unmerciful and as such unethical” — the precedent that legalizing these measures would establish would be highly dangerous.

It bears repeating that euthanasia should be distinguished from the provision of necessary pain-relief treatment — including, when necessary, treatment that could or would shorten life. That is not euthanasia. Nor is the justified withdrawal of treatment euthanasia. Further, the distinction between morality and law should be kept in mind. Not all matters regarded as immoral should be illegal. Even if some people consider refusal of life-support treatment immoral, this does not necessarily mean that it should be illegal as well.

I conclude with one example that should provide a warning and a lesson for those who oppose euthanasia. Nancy Cruzan, whose case was brought to the United States Supreme Court, was in a permanently comatose state. Hysteria centred around this case to the effect that withdrawing hydration and nutrition from Nancy Cruzan — even when doing so would accord with her wishes — constituted euthanasia and, as such, should be prohibited. This line of argument has caused much damage to efforts at convincing people to prohibit euthanasia. It might, indeed, have promoted pro-euthanasia sentiment. I do not propose that people should not argue against withdrawal of hydration and nutrition in these circumstances; as a matter of personal morality, integrity, and honesty, one might feel compelled to take this position. The point is that this problem must be handled separately from euthanasia. Not to do so is to risk the most serious confusion and the most unacceptable outcome, whether one is for or against euthanasia: it would be allowed or prohibited on the basis of allowing or prohibiting other measures, which are different in kind, not just in degree, from euthanasia.

6 Legalizing Euthanasia: Why Now?

Until very recently, all countries prohibited euthanasia, although it had been legally tolerated — not legalized, but not prosecuted, provided it complied with various conditions — since the early 1970s in the much studied and cited case of the Netherlands, where it has just been formally legalized.¹ Many countries are now experiencing an unprecedented rise in calls to legalize euthanasia.² Some of these demands come from within the profession of medicine.³ Oregon law⁴ now authorizes physicians to prescribe lethal doses of medication for their patients.⁵ And the United States Second Circuit Court of Appeals⁶ and Ninth Circuit Court of Appeals⁷ struck down prohibitions on assisting in suicide⁸ as constitutionally invalid, although these decisions were later overturned by the United States Supreme Court. In a then-unique example, the Northern Territory of Australia enacted a bill in 1995 to legalize euthanasia.⁹ This legislation was subsequently overruled by the Australian Commonwealth Parliament.

The euthanasia debate is a momentous one. It involves problems that range from the nature and meaning of human life to the most fundamental principles on which societies are based. This debate involves our individual and collective past (the ethical, legal, and cultural norms that have been handed down to us as members of families, groups, and societies); the present (whether we will change those norms); and the future (the impact that any such change would have on those who come after us).

As a result, we must consider the impact of legalizing euthanasia not only at an individual level (which, in the mass media, and therefore in the general public forum, has been the focus of debate) but also at
in institutional, governmental, and societal levels. And not only in the present but also for the future. We need to consider factual realities, such as the possibilities for abuse that legalizing euthanasia would open up, as well as the effect that doing so would have on the important values and symbols that make up the tangible fabric that constitutes our society and on some of our most important societal institutions.

DEFINITION

Whatever one's personal position on the acceptability of euthanasia, it is essential to know what we mean by that word. I discuss the definition elsewhere in more detail, thus a brief definition will suffice: "Euthanasia is a deliberate act that causes death undertaken by one person with the primary intention of ending the life of another person, in order to relieve that person's suffering." Refusals of treatment — including life-support treatment or artificial hydration and nutrition — and provision of necessary treatment for the relief of pain or other symptoms of serious physical distress are not euthanasia, even if they do shorten life. In the latter case, the primary intention is to respect the right to inviolability — the right not to be touched without consent — or to relieve pain, not to inflict death (as it is in the former case).

The term "physician-assisted suicide" is often used to describe what is really euthanasia. The physician carries out the act that causes death. In physician-assisted suicide, properly so-called, physicians would guide patients the means to kill themselves with the intent that patients would so use them. Legally, there is a difference between physician-assisted suicide and euthanasia. The latter is homicide, not suicide. It is either murder or manslaughter under the criminal law in the United Kingdom, Australia (except in the Northern Territory before the repeal of its euthanasia law), Canada, and each state of the United States. Criminal liability for physician-assisted suicide would lie in aiding, abetting, or counselling another person to commit suicide. The use of terms such as "physician-assisted suicide" — or the even more ambiguous "physician-assisted death" — to mean euthanasia leads to confusion. But although these interventions are legally distinct crimes (and, some believe, morally distinguishable), at a societal level many of the worries that legalizing them would present would be the same. From this perspective, they can be discussed together. Unless some distinction must be made, therefore, in this chapter I use the word "euthanasia" to include physician-assisted suicide.

It is necessary, and only honest, to state at the outset where one stands. I am against legalization. I cannot argue against euthanasia from an empirical base, however. Carrying out euthanasia constitutes a very serious criminal offence in the vast majority of jurisdictions; consequently, research may not be undertaken to produce "hard" evidence of the impact that legalizing it would have. Opponents of legalization are therefore open to the criticism and challenge that their arguments are purely speculative and lacking in scientific rigour. This difficulty has become manifest in another way. The burden of proof has somehow shifted from those who promote legalization to those who oppose it — a lamentable situation. How ironic that the norm that we must not kill must now be defended more vigorously than its opposite.

The problem of producing evidence is not as severe for those who are pro-euthanasia because they base their case on respect for individual autonomy, the failure of palliative care to relieve all suffering, and the allegation, often, that physicians are secretly practising euthanasia anyway. They can use polls and surveys — which have the appearance, at least, of producing "hard" data — to show that many people believe they should have a right of access to euthanasia, that the suffering of some terminally ill patients cannot be relieved, and that some physicians admit to carrying out euthanasia. The fact that it is easier to establish the case for legalization than against it, moreover, could distort the process of making a decision about legalizing euthanasia and, consequently, the ultimate decision. Other factors could have the same effect. It would be an interesting research project to compare the number of pro- and anti-euthanasia articles in leading medical journals and to examine the reasons for any discrepancies found between these numbers. I predict that a substantial majority would be pro-euthanasia. If so, we would need to take care that the popularity of that position does not unjustifiably influence the decision.

A NECESSARY QUESTION: WHY NOW?

Why are we considering legalizing euthanasia now, after our society has prohibited it for almost two millennia? It is true that the population is aging; modern medicine has extended our life span, with the result that it is more likely now than in the past that we will die of chronic degenerative diseases, not acute ones. It is also true that many countries lack adequate palliative care, and some physicians are ignorant about treatments for the relief of pain and suffering, while others either fail or refuse to provide them. Medical practice, too, has also changed. A lifetime relationship with "the family doctor" is largely a relic of the past, and the feeling of isolation that people can experience in seeking help from health-care professionals is probably a
reflection of the wider isolation that individuals and families experience. But the capacity to relieve pain and suffering has improved remarkably. Not one of the bottom-line conditions usually seen as linked with the call for euthanasia – that terminally ill people want to die and that we can kill them – is new. These factors have been part of the human condition for as long as humans have existed. Why, then, are we considering such a radically different response to this situation?

Societal and Cultural Causes

I suggest that the principal cause is not a change in the situation of individuals who seek euthanasia; rather, it is profound changes in our postmodern, secular, Western democratic societies. Some of these changes involve trends that have been emerging since the eighteenth century, but only recently have they all co-existed and each has overwhelmingly dominated its opposite, or countervailing, trend. The factors I single out here do not constitute a comprehensive list. They are not all of the same nature, so they are not all treated in the same way or depth. Indeed, I mention some very briefly. In any case, each requires a much more thorough examination. And my conclusions about their strength, causal link to euthanasia, or impact are clearly open to challenge. My aim is to provide a rough map – a somewhat impressionistic overview – of the societal and cultural factors giving rise to and influencing the movement to legalize euthanasia. There are, moreover, still strong forces that resist the legalization of euthanasia, most notably the Catholic Church, evangelical Christian churches, Orthodox Judaism, and Islam.

Individualism

Our society is based on “intense individualism,” even in connection with death and bereavement – possibly, individualism to the exclusion of any real sense of community. If this highly individualistic approach is applied to euthanasia, especially in a society that gives pre-eminence to personal autonomy and self-determination, it is likely to result in the belief that euthanasia is acceptable. There seems to be either a total lack of consciousness or a denial that this kind of individualism can undermine the intangible infrastructure on which society rests, the communal and cultural fabric. Individualism untempered by concern and recognition of a duty to protect and promote community will inevitably result in destruction of the community. Thus, although legalizing euthanasia is a result of unbridled individualism, the former would also promote the latter, at least in terms of tipping the balance between the individual and the community further towards the individual.

Almost all the justifications for legalizing euthanasia focus primarily on the dying person who wants it. Indeed, it is usually considered unacceptable to promote the case for euthanasia by arguing that it would benefit others or society, except possibly as a secondary gain. Here are two examples of such a secondary gain. People would be relieved of the burden of caring for terminally ill people. And countries with publicly funded health-care systems (such as those in the United Kingdom, Canada, and Australia), and Medicare and Medicaid in the United States – all countries in which the legalization of euthanasia has recently been a focus of controversy – would save limited health-care resources for allegedly more beneficial uses. This reticence to mention benefits to others or society might be changing, however. In the American case of Lee v. Oregon, the trial court noted that the defendant’s argument in support of the constitutional validity of the Oregon Death with Dignity Act allowing physician-assisted suicide would reduce the financial burdens caused by terminal illness.

There is yet another sense in which intense individualism might give rise to calls for euthanasia. In postmodern Western societies, death is largely a medical event that takes place in a hospital or other institution and is perceived as occurring in great isolation – patients are alone, separated from those they love and the surroundings with which they are familiar. Death has been institutionalized, depersonalized, and dehumanized. Intense individualism and seeking to take control, especially through euthanasia, are predictable and even reasonable responses to the circumstances. To avoid legalizing euthanasia, therefore, we must give death a more human scale and face.

Mass Media

At first, we created our collective story in each other’s physical presence. Later on, we had books and print media, which meant we could do so at a physical distance from each other. Now, for the first time, we can do so through film or television and, consequently, at a physical distance from – but still in sight of – each other no matter where we live on the planet. We do not know how this shift will affect the stories we tell each other to create our shared story, our societal and cultural paradigm – the store of values, attitudes, beliefs, commitments, and myths – that informs our collective life and, through that, our individual lives, and helps to give them meaning. Creating a shared story through the mass media could alter the balance between the various components that make it up. In particular, we might engage in too much “death talk” and too little “life talk.” We can be most attracted to that we most fear, and the mass media provide an almost infinite number of opportunities to indulge our fear of, and attraction to, death.
Failure to take into account societal- and cultural-level issues related to euthanasia is connected with “mediatization” of our societal dialogues in general and the one about euthanasia in particular. We see the stories that make up these dialogues only as they are presented by the mass media, an avenue that introduces additional ethical issues – those of “media ethics.” It makes dramatic and emotionally gripping television to feature an articulate, courageous, forty-two-year-old divorced woman who is dying of amyotrophic lateral sclerosis, begging to have euthanasia made available and threatening to commit suicide while she is still able – thus leaving her eighty-year-old son even sooner – if she is refused access. This scenario describes Sue Rodriguez, who became a national figure in taking her case for euthanasia to the Supreme Court of Canada. In 1993 the court denied her that right by a majority of five to four, with a plurality of dissenting judgments.18

The arguments against euthanasia, based on the harm it would do to society in both the present and the future, are much more difficult to present in the mass media than arguments for euthanasia. Anti-euthanasia arguments do not make dramatic and compelling television. Visual images are difficult to find. Viewers do not personally identify with these arguments, which come across as abstractions or ideas, in the same way they do with those of dying people who seek euthanasia. Society cannot be interviewed on television and become a familiar, empathy-evoking figure to the viewing public. Only if euthanasia were legalized and there were obvious abuses – such as proposals to use it on those who want to continue living – could we create comparably riveting and gripping images to communicate the case against euthanasia. Consider The Children of Men by P.D. James, set in the year 2025.19 The novel’s first chapter features a scene in which many elderly people die through mass euthanasia. That description evokes a powerful anti-euthanasia response in readers.

The vast exposure to death we are subjected to in both current affairs and entertainment programs might have overwhelmed our sensitivity to the awesomeness of death and, likewise, of inflicting it. Gwynne Dyer has described research showing that human beings have an innate resistance to killing each other, and that this resistance is operative even among soldiers in battle – unless they have been desensitized in order to overcome it. Frighteningly, children are subjected to the techniques developed to achieve this desensitization through their exposure to violence in the mass media.20 Reports from the 1990s on violent crime in major American cities have shown a drop in the crime rate. But “youth crimes – particularly violent crimes by the young [the super-predators] – are increasing and will continue to increase.”21

Ironically, the most powerful way in which the case against euthanasia has been presented on television is probably through Dr Jack Kevorkian’s efforts to promote euthanasia and the revulsion they evoked in many viewers, including those who support euthanasia. A documentary film about a Dutch physician providing euthanasia to a terminally ill patient who requested it has a similar impact.22 The film, telecast on prime-time television in Canada and the United States, elicited a chill in many viewers,23 and condemnation for exploiting both the patient and euthanasia itself.24 If capital punishment were televised, viewers might be horrified enough to demand its abolition. But the opposite could also occur. People might be as fascinated as they once were by public executions. This personal closeness to, or distance from, the infliction of death is an important difference between euthanasia and physician-assisted suicide. Everyone, including the physician, is more distant from the infliction of death in the latter case than in the former. In the Northern Territory of Australia, where euthanasia was legalized briefly,25 a computer-activated “suicide machine” that could be triggered by the terminally ill person was developed and used for carrying out the first death.26 We distance ourselves from inflicting death even when doing so is legal.

When it comes to euthanasia, it could be argued, people react one way in theory and another in practice. It is much easier to approve of euthanasia in theory than in practice, which probably reflects moral anxiety about euthanasia and an ethical intuition as to its dangers. That reaction should send a deep warning, which should be heeded. The difference might also partly explain why polls on euthanasia show that, even when over 75 per cent of those polled say that they approve of it, under 50 per cent of those same people actually vote for it – except in the case of the Oregon Death with Dignity Act of 1994. Maybe these people like “death talk”27 more than “death practice.” It is also possible that the survey instruments used in these polls are not well designed and, therefore, give rise to confused or ambiguous results.28

Denial and Control of Death and Death Talk
As I say several times in this book, ours is a death-denying, death-obsessed society.29 Those who no longer adhere to the practice of institutionalized religion, at any rate, have lost their main forum for engaging in death talk. As humans, we need to engage in it if we are to accommodate the inevitable reality of death into the living of our lives. And we must do that if we are to live fully and well. Arguably, our extensive discussion of euthanasia in the mass media is an example of contemporary death talk. Instead of being confined to an identifiable
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location and an hour a week, it has spilled out into our lives in general. This exposure makes it more difficult to maintain the denial of death, because it makes the fear of death more present and "real." One way to deal with this fear is to believe that we have death under control. The availability of euthanasia could support that belief. Euthanasia moves us from chance to choice concerning death. (The same movement can also be seen at the beginning of human life, when it results from the use of new reproductive and genetic technologies at conception or shortly thereafter.) Although we cannot make death optional, we can create an illusion that it is by making its timing, and the conditions and ways in which it occurs, a matter of choice.

Fear
We are frightened not only as individuals, however, but also as a society. Collectively, we express the fear of crime in our streets. But that fear, though factually based, might also be a manifestation of a powerful and free-floating fear of death in general. Calling for the legalization of euthanasia could be a way of symbolically taming and civilizing death — reducing our fear of its random infliction through crime. If euthanasia were experienced as a way of converting death by chance to death by choice, it would offer a feeling of increased control over death and, therefore, decreased fear. We tend to use law as a response to fear, often in the misguided belief that the law will increase our control over the things that frighten us and so augment our safety.

Legalism
It is not surprising that we have, to varying degrees, become a legalistic society. The reasons are complex and include the use of law as a means of ordering and governing a society of strangers, as compared with one of intimates. Matters such as euthanasia, which would once have been the topic of moral or religious discourse, are now explored in courts and legislatures, especially through concepts of individual human rights, civil rights, and constitutional rights. Man-made law (legal positivism), as compared with divinely ordained law or natural law, has a very dominant role in establishing the values and symbols of a secular society. In the euthanasia debate, it does so through the judgments and legislation that result from the "death talk" that takes place in "secular cathedrals" — courts and legislatures. It is to be expected that those trying to change society's values and symbols would see this debate as an opportunity to further their aims and, consequently, seek the legalization of euthanasia.

Materialism and Consumerism
Another factor, which I can mention only in passing, is that our society is highly materialistic and consumeristic. It has lost any sense of the sacred, even of the "secular sacred" (although some scholars in the field of religious studies, such as Paul Nathan, put forward an interesting case for the vitality of "secular religion"). The result favors a pro-euthanasia position, because a loss of the sacred fosters the idea that wornout people may be equated with wornout products; both can then be seen primarily as "disposal" problems.

Mystery
Our society is intolerant of mystery. We convert mysteries into problems. If we convert the mystery of death into the problem of death, euthanasia (or, even more basically, a lethal injection) can be seen as a solution. As can be seen in descriptions of death by euthanasia — for instance, of a young man dying of AIDS — euthanasia can function as a substitute for the loss of death rituals, which we have abandoned at least partly to avoid any sense of mystery. A sense of mystery might be required also to "preserve ... room for hope." And euthanasia could be a response "based on a loss of faith in what life may still have in store for us. Perhaps, what is needed ... is a different kind of faith in life and in the community of caregivers." This need is especially acute in situations of serious illness. If the interactions I have just outlined are occurring, I postulate a complex relation between some degree of comfort with a sense of mystery and being able to elicit in others and experience ourselves hope and trust. This leads to a question: Could the loss of mystery — and of hope, faith, and trust — be generating nihilism in both individuals and society? And could calls for the legalization of euthanasia be one expression of it?

The loss of mystery has been accompanied by a loss of wonder and awe, both of which we need in some form as humans. Also lost is the sense that we, as humans, are sacred in any meaning of this word (that we are, at least, "secular sacred"). These losses are connected in both their nature and their causes, but they might not be inseparable. We might be able to retain some of these senses (for instance, a sense of the sacred) and not others (a sense of awe, at least in the form of traditional taboos used to elicit awe).

Impact of Scientific Advances
Among the most important causes of our loss of the sacred is extraordinary scientific progress, especially because science and religion are viewed as antithetical. New genetic discoveries and new reproductive technologies have given us a sense that we understand the origin and
nature of human life and that therefore we may manipulate – or even “create” – life. Transferring these sentiments to the other end of life would support the view that euthanasia is acceptable. Euthanasia would be seen as a correlative and consistent development with the new genetics; its acceptance would be expected. According to this view, as I have noted elsewhere, it is no accident that we are currently concerned with both eugenics (good genetics – good at birth) and euthanasia (good death – good at death, of no trouble to anyone else). Yet another connection between genetics and euthanasia could arise from a new sense of our ability to ensure genetic immortality – seeing ourselves as an immortal gene – and, as a result, some reduction of anxiety about the annihilation presented by death.

The paradigms used to structure knowledge in general have been influenced by genetic theory. These paradigms have already been the bases for new schools of thought in areas well beyond genetics. They can challenge traditional concepts of what it means to be human and what is required to respect human life. For instance, evolutionary psychology, a subcategory of sociobiology, sees the characteristics usually identified as unique markers of being human – our most intimate, humane, altruistic, and moral impulses – as the product of our genes and their evolution. At a macrogenetic level, deep concern about overpopulation (as compared with earlier fears of extinction due to underpopulation) might, likewise, have diminished a sense of sacredness in relation to human life.

But countervailing trends, such as the environmental protection movement, are beginning to emerge. A powerful recognition of innate dependence on the ecological health of our planet has resurrected a sense of the “secular sacred” by reidentifying the absolute necessity of respectful human-Earth relations. Moreover, science can be linked with the sacred; it just depends on how we view it. Rather than assuming that the new genetics is a totally comprehensive explanation of life, for example, we can experience it as a way of deepening our sense of awe and wonder at what we now know – but even more powerfully at what, as a result of this new knowledge, we now know we do not know. We can, in other words, see the new genetics and other sciences as only some of the lenses through which we are able to search for “the truth.”

Competing World Views
Though immensely important in itself, the debate over euthanasia might be a surrogate for yet another, even deeper, one. Which of two irreconcilable world views will form the basis of our societal and cultural paradigm? As discussed in a previous chapter, there is also a third world view – the “pure mystery” view. It rejects euthanasia on the ground that it is prohibited by religious commandment. Important as such commandments are to their adherents, in secular societies they cannot be used directly as the basis for public policy on euthanasia. Consequently, this view is not discussed further here.

According to one of the other two world views, we are highly complex, biological machines whose most valuable features are our rational, logical, cognitive functions. This world view is in itself a mechanistic approach to human life. Its proponents support euthanasia as being, in appropriate circumstances, a logical and rational response to problems at the end of life. (Being anti-euthanasia can, of course, be just as logical and rational a response.)

I hesitate to refer to Nazi atrocities because they can readily be distinguished from situations in which the use of euthanasia is currently being proposed. It is easy to argue that those horrific abuses were different in kind from any that would occur if euthanasia were to be legalized in our society. But consider the question about the Nazi doctors that George Annas and Michael Grodin describe as “among the most profound questions in medical ethics”: “How could physician healers turn into murderers?” David Thomasma, citing the work of Robert Proctor, states that the primary answer is that “society, itself, was primed to develop a biological basis for its political platforms.” I propose that current efforts to legalize euthanasia might reflect a connection of these same two factors, but in the reverse order. Those who are pro-euthanasia are, at one level, seeking a political platform for a solely or predominantly biological view of human life – especially in terms of having it form an important element in any new societal paradigm. As I have noted elsewhere, this view can be called the “gene machine” or “pure science” position. Its far-reaching impact and consequences should, at the least, cause us to think carefully before taking any steps to legalize euthanasia.

The other world view (which for some people is expressed through religion, but can be, and possibly is for most people, held independently of religion, at least in a traditional or institutional sense) is that human life consists of more than its biological component, wondrous as that is. It involves a mystery – at least the “mystery of the unknown” – of which we have a sense through intuitions, especially moral ones. Again, as I have already proposed, this world view includes a sense of a “space for (human) spirit” and the “secular sacred.” It sees death as part of the mystery of life, which means that, to respect life, we must respect death. Although we might be under no obligation to prolong the lives of dying people, we do have an obligation not to shorten their lives deliberately. There are some fine, but immensely important distinctions to be made when it comes to grey areas of decision-making at the
end of life. Giving pain-relief treatment that is necessary to relieve pain, but that could or would shorten life, would be morally, ethically, and legally different from giving a lethal injection to end life deliberately. This view may be called the "science-spirit" position.49

**IMPACT ON MEDICINE**

We need to consider how the legalization of euthanasia could affect the profession of medicine and its practitioners. Euthanasia takes both beyond their fundamental roles of caring, healing, and curing whenever possible. It involves them, no matter how compassionate their motives, in the infliction of death on those for whom they provide care and treatment. It can be described as "a merciful act of clinical care"50 and, therefore, it can seem appropriate for physicians to administer. But the same act is accurately described as "killing," too. This means that euthanasia places "the very soul of medicine on trial."51 We need to be concerned about the impact that legalization would have on the institution of medicine - not only in the interests of protecting it for its own sake but also because of the harm to society that damage to the profession would cause.

With the decline of organized religion in many postmodern, secular, pluralistic societies, it is difficult to find consensus on the fundamental values that create society and establish its ethical and legal "tone" - those that provide the "existential glue" that holds society together. Many people do not personally identify with the majority of societal institutions. There are very few institutions, if any, with which everyone identifies except for those - such as medicine - that make up the health-care system. These, therefore, are important when it comes to carrying values, creating them, and forming consensus around them. We must take great care not to harm their capacities in these regards and, consequently, must ask whether legalizing euthanasia would run a high risk of causing this type of harm.

Can we imagine teaching medical students how to administer euthanasia - how to kill their patients? A fundamental value and attitude that we reinforce in medical students, interns, and residents is an absolute repugnance to killing patients.52 If physicians were authorized to administer euthanasia it would no longer be possible to teach that repugnance. Maintaining this repugnance and, arguably, the intuitive recognition of a need for it, are demonstrated in the outraged reactions against physicians carrying out capital punishment when laws provide for them to do so.53 We do not consider their involvement acceptable - not even for those physicians who personally are in favour of capital punishment. We, as a society, need to say powerfully, consistently, and unambiguously that killing each other is wrong. Physicians are very important carriers of this message, partly because they have opportunities (not open to members of society in general) to kill people.

It is sometimes pointed out that many societies justify one form of killing by physicians: abortion. This procedure was justified, traditionally, on the grounds that it was necessary to save the life of the mother. We now have liberalized abortion laws, which reflect a justification that hinges on the belief that the fetus is not yet a person in a moral or legal sense. In justifying abortion, attention is focused on the woman's right to control her body; access to abortion is considered necessary to respect this right. Besides, it is argued, abortion is aimed primarily not at destroying the fetus but at respecting women's reproductive autonomy. Indeed, when destroying the fetus is the primary aim - as it is in sex selection - even those who agree with abortion on demand often regard it as morally unacceptable. And the rarity of third-trimester abortions in most countries shows that, once we view the fetus as a "person," we do not find killing it acceptable.54 Consequently, legalized euthanasia would be unique in that the killing involved could not be justified on the grounds that it is necessary to protect the life of another (which, as well as being the justification for some abortions, is also that for the other examples of legally sanctioned killing - self-defence, "just" war, and, in theory and in part, capital punishment) or that it does not involve taking the life of a person (the justification used for some abortions). Euthanasia would seem likely to affect physicians' attitudes and values, therefore, in ways that, arguably, abortion does not.

We need to consider whether patients' and society's trust in their treating physicians and the profession of medicine depends in large part on this absolute rejection by physicians of intentionally inflicting death. Moreover, we cannot afford to underestimate the desensitization and brutalization that carrying out euthanasia would have on physicians. Keep in mind that the same might be true of abortion. We should remain open-minded about this possibility - even if we believe women should have a right of access to safe, legal abortion. Sometimes, dealing with new ethical issues can cause us to review ones we believe have already been settled ethically. It could be that rightful concerns about the impact on physicians of their being involved in euthanasia would cause us to reconsider the effect of abortion on physicians involved in it. In short, one problem with the position of those who promote abortion on demand is that it threatens to continue undermining the link between medicine and respect for life. Some will argue in response that abortion is "different." But that is another debate, which I will not explore here.
It is sometimes remarked that physicians have difficulty in accepting death, especially the deaths of their patients. This attitude raises the question of whether, in inculcating a total repugnance to killing, we have evoked a repugnance to death as well. In short, there might be confusion between inflicting death and death itself. We know that failure to accept death, when allowing death to occur would be appropriate, can lead to overzealous and harmful measures to sustain life. We are most likely to elicit a repugnance to killing while fostering an acceptance of death — and we are most likely to avoid confusion between a repugnance to killing and a failure to accept death — if we speak of and seek to convey a repugnance to killing, when that is the appropriate word (although it is an emotionally powerful one), instead of death. Achieving these aims would be very difficult in the context of legalized euthanasia.

The Art of Medicine

Finally, I propose that it is a very important part of the art of medicine to sense and respect the mystery of life and death, to hold this mystery in trust, and to hand it on to future generations — especially future generations of physicians. We need to consider deeply whether legalizing euthanasia would threaten this art, this trust, and this legacy.

CONCLUSION

Every country will need to decide whether to legalize euthanasia. Making this choice will be, and will require, a complex process. It is crucial that all of us in each of our roles — whether as concerned citizens, professional organizations, or policy-makers — engage in the euthanasia debate.

This debate will involve many questions about euthanasia at both the individual and societal levels, but three of the most important are the following. First, would legalization be most likely to help us in our search for meaning in our individual and collective lives? Second, how do we want our grandchildren and great-grandchildren to die? And third, in relation to human death, what memes (fundamental units of cultural information that are inherited by being passed from generation to generation) do we want to pass on?

7 Euthanasia by Confusion

"There's glory for you!"
"I don't know what you mean by 'glory,'" said Alice.
"I mean, 'there's a nice knock-down argument for you!'
"But 'glory' doesn't mean 'a nice knock-down argument,'" said Alice.
"When I use a word," Humpty Dumpty said in a rather scornful tone, "it means just what I choose it to mean — neither more nor less."

Lewis Carroll, *Through the Looking-Glass*, chapter 6

The euthanasia debate is beset by confusion — a condition caused both by accident and by design. One important way to promote the legalization of euthanasia is through various types of confusion. First, the examples of such confusion span the domain of semantics: confusion in definition; confusion created by choice of language; and confusion of association and analogy. Second, they span important areas of ethical and legal analysis: confusion of means and ends; confusion in the use of the legal concepts of intent and causation; and confusion in interpreting common-law precedents. We need to examine, understand, and, where possible, dispel these confusions.

CONFUSION IN SEMANTICS

Confusion in Definition

The definition of euthanasia, as of physician-assisted suicide, is highly confused. For the sake of clarity, as proposed elsewhere, euthanasia should be defined as "a deliberate act or omission that causes death, undertaken by one person with the primary intention of ending the life of another person, in order to relieve that person's suffering." The paradigm case of euthanasia is the giving of a lethal injection to a suffering, terminally ill person who requests it and gives informed consent. Yet neither a requirement for informed consent nor that the person be terminally ill is an element of the definition given above. This definition, therefore, includes both non-voluntary euthanasia (the patient is incompetent to give or withhold consent) and involuntary euthanasia (the