated as only one among multiple factors. There is no ranking of its importance in the mix. Taking all this with a further grain of salt is merited since these are not the direct reports of patients but rather the physicians' impressions or recollections after the fact. For all we know, most patients never said this but the doctors "heard" it because of their own projections into the patient's situation. "Becoming a burden" also could have just been another expression of patients' increasing dependence on others. Nevertheless, there is a concern. As we've discussed, some have feared that the "right to die" will quickly be transformed into a "duty to die." Is that what is happening here?

Standing back and looking at Oregon's brief experience with PAS, one must be candid that, at least at this point, it does not conjure the specter of the Netherlands. There is no evidence, and no one has even hinted, that a single competent (or incompetent) person has been killed without his or

her request. The Oregon experience gives no real support to those attempting to carry the burden that the risk of the slippery slope justifies an absolute moral ban on PAS.

The experiment, though now with eight years of experience, still carries too many areas of concern about both the act and the data compilation practices of OHD, however, to be able to cite the Oregon act and experience as absolute *proof* that there is no significant risk in legalizing PAS. On the other hand, the number of assisted suicides has remained relatively small and stable over the past few years, and a number of credible observers have concluded that the Oregon data of the past eight years demonstrate that the act has not had the negative impact on end of life care that those opposed to it predicted.¹⁸⁴

BACK TO BURDENS AND SAFEGUARDS

The Proponent's Burden

While I believe the opponents of assisted suicide make a troubling claim in their slippery slope argument and provide both human behavioral reasoning and empirical support, again I question whether it is sufficient to carry their initial burden for establishing an absolute utilitarian moral rule. Yet it is a serious enough claim that, if only out of respect for its proponents (who I recognize are not acting out of self-interest but trying to protect us all), it merits a response from those supporting PAS either as to why in a particular case the risk will not come to fruition or to the effect that they can provide safeguards to avoid the risk. In the first part of this section, I will expand on a concept I've developed, which I call "resilient lines," to explain why I believe the feared risk will not come to fruition. The second part is far more traditional, focusing on safeguards. These safeguards would come in a three-part package: consciousness, watchdogs, and guidelines and standards. In assessing these safeguards, it is appropriate to look not just at the individual parts but at the entire three-part package as providing the safeguard.

Resilient Lines

As I stand back and look at the assisted suicide debate as it will likely unfold in the future, I see what will ultimately be a struggle over lines. Virtually every moral theory I encountered valued life. They also accepted sui-

cide and intentional killing under some circumstances. All allowed self-defense, employing deadly force to repel an unprovoked, lethal assault; all condemned murder. All would condone a soldier who swallows a death capsule rather than reveal under torture the site of a planned counterattack against an evil enemy; all would disapprove of helping a clinically depressed teenager end his or her life. The real question becomes where each theory draws the line.¹⁸⁵

In the area of suicide, assisted suicide, and euthanasia, the lines have been moving. Doctors at one time were not permitted to pull the plug.¹⁸⁶ Later they were permitted to terminate “futile” medical treatment. From futile, the line moved to “excessive” or “extraordinary.” Then artificial feeding and hydration were added to those practices defined as “medical treatment.”¹⁸⁷ Again the line moved. Concurrently, the right of patients to refuse even lifesaving treatment was clarified and publicized. Now it appears that someone could refuse treatment even if death were a certain result. The patient could even incorporate these desires into living wills and give third parties the authority to substitute their judgment in these matters when the patient is no longer capable of doing so. My interest at this point is not whether any of these particular lines make sense or not.¹⁸⁸ It is whether they can hold, whether they are what I term *resilient lines*.

I envision a resilient line as a large barrier made of elastic material. People can push against it and move it a bit, but basically it holds. While in some historical sense all lines are temporary, there are boundaries that seem to hold for a particular society over a substantial period of time. Most people respect and maintain the line, though there will always be a minority that will challenge the line, defying the boundary by pushing against it. Yet the line will not move. There will be an occasional bulge here and there. It nevertheless will maintain its stability overall.

In thinking about this phenomenon, I find that resilient lines are those that meet four conditions. As these conditions are eliminated, or even weakened, the line can no longer hold its position and must move. The conditions are as follows.

1. Acceptable authority. The line must be the product of some socially acceptable authority—school, church, courts, traditions, and such.
2. No empirical slide. As factual reality begins to conflict with assumptions underlying maintenance of the line, the line weakens (e.g., DNA evidence that innocent people have been sentenced to death weakens

the notion that the line between those who do and those who do not merit capital punishment is a coherent one).

3. Narrative coherence. The underlying “story” maintaining and justifying the line must make “sense.” (Of course, this will tend to be weakened to the extent empirical slide becomes a factor.)
4. Functional clarity. The line must be clear yet possess sufficient flexibility to be capable of absorbing complexity.

Let me take as an example the traditional moral line that existed when I was growing up in the 1950s about young women and sex. The line could have been, for example, that sex was acceptable only if you were in love, in a stable relationship, or living with someone in a committed relationship. But it was none of these. The line was you must be married. No premarital sex was permitted. The line was very clear, had strong social support, and brought general negative labeling and condemnation to any woman who did not respect it. Of course, there were those who did not. Some were feminist pioneers, some were just rebels by nature, and some were confused and disturbed. Some openly flaunted their defiance of the line and pushed against it. Others violated the line in secret, hiding their conduct from all the world but their lovers. Still the line stayed in place. What changed?

To begin with, the power of the defining authority—religious, medical, and cultural pronouncements regarding the rules and consequences of pregnancy—diminished. The sway of religion, along with all centers of authority, lost its hold as we marched through the 1960s. At the same time, there was an empirical slide as the widespread availability of the birth control pill greatly reduced the fear of unwanted pregnancy.

When all this happened, the “good girl/bad girl” narrative no longer made sense. Young, unmarried women throughout America’s colleges and universities (and other locales) were having sex. These were the daughters of my parents’ generation, and no one could say that they were anything but normal young women. (In fact, a counternarrative arose. A conception of feminist theory, this counternarrative told the story of men attempting to control women’s natural sexuality by maintaining the good girl/bad girl narrative, which kept the good girls in check but allowed for a supply of bad girls whom men were free to exploit in satisfying their sexual desires.)

Finally, the line could not absorb the complexity of such phenomena as women choosing to be single mothers, lesbian couples having children

through insemination, and such. The line moved and moved dramatically. When it came to rest, mainstream society set a line that merely insisted that sex be “safe.” Unprotected sex was wrong; safe sex was generally condoned (though there certainly remain significant segments of the culture that adhere to the old “no premarital sex” line, principally on religious grounds).

Let me offer another illustration of how the concept of resilient lines describes the necessary conditions for maintaining a publicly held moral belief: witchcraft.¹⁸⁹ This may seem an odd example at first, but I think that beliefs about witchcraft provide fertile ground for the analysis. To be clear, I am not talking about beliefs in the existence or plausibility of witches, sorcerers, magic, and witchcraft. Rather, I wish to delve into the belief that those people identified as witches posed some ultimate threat to the very existence of society and thus appropriately were first tortured with hot poker and sharp instruments and then thrown in pots of boiling water or burned at the stake.¹⁹⁰

In fact, estimates of the number of people killed as witches in Europe by the church, state, or mobs in the fifteenth, sixteenth, and seventeenth centuries range from 500,000 to over nine million (making America’s Salem witch trials a kindergarten exercise by comparison).¹⁹¹

Every society on earth has some witchcraft concept.¹⁹² In the ancient world, witchcraft and magicians were a normal part of daily life.¹⁹³ Today witchcraft is practiced in West Africa, and voodoo is alive and well in the Caribbean and the Creole culture in New Orleans.¹⁹⁴ Many of us have met people who were reputed to be white witches and others we feared were of the darker variety. The occult is part of our culture. Along the roadways are signs advertising palm and tarot reading. Some people attend séances to communicate with the dead, while others contact the “psychic hotlines” advertised on television. Carlos Castaneda’s apprenticeship with the Yaqui sorcerer Don Juan made for best-selling literature.¹⁹⁵ There is even a branch of scientific study—parapsychology—that investigates psychic and extrasensory phenomena. And yet, as inundated with the occult as we may be, we never for a moment think that our government, our religious institutions, or any group of private citizens should grab these people or their patrons, tie them to a stake, and burn them to death.

How witch-hunting and the witch craze came to be is a matter of history and historical theory. Why the belief system underlying witch-hunting lost its hold and collapsed, on the other hand, is an illustration of the concept of resilient lines in action.

Initially, as the Middle Ages receded the power of the defining authority (the church and the nobles) diminished. While religion continued to play a significant role in the day-to-day lives of the people of Europe, the church lost its position as the primary political institution guiding the state. Also many more people rejected the idea of religion itself, and with the decline in belief in a God came a corresponding decline in belief in the devil (and his allies, the witches).¹⁹⁶ Similarly, increasingly democratic movements in Europe throughout the eighteenth and nineteenth centuries sapped the power of the aristocracy to legitimate witch hunts, particularly when some among the ruling nobility began to pronounce the witch craze “delusional.”¹⁹⁷

Accompanying this dilution of the authority that legitimated the belief system underlying the witch craze was a substantial empirical slide. The arbitrary nature of the accusations,¹⁹⁸ as well as the inadequate evidence used to support the execution of thousands of innocents,¹⁹⁹ gradually led to growing opposition by the educated. As the accusations began to be directed at higher-ranked men (earlier 82 percent of the victims had been women, generally poor, and older),²⁰⁰ the judges lost confidence in the confessions.²⁰¹ The herbs and potions used by peasants for healing and curing illness, which had been associated with witchcraft, started to become incorporated (as in our current culture) into mainstream medicine,²⁰² while alchemy gradually metamorphosed into chemistry.

Likewise, the notion that people’s neighbors and their families were the cause of hunger, illness, crop failures, hailstorms, animal deaths, stillborn children, and on and on ceased making sense. Society was learning about medical diagnosis and the causes of disease and overall began taking a scientific approach to understanding natural phenomena.²⁰³ Magical explanations, and evil ones at that, were antithetical to a mind-set in which power was in the reasoning ability of humans and their corresponding ability to dominate nature. Witchcraft, therefore, began to fall not into explanatory narratives but into narratives embedded in folk superstition²⁰⁴ and stock characters in Shakespearean plays.²⁰⁵

Finally, the belief system that supported the witch craze did not possess functional clarity; it was an either-or belief with no capacity for flexibility and adaptation. One had to believe that witchcraft was responsible for the major problems in society and daily life. When this belief could no longer be sustained, witchcraft could no longer be perceived as a danger to the state. Even if there did exist a few bad people practicing witchcraft here and there, casting an evil spell or two, that could not begin to fuel a witch craze.

What, then, are the resilient lines in the suicide, assisted suicide, and euthanasia discussion? The resilience of the line separating PDE, refusing treatment, and withdrawing treatment from physician-assisted suicide first will be a function of the magnitude of any empirical slide. To the extent that social experiments, such as the one Oregon has embarked on, indicate that fears of PAS underlying the line are unfounded, or at least vastly overstated, the line will tend to move. If narratives routinely arise of elderly, suffering patients driven to violent, horrible suicides or of those who seek death failing to obtain the assistance they require under law (even though similarly suffering patients who are able to refuse treatment can end their suffering), the line will also tend to move. The question then will be whether it will move from PAS to voluntary euthanasia.

Those who propose legislation permitting PAS generally draw the line between it and voluntary euthanasia. It is a line, however, that I do not believe can hold.²⁰⁶ The legislature is certainly a legitimate source of authority, but legislators are elected. Their votes can change to match the public will and pressure from lobbyists.

Courts can surely provide legitimate authority, particularly since their pronouncements ultimately are backed by the legally sanctioned use of force by the police, who enforce the law. In an area of moral controversy, such as that swirling about PAS and euthanasia, the legitimacy of any such authority will demand the type of judicial unanimity evidenced by the nine-to-nothing vote of the Supreme Court in *Brown v. Board of Education*. In contrast, five-to-four votes, such as in the court's abortion decision, may momentarily set laws but cannot set clearly accepted moral lines. For reasons I will make clear in chapter 8, where I discuss law, it is hard to imagine a unanimous Supreme Court vote holding PAS to be constitutionally protected. In fact, as I will discuss later, the Supreme Court recently held nine to nothing in the opposite direction. But, even if some future court held that PAS, though not euthanasia, was constitutionally protected, the line between assisted suicide and euthanasia would not hold.

The real assault on the PAS/voluntary euthanasia line will come from empirical slide and narrative incongruence. Helpless, suffering, elderly people on machines can find release with the pull of a plug. Suffering elderly people who can hold pills in their hands, put them in their mouths, and swallow them also can find release. Then we'll have a television special about people so sick and/or disabled that they cannot take and swallow the pills. They are not being kept alive by a machine that can be disconnected.

And they are in agony. At some point, the immediacy of such real life narratives will overshadow the hypothetical stories that voluntary euthanasia will turn into involuntary euthanasia. It simply will not make sense, and will in fact appear arbitrary, to make certain sick elderly people suffer because of their inability to swallow pills. The line will not hold.

Predicting the trajectory of the current line that we must not let people end their lives by means such as PAS unless they are informed and competent is a more complex task. Law, cultural tradition, and logic all provide authority for this line. The complexity will come from the juxtaposition of our narrative of competence from everyday life with the reality of the world of the elderly sick and dying. I predict that we will adjust our story of competence so that we will find people competent to end their lives even though we would not find them competent to sign a contract to purchase a car. In doing so, inevitably we will factor in our perceptions of the quality of their lives in the process of interpreting whether the request to die is “reasonable” and then from that assessment of reasonableness infer whether the requester is competent.

One line that I believe is resilient and will not move is the one that states that we do not intentionally participate in killing an innocent person who does not wish to be killed. There would be no involuntary euthanasia. This does not mean that no one would do it. Even the most resilient lines are violated. Yet our culture would have to change beyond recognition to publicly condone this as an accepted value.

But what about causing the death of a clearly incompetent elderly person who is just as clearly suffering (so-called nonvoluntary euthanasia)?²⁰⁷ Perhaps a mitigation on punishment for homicide or a separate crime of mercy killing might be our culture’s response. I do not believe, however, that we will ever find this permissible. On the other hand, I cannot say that we wouldn’t finess the issue by the sleight of hand of using some form of living will or substituted judgment permitting it. Such a living will then might become such a strong cultural expectation in the face of scarce resources that elderly people will feel compelled to concur in signing what may eventually be nothing but a routine form on the Internet. “Substituted judgment” will not add much more as a protection. It will just mean that the person given the medical power of attorney, or an ethics board or court, will assign someone to say it’s alright to euthanize the person. If killing off unconscious or even incompetent elderly people becomes an accepted norm, the substitute will merely follow the norm. This would not

require as drastic a cultural change as condoning involuntary euthanasia, yet it would still require a significant change in our medical narratives and accompanying empirical realities.

SAFEGUARDS

Consciousness

Things do not happen in isolation. Always there is context. Within this context, action begets reaction, revision, reformulation, and response. This is, in fact, an underlying assumption of the slippery slope argument. One action will lead to another while diminishing the likelihood of a second action and redefining the meaning of a third. There seems no reason to believe that inevitably, in the course of this process, some of the resulting actions and reactions won't run counter to the momentum of the slide. What I'm writing is an example, another pebble in the pond, a warning against the slide. The risk of the slide, therefore, is not sneaking up on people. It is the subject of a large and growing volume of literature and discussion. It raises a topic increasingly on the minds of that bulge in the population we call the baby boomers. Would-be patients and their families (for those who have that support) inevitably will bring with them an awareness of these risks.

On the other hand, this may not fully enter our public consciousness until after some story about a hospital or nursing home "death camp" comes to light and becomes the topic of television exposés and talk shows. That is in part because, while the poorest and most vulnerable may have perceived this risk all along (as demonstrated by the general disfavoring of assisted suicide by racial minorities in opinion polls), the more affluent and educated (those likely least at risk), who tend to be advocates for physician-assisted suicide, have focused much more on its benefits. Their concern, thus, has focused on nightmare visions of suffering, loss of control, and degeneration rather than on the risk that they will be killed against their will. When this last possibility becomes a reality to them, we can expect them to respond accordingly.

Watchdogs

At some point, the argument goes, watchdogs will emerge if the risk of involuntary or coerced euthanasia becomes palpable. While the business of

medicine is organized, focused in its goal, and capable of applying political pressure through lobbying, so are organizations such as the American Association of Retired Persons (AARP). Additionally, investigative journalists are always looking for an appalling scandal. Killing old people is a good one. While the state may have economic interests that coincide with coercion and euthanizing of the elderly infirm in its care, I do not think it could conduct such a program for long without attracting public scrutiny. More likely, to the contrary, state agencies would be authorized to conduct special inspections,²⁰⁸ demand paperwork as a condition of supposedly consensual suicides and euthanasia, and begin investigations (potentially leading to criminal charges) where appropriate.

Rules and Guidelines

Finally, any proposed program of assisted suicide is always accompanied by guidelines and standards, which purport to ensure competency, consent, and justification (e.g., terminal illness). The response by opponents, as we've seen when discussing the Netherlands and Oregon, is that these guidelines cannot provide a realistic safeguard against the slippery slope.²⁰⁹

I both agree and disagree with this stance. There will be cases of abuse, and there will be pressure at times to interpret a particular term in a broader way than before.²¹⁰ That is inevitable. Yet it does not lead one to conclude that permitting assisted suicide inevitably leads to the slippery slope, unless by that you mean that we've hit bottom if even one person is wrongfully killed. But if that's the case you have to measure the harm that results from this one wrongful death against the harm that results from keeping another person alive and suffering. I don't know how you can do that.

To say that because rules, standards, and guidelines can be abused, pushed at the edges to interpretations beyond the intent of the original drafters, is a long way from labeling them as worthless. Far from it. People who decide to deal with rules by intentionally deviating or relying on some expanded interpretation on the margins generally know that they are doing so at their own peril. The centerpiece of all assisted suicide guidelines is that the choice must be a voluntary one (with full information) made by a competent person. While I'll discuss the difficulties with both coercion and the cognitive capacity of very sick people in chapter 6, such a guideline makes one line abundantly clear: you don't kill people who haven't asked to be killed.²¹¹ And that is the precise line that divides vol-

untary from involuntary euthanasia and an American hospital or nursing home from a Nazi death camp.

Certainly there will be foreseeable issues in policing and enforcement, including the risk that if there is overregulation and too much autocracy any PAS regime will fail.²¹² Further, policing requires government intrusion into the physician-patient relationship, giving assisted suicide a public aspect. Assisting suicide, however, is a very private, intimate matter. Somehow a balance must be created between public and private.²¹³ Also, within a closed institution such as a hospital or nursing home, unless there's a whistle-blower (and, as in any field, we can expect the medical profession to protect its own within reason), deaths of those who were dying anyway are hardly likely to lead to inquests in which the cause of death on the certificate is questioned. On the other hand, doctors who euthanize patients and then write, for example, "cardiac failure" on the death certificate take real risks with their careers. Why would they do that (except in the rarest of circumstances)? They can already kill most dying patients in their care by means of legally approved methods: withdrawal of treatment, DNR codes, failure to treat flu or pneumonia, and double effect.

In short, all of the concerns underlying the slippery slope, though certainly considerations in the halls of policy-making, again cannot for me support an absolute *moral* prohibition. In fact, no concept or theory ultimately justifies morally labeling assisted suicide as wrong under all circumstances.

My beliefs had changed. But for me the journey was far from over. Throughout my inquiry into moral theories holding assisted suicide to be always wrong under all circumstances, I came across claims in the opposite direction, that is, that one has a right to assisted suicide. It was to those claims that my path then turned.