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Is Physician-Assisted Suicide Possible?

*John M. Dolan**

I. INTRODUCTION

Most reflective individuals feel a deep sense of moral distress when contemplating the deliberate destruction of a human being. Many react thus even when the killing is of someone convicted of a capital offense and the destruction is being carried out in accordance with procedures specified by law. Understandably, a still greater number of individuals feel profound moral distress when contemplating the deliberate killing of a human being who is neither engaged in a lethal assault nor convicted of a capital offense; that is, the deliberate killing of a human being who is "innocent" in the classical sense of the term.¹ Deliberate killings of this sort have historically been strictly prohibited by law (at least until the aberrations of the present century, which began, but did not end, when the killing programs of the Third Reich targeted, among others, unarmed citizens of the Reich itself).² Beyond the moral repugnance aroused by deliberate killing of the innocent, most persons however unreflective feel a particular moral discomfort when contemplating the prospect of a *physician* engaged in an act of deliberate killing.³ In this instance, there is

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1. That is, "in- nocere," not engaged in harm; neither engaged in assault nor guilty of a capital offense. Observe that a person is, in this sense, innocent, even when guilty of one or more of the moral shortcomings we might discover in ourselves or others in the course of our ordinary lives (shortness of temper, vanity, dishonesty, cowardice, greed, laziness, gluttony, lust, disloyalty, callousness, carelessness, self-absorption, thoughtlessness, etc.).

2. See, e.g., ROBERT PROCTOR, *RACIAL HYGIENE*, Harvard University Press, 1988; BENNO MULLER-HILL, *MURDEROUS SCIENCE*, Oxford University Press, 1988; RAUL HILBERG, *THE DESTRUCTION OF THE EUROPEAN JEWS*, Holmes & Meier, 1985; MARTIN GILBERT, *THE HOLOCAUST*, Holt, Rinehart & Winston, 1985.

3. Here it is interesting to note something said by Pieter Admiraal, a Dutch physician who has for years publicly admitted to deliberately killing patients (who has, indeed, boasted of killing patients) and who has played a central role in the introduction of euthanasia in the Netherlands. Speaking at a conference in Minneapolis in May of 1989, this hardened killer reported that he removes his white coat before killing a patient.

an almost visceral sense that the act is forbidden in an especially powerful way. Although the case against *anyone's* ever taking steps to end an innocent life is very strong and even overwhelming in the view of some of the gravest and most sober moral judges, the case against physicians taking such steps is not merely powerful, it may have the force of *logical necessity*.

Whether the prohibition against physician-assisted suicide does indeed have such remarkable strength is the focus of this article. One can, of course, raise many questions concerning physician-assisted suicide: For example, one can ask how often and under what conditions such suicide takes place, whether the practice is immoral, whether it should remain illegal, whether it is a practice likely to have evil consequences and so on. All of these questions presuppose an affirmative answer to a prior one, however, namely, the question which is our present focus: Is a practice of physician-assisted suicide possible? This question may strike some readers as bizarre. How could there be any doubt as to the possibility of physician-assisted suicide? Thousands of citizens advocate the practice. A physician-assisted suicide measure even won a (narrow) majority in a recent state election in the United States.⁴ In Australia's Northern Territories, the practice has been sanctioned by law.⁵ In the United States, a federal circuit court recently took the extraordinary step of ruling that access to the practice is a constitutional right.⁶ A reader aware of these facts may well conclude that the physician-assisted suicide practice must, at the very least, be logically possible.

The impossibility of something, and even the *logical* impossibility of something, has never foreclosed the possibility of people discussing the thing in question or of even trying to bring it about. Think of the millennia during which mathematical geniuses devoted intense effort to attempts to prove Euclid's Parallel Postulate from his other axioms and postulates. This could not be done since it is logically impossible. The question whether the practice of physician-assisted suicide is logically possible is not determined by the fact that there are individuals who say

4. Ballot Measure 16, which won its narrow victory at the polls in Oregon in November of 1994, but has, so far, failed to go into effect because of legal challenges brought against it by several physicians and representatives of persons with disabilities.

5. Indeed, on the 22nd of September 1996, in Darwin, Australia, capital of the Northern Territories, a physician named Philip Nitschke, acting under a belief that the new law is valid (despite the widespread and bitter opposition it has engendered) killed a patient by administering a lethal injection. According to Dr. Nitschke, the patient had requested the lethal injection. *NEW YORK TIMES*, Sept. 26, 1996, at A4.

6. *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *cert. granted*, *Washington v. Glucksberg*, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 96-110).

they want the practice instituted, nor by the fact that eight judges of the Ninth Circuit Court signed their names to an opinion which purports to discover a constitutional right of access to such a practice.

Clamoring for a practice or uttering solemn declarations about it settles nothing about its logical possibility. Logical contradictions can easily be overlooked if, as in the case of the parallel postulate, they are unobvious or deep. Less profound contradictions can be overlooked by individuals speaking carelessly or under the thrall of a vehement ideological conviction. In the past, throngs have urged and even voted for impossible programs, legislatures have passed impossible statutes and courts have handed down impossible rulings. Students of democratic societies do not have to search far for examples of candidates securing electoral victories with impossible programs, or for instances of legislatures passing impossible statutes. One interesting example of the latter case can be adduced without danger of stepping on the toes of any living persons: House Bill No. 246, which was passed by the House and Senate of the Indiana legislature in 1897.⁷ The author of the bill was a physician, Edwin Goodman, who lived in the town of Solitude in Posey County, Indiana (since the bill was in the strictest sense of the word, "idiotic,"⁸ he could not have lived in a more aptly named town). Dr. Goodman was convinced that he had accomplished several impossible things; he thought that he had discovered how to trisect angles by Euclidean means⁹ and how to square the circle. Dr. Goodman believed that his "results" rested on his discovery of the correct value of π . Dr. Goodman's bill offered his "discoveries" to the state of Indiana to be used in its textbooks without any payment of a royalty to him. Citizens of other states were, of course, to pay for the use of Dr. Goodman's important discoveries. As one deciphers the pretentious, ignorant and confused sentences of Dr. Goodman's bill, one discovers that the confused doctor has "discovered" that π is not a transcendental number¹⁰

7. An account of this legislative fiasco can be found in PETR BECKMANN, *A HISTORY OF PI*, (1971).

8. The term "idiotic" derives from the Greek word "idiotes" which was used to describe a person isolated and wrapped up in his or her own affairs, not focused on the affairs of the larger community. It is the root of such terms as "idiosyncrasy," a feature unique to a particular individual, and "ideolect," the language of a single speaker, and, of course, "idiot."

9. That is, a procedure which employs no other tools than a straight edge and compass.

10. A number is "transcendental" if it is not the root of any algebraic equation. Since the collection of all possible algebraic equations constitutes a countable or denumerable infinity and the collection of all real numbers is non-denumerably infinite,

after all, though he concedes that it is an irrational number.¹¹ According to Dr. Goodman's crackpot calculations, π has the exact value of $16/\sqrt{3}$, that is, to four decimal places, 9.2376. This may be the worst estimate of the value of π in human history. Four thousand years ago, and independently of each other, the Babylonians and Egyptians worked with approximations of π equivalent to 3.16, less than two hundredths from the correct value. Dr. Goodman overestimated the value by a factor of three. On the fifth of February 1897, nonetheless, Dr. Goodman's bill was passed by the Indiana House by a *unanimous vote* and sent to the Senate where it passed on an initial vote. Subsequently, a mathematics professor named A.C. Waldo visited the state legislature on business concerning Purdue University, saw a copy of the bill on a legislator's desk, read it, and gave an emergency tutorial to some of the senators. Bill No. 246 was referred back to a committee and in the hundred years since its passage, has not been considered again by the Indiana Senate.

Before investigating the logical status of physician-assisted suicide, we might briefly note some features of the larger context in which questions about physician-assisted suicide arise.

In a brief interval which has seen vast social, economic, technical and political structures across the globe altered with the speed of summer lightning, the practice of medicine has undergone startling changes and is at this moment subject to conflicting forces: some of which, like those pressing for physician-assisted suicide, are pushing in the direction of radical moral change. In the world outside of medicine, the destruction of the Berlin Wall, the collapse of the Soviet Union, the fall of apartheid in South Africa, the emergence of powerful (and sometimes ruthless) multinational corporations,¹² and the development of remarkable and inexpensive technical methods of storing, transmitting and manipulating information (personal computers, parallel computing devices, public key cryptography, the internet, and so on) have all taken place in an historical blink of an eye. Within medicine, the transformations have been as swift and dizzying as elsewhere with the introduction of astonishing therapeutic interventions, techniques of transplantation, genetic probing and manipulation, and remarkable non-invasive tech-

it follows that most real numbers are transcendental. Lindemann demonstrated in 1892 that π is transcendental.

11. A number is irrational if (and only if) it is not the ratio of two integers.

12. These enterprises confound as much as they illustrate Thomas Jefferson's remark that "the merchant feels no loyalty to the mere place on which he stands so strong as to that from which he derives his profit." Jefferson did not foresee the archipelagos of sweatshops that now blight the planet.

niques of diagnosis, some of which would have been deemed science fiction not long ago. Additionally, as these scientific and clinical innovations have unfolded, movements have been underway to change the contract between the physician and society to alter the very definition of the office of physician.¹³ These movements are connected in interesting ways with other vast transformations which have been underway in the United States, such as radical changes in the arrangements of economic incentives and disincentives in the health economy, dramatic shifts in federal health policy in the post World War II era, the move from an industrial to a post-industrial economy, massive deterioration in the stability and strength of family structures, attendant declines in adolescent health and increases in criminal activity, a relentless drive to stretch the notion of "health" (whose most hilarious illustration is the latest edition of the Diagnostic and Statistical Manual's listing¹⁴ of bad writing as an illness), the emergence of powerful pressures to contain health care costs, and still other forces and changes. There has probably not been a time in human history when medicine has been subjected to pressures more powerful than those currently bearing upon it. Nonetheless, powerful as these pressures are, there is an absolute barrier beyond which they cannot pass: they cannot cross the line of logical impossibility.

The Ninth Circuit ruling mentioned above and a related Second Circuit court ruling also handed down in the Spring of 1996¹⁵ are striking expressions of one of the movements exerting pressure on medicine. This movement aims to alter the practice of medicine so that a physician is invested with the authority, under certain circumstances, to deliberately kill patients. Plainly, this is no small alteration: it is radical. Indeed, the present task is to explore the question whether physician-assisted suicide might be even more extreme than its proponents realize; for it may do more than simply press against fundamental principles in our social order, it may press against the limits of logical possibility itself.

Each year in this country, roughly thirty-two thousand people kill themselves. Most of these individuals are male and almost all are clinically depressed; that is, suffering from a treatable

13. One of these movements, whose success in the English-speaking world, at any rate, is very nearly complete, was the movement to incorporate into the practice of medicine an obligation for the physician to respect his patient's autonomy.

14. Diagnostic and Statistical Manual of Mental Disorders: DSM IV, 4th ed., American Psychiatric Press 1994, pg 51-53.

15. *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *cert. granted*, *Vacco v. Quill*, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 95-1858).

medical disorder. Notwithstanding the impressions created by journalists, it is very rare for a terminally ill person to attempt suicide. The cohort among whom suicide is growing at the fastest rate is males over the age of eighty-five. An able Korean scholar, who earned a doctorate in economics at the University of Minnesota a few years ago and is now teaching in Korea, was asked recently if he had considered the possibility of accepting an academic appointment in the United States. The scholar replied: "America is not a country to grow old in."

How does one settle questions of logical possibility? This depends on the character of the case at issue. If an individual reports viewing a naked boy wearing a green suit, it does not require an investigation to perceive that the reported event is logically impossible. Such a report is a contradiction in terms. Many other logical impossibilities, however, are less transparent and blatant. The object of this article is to determine whether or not physician-assisted suicide is logically possible.

The phrase "practice of physician-assisted suicide," is short and simple-looking but each word within it is a source of complexity. The very first word, "practice," expresses a notion whose logical richness has been appreciated more fully since the important work of John Rawls four decades ago.¹⁶ The term "physician," besides the well-deserved glory which surrounds the office it designates, trails with it a cluster of closely related concepts ("medical," "health," "treatment," "patient," etc.) and an intricate network of constitutive rules elaborated over a vast history stretching back two-and-a-half millennia. The word "assisted" brings in notions of intention, causal efficacy and still other deep and contested concepts. Finally, the term "suicide" itself turns out upon inspection to be less straightforward than one is initially inclined to suppose.

The task of this article is to thread a path through the concepts noted above, investigating them, and noticing some of the arguments and conceptions advanced in the vast literature on assisted suicide and euthanasia, a literature in which one encounters a number of curious and fallacious patterns of thought. The task of identifying and clarifying all of the notions implicit in the idea of physician-assisted suicide is beyond the scope of the present inquiry. Equally, the task of analyzing all of the arguments in the literature on assisted suicide and euthanasia is outside the scope of this article. In this article, we undertake only as much work as is necessary to answer the question

16. See John Rawls, "Two Concepts of Rules," *The Philosophical Review*, Vol. 64, No. 1, January 1956

we have has posed. In the course of this work, we examine various concepts and arguments concerning the practice whose logical status is at issue. In the course of our work, we describe and analyze a few spectacular howlers which have not yet received the attention they deserve. Proceeding in this manner, we will discover whether or not the practice of physician-assisted suicide is logically possible.

II. ASSISTED SUICIDE AND EUTHANASIA

If the practice of physician-assisted suicide were possible, it would be a special case of euthanasia. Physician-assisted suicide would be a case in which a person desiring to kill himself or herself seeks the assistance of another individual to carry out the killing, an assistant who happens to have a particular professional background. Yet, how can *assisted* suicide be *suicide*? This appears to be as logically objectionable as saying "Jim and I carried the table up the stairs by myself." If Jim and I carried the table up the stairs, I did not carry the table up by myself. Likewise, If I carried the table up the stairs by myself, Jim was not assisting me. Does the notion of suicide or self-homicide carry with it the logical implication that the individual who kills himself or herself performs the act alone? Apparently, this is not so. An individual can be held responsible for the death of another person even if he or she had an accomplice in carrying out the killing. The judgment recorded in ordinary use of the phrase "assisted suicide" is that the suicide victim can be deemed responsible for his or her own death even if an accomplice helped carry out the killing. It would be a mistake to declare assisted suicide logically impossible. Though the phrase appears to fly in the face of its own etymology, it has found a perfectly coherent use in ordinary discourse. Declaring the phrase assisted-suicide self-contradictory would be as foolish as invoking the law of non-contradiction to refute an individual who says: "It is, and it isn't," when asked whether it is raining.

Dealing with assisted suicide is dealing with the case that arises when someone decides to commit suicide and enlists the aid of another individual to carry out the killing. There are obvious moral objections which need to be evaluated before one could decide the acceptability of such an undertaking, but no logical contradictions in the conception of such an undertaking. The focus of this article is a problematic special case of assisted suicide, whose logical status we intend to clarify: the case in which the individual whose assistance is sought is a physician. In this case, the assistance supplied consists in carrying out certain acts, such as writing a prescription for a lethal dosage of drugs,

cutting off a patient's supply of food and water, administering a deadly drug, and so on. All of these acts are intended to cause the death of the individual asking for help. The physician acts deliberately to cause death and does so on the basis of several assumptions. One of which is that the person whose death the physician is causing does actually want to die. Another is that the individual in question has authorized the physician's participation in bringing about that death. These assumptions, however, do not exhaust those made at least implicitly. In order to view the individual's testimony as a reliable guide to his or her actual wishes, the physician must assume or ascertain that the individual is rational and not encumbered by any condition rendering the expressed wish for death invalid. The most common encumbrance in such cases is the medically treatable disorder of clinical depression. Furthermore, these implicit assumptions do not exhaust those that must be made. In order to understand what may be the most crucial assumption required here, we must address the task of providing a formal definition of "euthanasia."

What is euthanasia? The term "euthanasia" derives etymologically from two Greek words meaning "good" and "death." The phrase "good death" by itself probably prompts as many different thoughts and conceptions as there are persons who read it, but the English term "euthanasia" has a quite specific meaning. Philippa Foot, the author of one of the more thoughtful essays addressing the topic of euthanasia,¹⁷ correctly criticizes one of the Shorter Oxford English Dictionary's definition of the term: "a quiet and easy death." This definition fails to distinguish euthanasia from all sorts of killings which have nothing to do with relieving suffering or granting the wishes of a terminally ill patient. A murderer who happens to choose a painless method of killing victims (slipping into their rooms and administering lethal injections while they sleep for example) cannot be said to have committed an act of euthanasia. Having dismissed the Shorter Oxford English Dictionary's erroneous definition, Foot goes on to make various remarks about euthanasia, some of which we will call into question.

Any plausible definition of the term "euthanasia" must specify at least three elements: (1) an act or deliberate omission on the part of the agent;¹⁸ (2) a specific intention which accompanies

17. See Philippa Foot, *Euthanasia*, 6 PHIL. AND PUBLIC AFFAIRS (No. 2 1977).

18. Notice that there is something slightly odd in the use of the term "agent" here, since our analysis covers the case in which the person who "carries out the euthanasia" does so by deliberate omission, for example, by withholding a particular treatment biologically required to sustain a given life. That is, as used here, "agent" covers an individual

that act or deliberate omission, namely, the intention to cause death; and (3) success at causing death. These three conditions, while necessary, are clearly not sufficient. A definition specifying only these three elements fits all cases of deliberate killing. But, Josef Stalin and Genghis Khan, whose mass murders were quite deliberate, were not performing euthanasia. Clearly, a fourth element is required if a deliberate killing is to count as "euthanasia." The task of specifying this fourth element is usually mishandled in the published definitions with which this author is familiar. Philippa Foot makes the following suggestion as to how the fourth element should be specified:

Let us insist, then, that when we talk about euthanasia we are talking about a death understood as a good or happy event for the one who dies.¹⁹

Foot is more scrupulous than most writers on euthanasia, so it is interesting to observe that even she euphemistically describes the person who is killed as "the one who dies."²⁰ Later in the essay, Foot employs more honest and accurate language. Of particular import in the present context is Foot's specification of "the fourth element" in the definition of "euthanasia." Her condition is that the death brought about by the agent performing euthanasia must be "good" for the person who is killed. Distinguishing euthanasia from other deliberate killings in this manner has a striking consequence: the term "euthanasia" might turn out to be empty, that is, to have no application in the world. Defined in this manner, the term "euthanasia" could never have any actual application to the world, if it turns out that there are no cases where an individual's own good is advanced by someone's deliberately killing him or her.

There are thoughtful moral judges who deny the existence of such cases and would, thus, deny that euthanasia in Foot's sense is possible. Some judges would argue this conclusion on the ground that death is never a good, that the death of a human being, however compromised and afflicted his or her condition, is always a bad thing, never a happy event for the individual whose life ends. It is also possible, however, to argue against the possibility of euthanasia in Foot's sense on quite different grounds.

who achieves an intended effect by deliberately refraining from action in order to cause that effect.

19. Foot, *supra* note 17, at 86.

20. The unwillingness of writers sympathetic to euthanasia to use the word "kill" to describe the action they view with sympathy is a fascinating area of investigation. Foot, whose sympathy to euthanasia is strictly limited and hedged with very strong qualifications, does use the verb "kill" elsewhere in the essay we are discussing.

The possible arguments at issue here depend upon attending to an important logical distinction which escaped Foot's notice and is not mentioned in the literature with which this author is familiar. It must be observed that a moral agent willing to make the judgment that death might be better than continued existence for a given afflicted individual is not at all committed on grounds of logic to concluding from this judgment that it would, therefore, be good for someone deliberately to destroy the afflicted person. The distinction to which we are calling attention is the contrast between two quite different propositions:

- (1) Given the degree of affliction from which *x* is suffering, it would be a good thing for *x* if *x* were to die sooner rather than later.
- (2) Given the degree of affliction from which *x* is suffering, it would be a good thing for *x* if someone were to kill *x* deliberately.

It is quite clear that the first proposition follows from the second. Since it is logically impossible for an individual to be killed without dying, it follows that it is logically impossible for an individual to be better off killed but not better off dead. Thus, if proposition number (2) holds in a given case, proposition number (1) must also hold in that case. The opposite, however, is not true. The proposition, "this person would be better off dead," whatever epistemological and moral difficulties might attend its justification (and, as shall become evident, they are many and deep) is compatible with the most scrupulous respect for human life. It is a judgment which could be made in a particular case by an individual who rejects every form of lethal action against innocent persons. A moral agent prepared to make the judgment that an individual is better off dead in a particular case is not bound by logic to conclude that the individual would be better off if deliberately killed. And it is precisely the second judgment that must be made by an agent carrying out euthanasia.

To see that the judgment, "this person would be better off killed," does *not* follow from the judgment "this person would be better off dead," consider a hypothetical case. You might leave your grandmother's bedside with the thought that, in her present wretched state, it would be better if she were to die. Yet, at the same time, and without any contradiction, you might react with horror and outrage at the suggestion that someone, even someone acting out of motives of mercy, should kill her. Recall the rage of Henry the Fourth after learning that Richard the Second had been murdered. Henry had said that he wished he were rid of Richard, but was furious to find out that Exton, attempting to please him, had actually killed Richard. Henry stated, "Exton, I

thank thee not, for thou hast wrought a deed of slander, with thy fatal hand, upon my head and all this famous land. . . . Though I did wish him dead, I hate the murthurer, love him murdered."²¹

If the "better off dead" judgment entailed the "better off killed" judgment, the utterance Shakespeare placed in Henry's mouth would be contradictory, but it is not. Plainly, someone making the weaker "better off dead" judgment in a particular case can, without the slightest trace of inconsistency, strenuously reject the much stronger "better off killed" judgment. The moral reasoner in such a case could reject the stronger judgment for any one of several morally substantial reasons. Such a person might appeal to the principle that the right to life is unalienable, and, thus, that it is always a fundamental violation of justice to carry out a lethal assault on an innocent human being, even one whose life is blighted by severe illness or affliction. This principle, coupled with the plausible principle that no one is ever "better off" as the victim of a radical violation of his rights, yields the inescapable conclusion that no one is ever "better off killed," not even someone who is "better off dead". Essentially, this same reasoning can be conducted in somewhat different language. In place of the principle mentioned a few lines back, one might invoke the principle that the deliberate destruction of an innocent person is always murder. This principle, coupled with the principle that no one is ever better off murdered, yields the conclusion that no innocent person is ever better off deliberately killed; again, not even someone who is "better off dead". Those who doubt the gravity of the charge of murder might attend to Thomas DeQuincey's warning: "If once a man indulges himself in murder, he thinks little of robbing and from robbing he comes next to drinking and Sabbath-breaking and from thence to incivility and procrastination."²² It is grave business, indeed, that risks landing one in incivility and procrastination! The logical facts illustrated here, establish by themselves the invalidity of deducing the stronger "better off killed" judgment from the weaker "better off dead" judgment.

The substantive moral principles appealed to in the preceding paragraph are clearly potential grounds for blocking the inference that an individual would be "better off killed" from the judgment that the individual would be "better off dead." Notice that even an individual who rejects these principles must acknowledge that the reasoner who invokes them does not

21. WILLIAM SHAKESPEARE, *THE TRAGEDY OF KING RICHARD THE SECOND*, (Robert T. Petersson ed., Yale University Press, 1957)(Act V, Scene 6).

22. THOMAS DEQUINCEY, *SUPPLEMENTARY PAPERS*.

thereby become ensnared in contradiction. One can argue against the principles. Undoubtedly, some writers would be eager to do so. One cannot, however, refute these principles on purely logical grounds.

An entirely different set of considerations also demonstrates that there is no inconsistency involved in accepting a "better off dead" judgment in a particular case, but rejecting a "better off killed" judgment in that same case. It is true that certain ways of treating a person accord with human dignity while others do not. A moral agent who believes that an individual would be better off dead might, nonetheless, deem it an offense to human dignity for someone deliberately to destroy that individual out of motives of mercy. Even a moral agent who believes that there are certain cases where it is morally permissible to kill an innocent person might find it an affront to human dignity to put a human out of misery in the manner that one might put down an injured horse or dog. It is a curious circumstance that, in current popular debates, the phrase "death with dignity" is increasingly associated with actions which find their natural home in veterinary medicine.

For these reasons, it follows that, on Foot's definition of the term, it is a nontrivial moral question whether euthanasia, at least euthanasia of human beings, is possible, whether any acts of euthanasia have ever occurred in the history of the world, whether any could ever occur. This is a defect in the formulation.

This defect stems from Foot's incorporating into her definition the assumption that it is possible deliberately to kill someone for his or her own good. A wiser course is to frame the definition so that it makes only the more modest assumption that it is possible for an individual engaged in killing to *believe* that the individual being killed will benefit from being killed. Interestingly, for reasons independent of the present considerations, Foot considers the possibility of amending her definition along these lines. Somewhat surprisingly, however, she writes:

A second, and definitely minor, point about the definition of an act of euthanasia concerns the question of fact versus belief. It has already been implied that one who performs euthanasia thinks that death will be merciful for the subject since we have said that it is on account of this thought that the act is done. But is it enough that he acts with this thought, or must things actually be as he thinks them to be? If one man kills another, or allows him to die, thinking that he is in the last stages of a terrible disease, though in fact he could have been cured, is this an act of euthanasia or not? Nothing much seems to hang on our decision about this. The same condition has to enter into

the definition whether as an element in reality or only as an element in the agent's belief.²³

Notice that the sort of mistake which occurs to Foot is a mistaken judgment of incurability. It is a substantive and controversial inference from a judgment of incurability to the judgment that the person is "better off dead". In this passage, however, Foot views the inference as automatic. It is not surprising, then, that she overlooks the further, even more problematic, step from "better off dead" to "better off killed." In any case, an enormous amount hangs on the decision Foot mentions in the passage just quoted. If we are convinced that the term "euthanasia," as employed in daily discourse, applies to actual events in the world and, at the same time, we entertain doubts as to whether it is ever possible to benefit a human being by deliberately killing him or her, then what hangs in the balance is the question how euthanasia can ever occur. Sticking with Foot's definition requires the conclusion that if even a single act of killing counts as "euthanasia," then *a fortiori* someone has benefitted from being deliberately killed. Removing from the definition the condition that the killing benefit the individual killed and placing it in the thoughts of the killer has the consequence that the possibility of euthanasia becomes straightforward and uncontroversial. Defined in this manner, euthanasia is possible even if it is impossible to kill someone for his own good, because the reformulated definition requires only that the killer *believe* that he is benefiting the person he is killing.

Thus, bearing in mind that euthanasia often involves killing creatures belonging to other species, recalling the three necessary conditions with which we started, and introducing a fourth condition which attributes the belief just mentioned to the person carrying out the killing, a fairly compact definition can be formulated:

Euthanasia is any act or deliberate omission undertaken with the specific intention of causing the death of another creature and actually causing that death, where the agent acts or deliberately forbears from action on the basis of a conviction that the death being caused will be good for the creature who is being killed.

Notably, this definition is entirely neutral with respect to the question whether it is ever possible to kill someone deliberately for his or her own good.

Before leaving the topic of euthanasia, it is useful to record a few further observations about the judgment which underlies any performance of euthanasia. Under the definition just formu-

23. Foot, *supra* note 6, at 87.

lated, an agent carrying out euthanasia must be making the logically stronger of the two judgments distinguished earlier. An agent who confines himself or herself to the weaker judgment, namely, "death would be good for this person," falls short of the thought that is at work in euthanasia because the euthanasiast²⁴ agent is killing a creature he or she judges to be in need of death and to fulfill the conditions of our definition (or of Foot's, for that matter), the agent must be acting on the basis of the conviction that "the death being caused will be good for the creature who is being killed." But, the death being caused is being deliberately caused; that is, it is a death which is the result of deliberate killing. Thus, the agent must be making the stronger of the two judgments distinguished above. The judgment that someone is better off killed might, in the language of the Third Reich, be expressed: "We have here a case of *lebensunwertes Leben* (life unworthy of life)."

Various reasons for rejecting the possibility of *lebensunwertes Leben* (in this sense) have already been discussed, but there is more to be learned concerning judgments of this sort. In fact, a great deal more could be learned about these judgments even if the examination was confined to important features of the weaker ("better off dead") judgment. Since the weaker proposition is logically entailed by the stronger one, any difficulties uncovered concerning the weaker proposition automatically apply to the stronger one. In the following paragraphs, both the "better off dead" and "better off killed" judgments will be considered. There are several additional points concerning these judgments worth noting.

The first point to observe is that each judgment presupposes something that does not exist, namely, a *standard* for judging lives, a criterion for determining when a life is no longer worth living. The "better off killed" judgment requires an additional condition specifying when the possessor of a life is no longer protected by the general prohibition against murder. From time to time in the literature, one comes upon unballasted essays in which writers attempt to supply criteria which determine whether a life is worth living. Joseph Fletcher's efforts in this direction come to mind. Two problems attend these projects. First, the standards proposed do not survive careful scrutiny. In the second place, there is nothing remotely approaching a consensus, even among the minority of writers attracted to the task of attempting to formulate such criteria, not to mention the total

24. This term appears in Yale Kamisar's article, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 M^{INN}. L. REV. 969, 978 (1958).

lack of a consensus among the larger group of writers and thinkers who find the very project of articulating such standards either misguided or morally reprehensible or both.

Second, the judgment that an individual would be better off dead and the judgment that an individual would be better off deliberately killed are not medical judgments. There is no clinical rotation in any medical curriculum devoted to the topic, "lives so compromised that it would be better if they ended," nor is there a clinical rotation devoted to the topic, "lives so compromised that deliberate killing of their possessors would be preferable to allowing them to continue." Both of these judgments are moral judgments, not medical judgments. Moreover, the judgments are moral judgments which, for reasons that will emerge in the course of the present study, could not be introduced into a medical school curriculum without logical collision with the remainder of the curriculum.

Third, even if there was a standard by which judgments such as these could be made, it cannot be assumed that anyone would be able to apply the standard, because it would be impossible to acquire the necessary information about a given life to determine whether or not the standard applied. It is easy enough to state the standard which an integer must satisfy if it is to count as prime (it must be greater than one and not divisible by any integers other than one and itself), but it can be extremely difficult to determine whether a particular integer is prime. For example, is 5,713,347,371 prime? The standard is clear. No emotions or mysteries intrude. All that is at issue is a fact about an integer, but it is possible that even the use of a high performance computing machine would not enable us to determine whether a given integer is prime.²⁵ Consider how much more difficult it would be to answer questions about human lives. The lives of other individuals are notoriously inscrutable. The lives of other individuals possess a richness and inexhaustibility which renders them inaccessible to others in certain crucial respects. Moreover, one's own life possesses an inexhaustibility and richness that renders it inaccessible even to oneself. It is commonplace for individuals to falsely predict their responses to particular circumstances. An individual who declares "I'd rather be dead than in a wheelchair" may be startled to discover that life looks awfully precious even when one happens to be seated in a wheelchair. An even more common blunder is utterly to miss the significance of one's

25. 25 Several ingenious implementations of Diffie and Hellman's system of Public Key Cryptography depend on the difficulty of determining whether or not certain large integers are prime.

actions or life, for example, to imagine falsely that one is accomplishing grand things when one is pouring one's energies into mediocre projects, or to be utterly unaware of blessings one is conferring on others or the deep importance of a project in which one has been engaged, whether raising a child or performing an "ordinary" occupation with skill and fidelity. Thus, if, contrary to all rational expectation, we were presented with a clear standard for lives not worth continuing or lives best deliberately destroyed, there is no reason to expect that any of us would be able to apply the standard to his or her own life, much less to the lives of others.

Finally, a fourth point which deserves attention here is that, even if, contrary to fact, there were a standard for determining whether a given human being is better off dead, and even if, contrary to fact, we had the knowledge and competence to apply that standard, *it still does not follow that anyone has the authority to destroy another human being*. If a standard existed for limbs that were unworthy of continued existence and it was determined that a given person's hand was so malformed as to be unworthy of continued attachment to that person's body, nothing at all would follow about any of us acquiring the authority to amputate that person's hand. How much less authority would we have to amputate anyone's life?

III. CONTRAFACTUM INTERRUPTUM

The debates now raging over proposals to establish practices of euthanasia or assisted suicide are more remarkable than many participants seem to realize. If one listens carefully to the voices raised on one side or the other of the vast controversy, one is struck by a realization that all of the parties, however divided on other points, share two *extraordinary* assumptions about the practices whose merits are being debated. Before identifying the two assumptions, it is important to recall some of the principal reasons adduced for and against euthanasia and assisted suicide. Since the reasons given in the case of euthanasia are nearly identical to those adduced in the case of assisted suicide, we will consider the reasons as they are formulated in the context of assisted suicide.

Let us begin with arguments in favor of assisted suicide. Advocates of the practice point to debilitated patients whose ordeals have been prolonged and difficult, who are suffering physically and spiritually. Surely, they say, we can find it in our hearts to allow physicians help these unfortunate patients end their lives, if that is what the patients want. "Whose life is it, anyway?" they ask. They argue that respect for patient auton-

omy demands that the physician supply aggressive treatment if that is what the patient wants; no treatment at all, if the patient prefers that; and a lethal injection, if that is what the patient wants. Thus, in their view, respect for patient autonomy requires that we rearrange our practices in such a way that patients who want to accelerate their dying can do so. The advocates of assisted suicide also point to patients who, in their judgment, are no longer truly living but merely lingering on in a primitive biological life that is, in their words, "no longer recognizably human." Surely, they argue, anyone whose prognosis is existence in such a state is entitled to arrange for a more swift and dignified exit. These advocates also assure us that the option of assisted suicide is no more than what they would want for themselves and for their own loved ones and no more than what any of the rest of us would want for ourselves in the dire sort of cases they are describing. Surely, if a swift, painless exit is something we would each prefer for ourselves over a life of agonized and possibly demented disability, we owe it to others on the verge of such an existence to arrange for their swift, clean, and dignified departure.

Opponents of assisted suicide, on the other hand, argue that the acts that would be performed under such a practice are intrinsically wrong and, further, that the effects of establishing such a practice would be injurious. Enumerated with stark brevity, their objections run as follows: If we institute a practice of assisted suicide, patients will lose trust in doctors. Many patients who request assisted suicide will be clinically depressed and in need of treatment for their depression, rather than lethal action against their lives. Others will be patients whose suffering is the result of their not getting proper pain medication; what such patients need are medications that will relieve their pain, not actions designed to kill them. Still others who request assisted suicide will be individuals with discriminatory attitudes toward persons with disabilities who find themselves facing the prospect of disability. "It is very difficult to fight an enemy who has outposts in your own head." These patients should be receiving counseling for their discriminatory attitudes about disability rather than lethal injections. And the list of objections goes on. Greedy heirs may pressure elderly relatives to ask for the procedure. Family members tired of hospital visits and care conferences may push sick relatives to request it. Doctors may abuse their new power. As a physician once remarked, if we allow doctors to kill patients in cases that are hopeless, why, they may start killing patients whose cases are not hopeless. Physicians will be embracing a power over life and death that only God can

assume. We will be instituting a practice of state sanctioned murder. Further, the mere knowledge that assisted suicide has society's sanction may push some persons with disabilities to opt for it not because they want to die, but, because they fear they are imposing burdens on their families. With mounting pressures toward cost-containment, the practice could become a means of disposing of poor and uninsured patients who are likely opt for (or be pressured into) assisted suicide more often than affluent and insured ones. Woody Allen points out that "[d]eath is a very good way to cut expenses." We will inevitably wind up killing patients who would have enjoyed full recoveries if we had continued to treat them instead of causing their deaths. Finally, a practice of voluntary assisted suicide can be expected to widen inevitably, first, into a practice of voluntary euthanasia and then, as the experience of the Netherlands teaches, into a practice of involuntary euthanasia.

We could easily extend these lists, but will stop here, because we have enumerated many of the arguments that can be found in the literature (and one or two this author has not seen there). These arguments are a mixed lot, reflecting diverse (in some cases incompatible) background assumptions and various levels of sophistication and insight, but each performs the valuable service of directing our intelligence to a consideration which deserves attention and analysis. Yet, with due respect to the various writers who have advanced one or more of these reasons, we must observe that these arguments for and against assisted suicide are in an important and sharply defined sense, *superficial*. They operate *outside* of the practice they are intended to address and, thus, fail to touch the heart of the issue.

Look closely at the language of these arguments. Irrespective of the side they take in the controversy, they talk about "the doctor," "the physician," "the patient," and "medicine." If assisted suicide is at issue, the deliberate ending of a human life, how do *doctors* get into the act?

It is remarkable that nearly everyone, whether in favor of assisted suicide or opposed to it, agrees with Viktor Brack, one of the architects of the Nazi euthanasia program, that, "[t]he needle belongs in the hand of the doctor."²⁶ Both sides of the assisted suicide debate make clear that what they are arguing for or against is a practice in which physicians are involved in killing or arranging for the killing of patients.

26. Robert Proctor, *The Destruction of 'Lives Not Worth Living,' RACIAL HYGIENE: MEDICINE UNDER THE NAZIS*, 177 (1986).

The assumption that physicians will be playing the central role in any practice of assisted suicide, however, presupposes another, even more basic assumption, namely, the one which we are here calling into question: the assumption that physician-assisted suicide is actually *possible*. If this more basic assumption is false, then the real objection to physician-assisted suicide is not that it would involve intrinsically evil acts nor that it would have injurious effects of one sort or another: The real objection, in that case, is that it is *impossible*.

Let us look at the first of the two assumptions just identified, the assumption that any established practice of assisted suicide will necessarily involve physicians in a central role. Whatever else we may discover about this assumption, we can see without too much effort that it involves an interestingly flawed use of counterfactual reasoning. It will be worth our while to describe that flawed counterfactual reasoning before we go on with our main purpose, which is to determine whether or not there might be some deeper flaw in the very idea of physician-assisted suicide.

To begin with, we can ask *why* the Nazi Brack and everyone else contemplating euthanasia and assisted suicide naturally assumes that “[t]he needle belongs in the hand of the doctor.” If the killing is going to go on, doctors will do it or at the very least oversee and supervise. Why?

It is not because doctors have technical skills which could, theoretically, enable them to kill people, though, presumably, some of them could misuse their technical knowledge and do just that. Still, we should not expect physicians to be especially good at it. We can expect to find a great deal more sheer ability to kill or supervise killing if we turn to former members of Central American death squads, retired underworld hit men, or even veterinarians. Anyone setting out to create a class of authorized killers would be making a mistake overlooking these people as a rich source of potential killers. It is not because the doctor's technical skills admit of lethal perversions that so many people assume that a practice of assisted suicide would involve killing by doctors. Neither does this curious assumption arise from the circumstance that so many deaths now occur in institutional settings (nursing homes and hospitals) with the result that doctors are often on the scene or in the vicinity when death takes place. That is not why some people want to assign the task of killing to doctors. Plenty of other persons are on the scene in those institutional settings: nurses, social workers, chaplains, administrators, janitorial staff. With the exception of some administrators, all of these people need the extra income more than doctors do.

Why not consider attorneys or philosophy professors? Both professions are also represented in the corridors of the institutions where most deaths take place. Both abound with individuals only too ready to defend assisted suicide; very likely, some of them are prepared to carry it out.

Hilariously, a principal reason why people want to assign the task of killing to doctors is this: *we trust them*.

This is a spectacular blunder of thought. Over the centuries, under the conviction that conferring compact, vivid names on various blunders of reasoning will help us avoid falling into them, logicians have given names to various common logical mistakes: "Denial of the Antecedent," "*Argumentum ad Hominem*," the fallacy of reasoning "*Post Hoc Ergo Propter Hoc*," and so on.²⁷ The tradition, however, seems to have overlooked the error of thought involved in assigning to physicians the authority to kill on the ground that we trust them.²⁸ Before giving the fallacy in question a definition and a name, we might look at a few additional illustrations of it. One of Lewis Carroll's characters, a little girl, says: "I don't like asparagus and I'm very glad I don't, because if I did I should eat them and I can't bear them!" Another example involves a nonfictional child:

Once the present author came upon his youngest brother, then aged nine, struggling to get a sneaker on his foot. He was lying on the floor, his foot over his head, saying: This sneaker doesn't fit me! And even if it did, I can't get it on!

In the preface to "Man and Superman," George Bernard Shaw writes: "A lifetime of happiness! No man alive could bear it. It would be hell on earth."

The present author calls this fallacy *Contrafactum Interruptum* and defines it as follows:

The fallacy of reasoning *Contrafactum Interruptum* occurs when, reasoning about a counter-factual state-of-affairs, we enter in thought the counterfactual situation that concerns us and, in the midst of our reasoning about it, forget the counter-factual premise which defines the state-of affairs in question and draw conclusions that are flatly excluded by that premise.

27. For a discussion of the traditional fallacies, see Chapter 8 of JOHN M. DOLAN, *INFERENCE AND IMAGINATION* (1994).

28. At any rate, the tradition overlooked this fallacy until Saul Kripke carried out his penetrating investigations of modality and reference which exposed a wide range of fallacies in the context of modal reasoning. Kripke does not bother to confer formal labels on any of the modal misunderstandings he examines, but it is clear that several of the thinkers whose reasoning he dissects are in fact committing the fallacy under discussion here. See SAUL A. KRIPKE, *NAMING AND NECESSITY* 49-53 (1981).

This fallacy underlies recent work in analytical philosophy, such as David Lewis's work on "counterpart theory,"²⁹ and work, since disowned, by David Kaplan on the false "problem of identity across possible worlds," which he sought to solve with his account of "trans-world heir lines."³⁰

What is more important for our present purposes, the fallacy of *Contrafactum Interruptum* is precisely the fallacy committed when anyone reasons as follows: "We can't give the awesome authority to assist in the destruction of innocent persons to just anybody. Let's give it to the doctors! They have been single-mindedly committed for thousands of years to the protection, restoration, and maintenance of human health and life. Surely we can trust them!" This is straight *Contrafactum Interruptum*.

So, the common assumption that assisted suicide should be carried out by physicians rests on the fallacy this author calls *Contrafactum Interruptum* reasoning. We are now, however, in the course of an investigation whose purpose is to determine whether a more radical blunder might be involved in that assumption: we are calling into question the *possibility* of physician-assisted suicide. The path we shall follow is this: first we shall attend to a fundamental feature of certain moral rules, in virtue of which they are called "constitutive rules;" second, we shall examine some of the constitutive rules contained in the contract between the physician and society, a contract, which for two-and-a-half millennia was embodied in the Hippocratic Oath; and third, we shall address the question whether physician-assisted suicide is possible. If the practice turns out to be impossible, then the fallacy of *contrafactum interruptum* which we have just described might be seen as a mere surface indication of the incoherence of the idea of physician-assisted suicide, though it may also turn out to have an interesting deeper connection to that incoherence.

IV. CONSTITUTIVE RULES

Tradition attributes a striking counsel to St. Thomas Aquinas: "Beware the man of one book."³¹ A related, equally useful, maxim runs: "To a man whose only tool is a hammer, every problem looks like a nail." A number of writers who address topics in medical ethics seem to be in the position of a man whose only tool is a

29. See David Lewis, *Counterpart Theory and Quantified Modal Logic*, 65 J. OF PHIL., 110-28 (1968); DAVID LEWIS, *COUNTERFACTUALS* (1973).

30. See David Kaplan, *Trans-World Heir Lines*, *THE POSSIBLE AND THE ACTUAL* 88-109 (Michael Loux ed 1979).

31. ISAAC D'ISRAEL IN *CURIOSITIES OF LITERATURE*, 1791-1793.

hammer. In particular, they appear to labor under the mistaken impression that rules and principles are all of one kind. The result is that they wind up swinging hammers at objects that do not even remotely resemble nails.

The writers in question conceive every rule to have the character of laying down some restriction or constraint or guide for a class of circumstances whose existence is logically independent of the existence or adoption of the rule. For them, the paradigm of a rule is a regulation like, "[d]o not exceed thirty-five miles an hour in the posted area," or a rule of thumb like, "[g]et an hour of exercise each day." Rules like these are guides or commands concerning how one should behave in certain circumstances, where the circumstances can be described without making any reference to the rules themselves. There is, however, a vast and important class of rules, "constitutive rules,"³² whose relation to the cases they treat differs radically from the relation between a regulation and case regulated. The relation of a constitutive rule to a case to which it applies is the relation of a clause in a definition to an object which falls under the definition.

Thus, a rule like the rule in chess that rooks always move parallel to the edges of the board is not a *regulation* of some objects, rooks, which exist prior to the adoption of the rule. Rather, the rule is part of the *definition* of what it is for something to count as a rook. For this reason, the rule is called *constitutive*. Prior to the formulation and adoption of the rules, there simply is no such thing as a rook, no such thing as a pawn, no such thing as "checkmate," and no such thing as chess. The rules of chess are not regulations adopted to govern the behavior of already existing objects called rooks, pawns, knights, and so on. On the contrary, the rules of chess define those objects, by specifying their initial configuration, their permitted moves, and the object of the game.

Similarly, a rule like the rule that physicians are not to divulge information acquired in the context of the physician-patient relationship (or the corresponding rule concerning attorneys and their clients) does not result from applying *general* ethical principles to the specific context of medical (or legal) practice. Rather, such rules are constitutive rules which *define* what it is for someone to count as a "physician" (or as an "attorney"). Such a rule also partly defines what it is for an act to count as part of "medical practice" (or "legal practice"). If one does not have a

32. See John Rawls, *Two Concepts of Rules*, 64 *PHILOSOPHICAL REVIEW*, (1955) (where constitutive rules are called "rules of practice"); G.E.M. Anscombe, *On Brute Facts*, *ANALYSIS* (1955); JOHN R. SEARLE, *SPEECH ACTS* 33-42 (1969).

body of rules which *defines* the practice of medicine (or law), a system of rules that *specifies* the office of physician (or attorney), there simply is no domain of medicine (or law) about which to raise questions or to apply moral rules or any other kind of rule.

A field like medicine, unlike a natural phenomenon, is constituted by rules. It does not occur in a state of nature. If all we know about an individual is that the individual happens to have a certain amount of biological knowledge, and that, by applying that knowledge, the individual succeeds in lending aid to another individual, we do not yet have enough knowledge to know whether or not the individual performed an act that belongs to the practice of medicine. Mere biological "body work" by some individual who has biological knowledge does not constitute medicine. The rules that define the practice of medicine bear on roles and moves that are logically inconceivable apart from the rules themselves. The system of constitutive rules *defines* the roles and moves in question. Constitutive rules do not regulate or govern acts and moves which are logically possible apart from the system of defining rules; rather, constitutive rules define and make possible the cases they treat. Thus, the prohibition of stealing is not an ethical rule which results from applying general ethical principles to the phenomenon of owning property. On the contrary, the practice of property and of ownership and the very idea of "stealing" are *defined* by a system of rules, one of which is that people are not allowed to appropriate or use objects owned by others without their permission, that is, "stealing" is not allowed. The concepts of "ownership" and "stealing" are defined by the constitutive rules of the practice of property.

V. THE OFFICE OF PHYSICIAN

When we spoke of the practice of medicine earlier (in section 1), we referred to "an intricate network of constitutive rules elaborated over a vast history stretching back two-and-a-half millennia." The rules in question, which define the official roles, duties, privileges, and permitted moves which belong to medicine, cannot be found in a single canonical source in which all are written down explicitly, but there is a document, a very celebrated one, composed 2,400 years ago, which has throughout its very long history occupied a central place in medicine. That document, whose task is to define the office of physician, is the Hippocratic Oath, written by the man generally recognized as the "Father of Medicine," or by one of his students. Historians have not the slightest doubt as to the historical reality of Hippocrates, but it is difficult to know which of the writings handed down to us from his school were actually composed by him and which by his stu-

dents. All of the writings in the Hippocratic corpus were handed down by the school as works of Hippocrates. The practice of crediting all the works and discoveries of a school to the master was common in the ancient world. Thus, all of the discoveries of the Pythagoreans were credited to Pythagoras.³³ Historians adopt the device of employing the term "Hippocrates" to refer to the composite figure who composed the Hippocratic corpus and we shall follow them. Hippocrates is credited with three major contributions. First, he introduced scientific method into medicine. Thus, he wrote of epilepsy, which, before his time was known as "the divine disease," that the disorder does not have a supernatural origin, but rather natural causes like all other diseases. Second, he transformed, or rather invented, clinical practice ("*kline*" is Greek for bed; it derives from "*klinein*" meaning lean or recline, from which our words "recline," "decline," "incline," and so on all derive). Hippocrates instructed his students to pay careful attention to much more than the particular physical symptoms that prompt the patient to seek help. They were to observe the patient very carefully and to investigate the patient's diet, the climate in which the patient lives, and the entire context in which the patient developed the symptoms in question. Thus, Hippocrates initiated the practice of taking careful case histories, and the meticulous case histories he drew up have survived and can be studied with profit by contemporary physicians. Hippocrates is also the author of one of the most powerful sentences in world literature. Often quoted only in part, it reads: "Life is short; the art long; experiment dangerous; opportunity fleeting; and judgment, difficult."

Hippocrates's third major contribution, our present concern, was to formulate the Oath which has provided the principal definition of the office of physician for 2,400 years. The definition in question has not been entirely static over that period of more than two millennia. Two ancient provisions have been dropped: the requirement that the physician share his income and wealth with his teacher and the promise not to engage in surgery. The version of the Oath which survived may have been one taken by the people entering what we would call "internal medicine," or the forswearing of surgery may have bound the learner only during a novitiate period. Scholars have, so far, been unable to determine the correct explanation of the clause. Again, not sur-

33. Young assistant professors of medicine are sometimes startled to discover a counterpart of this practice in certain modern medical laboratories in which it is routinely assumed that the name of the laboratory's head will appear on articles coming out of the laboratory.

prisingly, two constitutive rules have been *added* to the definition of physician in recent history: the first, a duty to keep current on developments in medical science, and the second, a duty to respect patient autonomy by speaking truthfully to competent adult patients and allowing them to make informed choices about the course of their treatment. That a few changes took place over two-and-a-half millennia is not surprising. What is astonishing is the remarkable stability of the definition of the office of physician over so many centuries, in so many places, on so many continents, amid so many cultures. In ancient times, the physician swore never to take sexual advantage of his patients, and abstinence from sexual relations with patients is still strictly observed. In ancient times, the physician swore never to violate the confidence placed in him by the patient, and strict confidentiality is still a cornerstone of medicine.

One especially stable clause of the definition of the office of physician is presented in a clause of the Oath particularly relevant to our present concerns:

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.

This clause, which until quite recently has been an unchallenged specification of the office of physician bears a specially close relation to the inner nature of the practice of medicine. As a constitutive rule, it does not present an ideal or a goal. It gives us a clause of a definition.

Let us now look at evidence showing how some current commentators fail to appreciate the logical character of the constitutive rules contained in the Oath. Our first example is a comment by Justice Blackmun in his *Roe* ruling:

Although the Oath is not mentioned in any of the principal briefs in this case . . . it represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day.³⁴

There is serious misunderstanding at work here. To speak, as Blackmun does, of "the development of strict ethical principles in medicine," implies that you are able to pick out a certain class of workers, the "physicians," perhaps characterized by their knowledge of biology and human illness, and that, having picked out those workers, you can then address the task of attempting to decide which "ethical principles" will be proposed to govern their work, to define an "ideal" toward which they should aim.

34. *Roe v. Wade*, 410 U.S. 116 (1973).

The rules of the physician's code or any other professional code, however, are not a set of "ideals" toward which the members of some pre-existing group are encouraged to direct their efforts. On the contrary, there is no way to pick someone out as a "physician" or a "lawyer" in the absence of the constitutive rules in the codes. Absent those rules, there are no physicians or lawyers. The rules *define* the offices in question. It is not knowledge of biology or illness which makes someone a physician, just as it is not mere knowledge of law which makes someone a lawyer. In each case, the role in question is defined by an intricate system of rules. If you describe someone as a lawyer, it is not an open question which obligations or duties might belong to that individual. Once you have described someone as a lawyer, you have already settled a long list of questions about the obligations under which that individual labors. The individual is, for example, bound to honor client confidentiality. This obligation is not an ethical ideal to which the attorney is encouraged to aspire. Rather, it is an obligation automatically settled when the individual assumes the office of attorney. The physician is bound by a similarly strict obligation to honor patient confidentiality.³⁵ Blackmun's mistaken impression that the document which has served as a canonical articulation of the central clauses in the definition of the office of physician is "the apex of the development of strict ethical concepts in medicine" rests on a serious misunderstanding of the logical character of a professional code. The Hippocratic Oath has functioned not as a lofty ideal toward which practitioners are encouraged to strive. Rather, it has functioned for two-and-a-half millennia as a definition, a specification of the office of physician.

It is a curious circumstance that Blackmun said of the Oath that "its influence endures to this day," even as he made the radical (implicit) proposal that we strike from the Oath one of its central provisions, namely, the clause which bars the physician from performing abortion. Whole libraries have been written on the question of whether the *Roe v. Wade* opinion amounted to judicial activism. Far less attention has been directed to the important question of whether the decision amounts to an effort to derange the medical profession. What is important for us in our

35. The requirements of client confidentiality and patient confidentiality each have attached a narrow range range of strictly defined exceptions. Thus, a physician who treats a victim of a gunshot wound is, in most jurisdictions, required by law to report the episode. Even here, within the narrow range in which disclosure is required, the physician is not free simply to chat about the matter at the random, but, rather, operates under strict standards specifying which government officials are authorized to receive information concerning the case.

present study is this: The assumption underlying Blackmun's remark that the Oath represents an "apex of the development of strict ethical concepts in medicine" is a false assumption. The central clauses of the Oath have far greater power than a mere proposed "ideal:" they define what it is for someone to count as a physician, for an act to belong to the practice of medicine. Justice Blackmun's remark notwithstanding, we cannot pick out doctors in virtue of some characteristics such as their knowledge of biology and human illness and then, having done that, ask ourselves which moral rules or "ethical ideals" should be proposed for them to follow. To characterize a person as a physician is already to settle a host of questions about that individual's obligations.

Blackmun's error is repeated by countless writers. Examples could be multiplied at will. Consider, for example, a comment by Sherwin Nuland:

With the Hippocratic physicians, medicine as we know it began to develop. Divorced from superstition and necromancy, devoted to systematic observation of disordered life processes, and committed to a set of ethical principles that declared the physician's primary obligation to be to his patient, it formed the trellis upon which subsequent growth of medical thought could be guided.³⁶

The first part of this passage conveys an undeniable truth: "With the Hippocratic physicians, medicine as we know it began to develop." However, to speak, as Newlund does, of the "physician's" being "committed to a set of ethical principles," once again implies that there is a worker, the "physician," perhaps characterized by possessing special knowledge of biology and human illness, and a question for this "physician" is to decide to which "ethical principles," if any, the "physician" will be committed. Once again, we find a writer who fails to grasp the logical force of the provisions of an oath of office, someone who does not perceive the special character of *constitutive* rules.

Not long ago, this author attended a lecture on the history of medicine which touched on the Oath of Hippocrates. The lecturer, a distinguished physician, projected a slide displaying the clause of the Hippocratic Oath prohibiting euthanasia and abortion and said, "I agree with that." A curious remark to make about a clause of an oath, a remark which invites misunderstanding. A clause of an oath is not a request for *agreement*. A clause of an oath is not an assertion to which the reader of the oath gives or withholds assent. An oath asks for something other than assent. One *swears* the oath or refuses to swear it. One may legitimately ask whether a particular clause of the Hippo-

36. SHERWIN NULAND, *DOCTORS: THE BIOGRAPHY OF MEDICINE* 8 (1988).

cratic Oath represents one of the constitutive rules of medicine, but the constitutive rules of medicine are no more general *assertions* about the practice of medicine than they are *applications* of general ethical principles to the practice of medicine; the constitutive rules of medicine *define* the practice of medicine.

The clause in the Oath quoted earlier reads in full:

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to induce abortion. But I will keep pure and holy both my life and my art.³⁷

This clause unambiguously excludes euthanasia. It proceeds next to exclude unambiguously even the suggestion of euthanasia: The sentence after the two dealing with euthanasia addresses abortion. It reads: "Homoios de oude gynaiki pesson phithorion doso," which is translated above as: "Similarly, I will not give a woman a pessary to induce abortion." One must exercise care when interpreting this sentence. It is tempting to explain the use of "similarly" (*homoios*) in this sentence as follows: The Oath is specifying that, just as the physician rejects lethal action against a human being out of the womb, so the physician rejects lethal action against a human being in the womb. That is, the clause absolutely excludes lethal action against human life at any stage in the life process.

This gloss is certainly correct as far as it goes. To stop here, however, would leave us with a puzzle. If we understand "similarly" in the way just indicated, we are left with a puzzling asymmetry. For on that reading, the Oath forbids even counseling euthanasia, while, in the case of induced abortion, it merely forbids the act and is silent on the question of whether the physician might in some cases suggest abortion. The improbability of Hippocrates's intending such an asymmetrical outcome prompts us to realize that the term "similarly" in the sentence we are considering conveys more than our initial gloss allowed. "Similarly" is certainly intended to call the reader's attention to the parallel between renouncing lethal assault against human life outside the womb and renouncing lethal assault against human life within the womb, but it also intended to convey that the renunciations in each case are exactly parallel. Just as the Oath has the physician reject both performing euthanasia and even suggesting it, so, in the same fashion, it has the physician reject both performing induced abortion and even suggesting it.

37. 1 HIPPOCRATES 299 (W. H. S. Jones, trans., 1923).

The crucial question for our present purposes is this: "Is the constitutive rule forbidding the physician from performing euthanasia still in force and is the office of physician still defined, in part, by that rule?"

We might prepare ourselves for the task of answering this question by addressing another, namely, "is the constitutive rule forbidding the physician from performing induced abortion still in force?" The correct answer to this second question is independent of the answer to the one about euthanasia, but we shall briefly consider it, nonetheless. Before we do so, it is instructive to look at the treatment of the abortion clause by a scholar whose discussion and translation of the Oath were, unfortunately, an influence on Justice Blackmun. Ludwig Edelstein, in his *Hippocratic Oath* (1943), translates Hippocrates's sentence on abortion as follows: "Similarly, I will not give a woman an abortive remedy." This is a remarkable exercise of translator's license. The phrase "abortive remedy" is so alien to Hippocrates's conception of medicine, and so far from the actual language of the Oath, that one is forced to conclude either that Edelstein has a moral tin ear and a dismally incomplete understanding of the author he is translating or else that Edelstein is such an enthusiastic supporter of legalized abortion that he has allowed his enthusiasm to overcome both his knowledge of history and his knowledge of the Greek language. Since it is improbable that a scholar as erudite as Edelstein could be simply misreading the Greek, the more reasonable inference is that Edelstein has a strong bias in favor of legalized abortion. It is interesting to note that Edelstein's defective translation is the one quoted by Blackmun in his *Roe* opinion. Even more significant is the fact that Edelstein's unsound remarks about the status of the Oath are also quoted with respect by Blackmun.

For, however limited Blackmun's grasp of the logical character of constitutive rules, it is to his credit that he realized, when he reached his decision in *Roe v. Wade*, that he was engaged in proposing a radical change in the traditional definition of the role of the physician and that he, therefore, owed us two things: first, an answer to the questions, "why is the prohibition of abortion in the Oath and why has it survived so long in so many cultures?," and, second, a justification of his proposed radical revision. The unconvincing argument Blackmun advanced to support his attempted undermining of the abortion clause in the Hippocratic Oath³⁸ is an argument he derived from Ludwig Edelstein, whose bias in favor of abortion, as we have just seen, led him to mis-

38. *Roe v. Wade*, 410 U.S. 116 (1973).

translate the Oath. Following Edelstein, Blackmun attempted to dismiss the Oath's prohibition of abortion as the influence on Hippocrates of a specific "religious dogma" of an ancient religious sect, the Pythagoreans. Wisely, Blackmun forbore from actually stating the "dogma" in question, which was simply that life is precious.

The weakness of the argument Blackmun derives from Edelstein is clear. A reader aware that the Oath amounts to a crucial component of the definition of a special social institutional role, namely, the office of physician, might without too much reflection be able to think of one or two very good reasons having nothing to do with Pythagoreanism (or any religious sect, for that matter), why it might be a good idea to have individuals assuming the important office of physician swear never to enter into a relationship adversarial to any form of human life, and never to engage in a lethal assault on human life at any stage in the life process. Anyone undertaking to view the practice of medicine from the point of view of the designer of a social institution is likely to think of excellent non-religious reasons why it might make sense to define the office of physician in such a way that holders of the office absolutely and irrevocably renounce the possibility of taking lethal action against any form of human life; reasons which anyone, utilitarian, deontologist, Pythagorean, non-Pythagorean, atheist, agnostic, or theist would find convincing. One of the first reasons likely to occur to anyone viewing the matter from this perspective is the following. It will be crucial for workers who undertake this important work to have the complete trust and confidence of their patients. The physician will be asking the patient to disrobe, to disclose intimate details about the patient's life, to submit to the surgical scalpel, to ingest sometimes powerful and ill-tasting concoctions, to submit to unpleasant and uncomfortable regimens, and so on. If it is understood clearly and without doubt by everyone that physicians never under any circumstances aim at injury or death, all of the necessary cooperation can be reasonably expected and various crucial elements of the physician's task become feasible. A second, wholly independent reason, however, can be adduced. Every art requires a master aim. Confusion of tasks and potential conflicts among competing tasks are to be scrupulously avoided in all settings. If the attorney hired by a client had the option to also work for the prosecution in the very case in which the client is a defendant, a grave conflict of tasks would have been introduced. Henri Cartier-Bresson spoke of the photographer having "head, eye,

and heart in one line of sight."³⁹ If physicians assume the task of healer and protector of life, they have assumed a task of enormous difficulty and importance, and it makes obvious good sense for them to have head, heart and eye in one line of sight. If, in addition to assuming this task, they are persuaded to take on any other task, whether it be seller of pharmaceutical products or authorized killer, they will be deflecting their aim, confusing their mission, introducing potential conflicts of interest, compromising their primary mission, and making it impossible to have head, eye, and heart in one line of sight. Surely obvious considerations of this sort are far more probable explanations of the remarkable longevity and stability of the definition of the office of physician than the conjectural initial influence of an ancient religious sect. In any case, explanations as to how a term came to be defined one way rather than another are in an important respect irrelevant to logical investigations. We must not forget that rules with definitional authority bind in a specially powerful fashion: they bind with the power of logical necessity.

Let us return to the question raised a few paragraphs back. Is the rule against performing induced abortions still part of the definition of the office of physician? An uncritical thinker might reason as follows: "The very fact that more than a million abortions are performed by physicians in this country every year is clear evidence that the rule is no longer in force." This quick comment, however, overlooks something important: the million and a half or so abortions carried out each year are performed by a remarkably small number of physicians. It is extremely difficult to get physicians to perform abortion.⁴⁰ Proponents of legal abortion have been lamenting this difficulty for years, and have recently acted to put pressure on residency program in obstetrics and gynecology to incorporate abortion training in their curriculums.⁴¹ Fear of physical assaults by extremists is not a likely explanation of the reluctance of physicians to carry out abortion.

39. Michel Nuridsany, *The Moment that Counts*, N. Y. REV. OF BOOKS, Mar. 2, 1995, at 17 (quoting Carter-Bresson). Cartier-Bresson writes: "Photographing means recognizing, in a single instant, a split second, both a fact and the precise organization of visually perceived forms that expresses that fact. It means putting head, eye, and heart in one line of sight." *Id.*

40. The induced abortions at issue do not include those extraordinarily rare cases, for example, ectopic pregnancies, in which it is literally correct to say that there is no prospect of the unborn child's being born alive and that continuation of the pregnancy poses a lethal threat to the life of the mother.

41. In the Spring of 1996, under strong pressure from advocates of legal abortion, the American Council on Graduate Medical Education (ACGME) issued a ruling that all residency programs in obstetrics and gynecology are henceforth required to include training in abortion techniques.

The deep-seated reluctance in question existed throughout the roughly two decades before there were lethal attacks on abortionists by two or three extremists. Fear of damage to one's professional practice is probably part of the deep reluctance of physicians to perform abortion, but such a fear if well grounded, reminds us of something important: it reminds us that a large number of persons, including a number who support legal abortion, have deep feelings of uneasiness concerning a doctor who carries out abortions. Far more important than the profound unease others may feel about a doctor's carrying out induced abortion, however, is the physician's own deep disquietude on the matter. A cultural institution as vast and powerful, clearly defined, and important as medicine, a cultural institution with a history stretching over two-and-a-half millennia and an absolutely central place in our lives, is not likely to be altered by a report issued by a task force in Washington or by a few rulings handed down by a single court, even the United States Supreme Court. The widespread and deep unease about physicians who perform abortions and the near impossibility of persuading physicians to enter into the business of performing abortions provides powerful evidence that the constitutive rule forbidding doctors from performing abortions was not destroyed by the *Roe* ruling, a Court decree whose history is not yet even a hundredth as long as the history of the Hippocratic Oath; it is evidence that the clause concerning abortion still has definitional authority.

Our concern, however, is the clause forbidding euthanasia by physicians. We must address the question: "Is the constitutive rule forbidding the physician from performing euthanasia still in force, is the office of physician still defined, in part, by that rule?" Here a response likely to occur to some readers is this: "The very fact that there are thousands of persons clamoring for the institution of a practice of physician-assisted suicide is itself evidence that the clause of the Hippocratic Oath forbidding euthanasia is no longer in force." This response, however, may be as superficial as the one we considered earlier concerning the abortion clause. Indeed, the reasons adduced earlier to establish the continuing definitional authority of the abortion clause apply directly to the euthanasia clause or have counterparts which apply to the euthanasia clause. First, the moral misgivings and deep disquietude triggered by a physician's performing abortion are matched by deep misgivings and disquietude triggered by a physician's deliberately killing a patient, and there is strong evidence that a randomly selected individual physician, whatever the physician's declared view on the desirability of physician-assisted suicide or euthanasia, will be *extremely* reluctant to kill

a patient under any circumstances. Second, the considerations about each art having a master aim, about the confusion and conflicts inevitably introduced by assigning competing aims to a practitioner, apply here with equal force. The physician battling to save your life, but also keeping an eye to the possibility that it might make better sense to kill you, can hardly be accused of having head, eye, and heart in one line of sight.

In the case of the euthanasia clause, however, there is an important piece of evidence we are likely to overlook because it is staring us in the face. There is, in this case, an interesting, indeed, startling, possibility, namely, that the clamor for physician-assisted suicide is *itself* strong evidence of the ongoing definitional authority of the clause excluding assisted suicide and euthanasia. The blunder of reasoning *contrafactum interruptum* which we defined and analyzed earlier may deserve a closer look. Nowhere on earth have ballot measures been introduced attempting to institute "attorney-assisted suicide" or "philosophy professor-assisted suicide." And the reason no such measure has ever been introduced is not far to seek. It is because the probability of success of such a measure is effectively zero. Under our existing practices, a family has good reason to believe a physician who says that the battle for a particular patient is lost and that treatment should be stopped. Under our existing practices, a physician is charged to battle for the patient, even against steep odds, even at risk of personal injury or infection. Therefore, we place considerable trust in a physician's judgment that the battle has been lost in a given case. Under our existing practices, which strictly forbid physicians from ever engaging in lethal assaults, it is not entirely irrational to think that a physician who crosses the line and kills a patient whose case the physician deems hopeless must have been acting in good faith.⁴² If the patient was in such irremediably bad condition that a physician killed him or her, the patient must have been in very bad condition indeed.

Such reasoning, whatever its defects and shortcomings, has at least some plausibility under our existing practices. It would have none under a practice brought about by instituting "physician"-assisted suicide. Under such a practice, with deliberate killing a routinized element of "medical" practice, the ground of our deep-seated trust of the physician's motives and aims vanishes. People who would have fought tooth and claw against

42. Here, naturally, one excludes on grounds of irrelevance the lethal actions of Mr. Jack Kevorkian, the former physician in Michigan whose resignation from the office of physician is spelled out in a pile of forty-one mostly female corpses.

establishing a practice of attorney-assisted suicide could be expected to discover themselves in a terrible fix if they established "physician"-assisted suicide. For it is reasonable to expect that they would find themselves facing all the dreaded consequences which made them oppose attorney-assisted suicide, the "physician" of their new practice turning out to be indistinguishable in crucial respects from an attorney authorized to kill, but they would at the same time have suffered an incalculable loss, namely, the loss of a precious cultural heritage, the loss of the practice of medicine.

There is a contrast between the constitutive rule which requires strict confidentiality and the constitutive rule which forbids euthanasia and assisted suicide. A physician who deliberately violates the crucial requirement of confidentiality does something profoundly wrong, but the violation is possible only for one who has taken a special oath of office, such as the nurse or physician: no *general* moral principle dictates that it is always wrong to transmit personal information concerning individuals with whom one is in contact. And there can certainly be no general moral principle about transmitting medical or legal information, since, in the absence of the constitutive rules that define the terms "medical" and "legal," the categories are not even available for discussion. Nonetheless, the designers of the practice of medicine⁴³ (or of law), could foresee that the sort of activities they wanted to make possible would proceed more successfully if they built in certain absolute constraints on officers who would be operating within the practice. Thus, they could see that it would be important for the persons who occupy the office of "physician" (or of "attorney") that they have available to them a rich supply of information concerning the persons who come to them for professional assistance. Recognizing that many individuals will be reluctant to disclose intimate or potentially compromising information about themselves, they stipulated that the office of physician (or attorney) has attached to it an absolute obligation to forbear from disclosing information about clients without the permission of those clients, thus opening the door to uninhibited provision of information.⁴⁴

43. Speaking of "the designers" of such practices as medicine and law is to speak of countless persons whose decisions and actions over long periods of time gave rise to the practices we have inherited. To be sure, most of the persons involved in the process of designing these practices did not think of themselves as designers of social institutions, nor were the considerations we are here setting forth always fully explicit in their conscious thoughts.

44. There are, of course, certain narrowly specified exceptions to the prohibitions on violating the confidentiality of the physician-patient or attorney-client relationship:

Notice, in this case, what is at issue is an act (transmitting information about the health status of another person) which is in itself morally allowable for individuals who have not made any special promises or sworn any special oaths of office. It is denied the physician by the physician's oath. When we turn to the act of killing a person who is innocent in the sense that the person is neither engaging in a lethal assault nor convicted of a capital offense, we are contemplating an action which is intrinsically wrong, hence not an option for anyone.⁴⁵ It is thus not an option to the physician twice over: once on grounds of law and morality and again on grounds of logical necessity.

VI. CONCLUSION

Medicine is not a practice which was invented a few months ago by a task force in Washington; it is, rather, an institution which is one of the more remarkable cultural achievements of our species. The constitutive rules which define medicine have been in force for millennia; the definitions and understandings they embody are deeply entrenched. Tinkering with them is no casual undertaking. To remove a rule as central to the specification of the intrinsic goals and inner logic of medicine as the prohibition of euthanasia and assisted suicide is not so much to change medicine as to *abandon* it. Not all revisions of our practices stand on the same level: some revisions are derangements. Nor do all derangements stand on the same level: some derangements amount to *abolition* of the practices into which they are introduced. Any social role, any office, admits of modification and revision. No social role, however, is open to all possible revisions. At some point, revision slides into obliteration, modification becomes annihilation.

A practice under which doctors deliberately kill patients is no more possible than one under which police officers engage in criminal activities or one under which firefighters engage in deliberate arson or one under which naked boys wear green suits. A practice under which "physicians" are authorized to kill "patients" deliberately is a practice which has no physicians, just as a practice which authorizes "police officers" to carry out crimi-

for example, when a physician treats the victim of a gunshot wound or a patient with a "reportable disease," the physician is obliged to notify the proper authorities. Observe that, even within this narrow range of exceptions, there are careful and narrow restrictions concerning the persons who are permitted to have the confidential information.

45. In an insightful essay, G.E.M. Anscombe, *Murder and the Morality of Euthanasia: Some Philosophical Considerations*, (pages 37 - 50 of *Euthanasia, Clinical Practice and the Law*, Luke Gormally, Linacre Centre ed.), 1994), G.E.M. Anscombe asserts that intentional killing of the innocent constitutes "the hard core of the concept" of murder.

nal acts is a practice which has no police officers, or a practice which authorizes "firefighters" to commit arson is a practice which has no "firefighters." The obstacles to deliberate killing by physicians are very steep indeed: they are *logical*.

Ignoring these logical obstacles leads one into trouble of a sort illustrated by an article in the *New England Journal of Medicine*. The article, which lists about a dozen authors and deals with caring for terminally ill patients, contains a remarkable passage:

... all but two of us ... believe that it is not immoral for a physician to assist in the rational suicide of a terminally ill patient. However, we recognize that such an act represents a departure from the principle of continually adjusted care that we have presented.⁴⁶

Imagine a panel of a dozen experts on legal practice writing:

... all but two of us ... believe that it is not immoral for an attorney to engage in the deliberate incrimination and prosecution of his client. However, we recognize that such an act represents a departure from the principle of continuous protection of client interests that we have presented.

Or a panel of a dozen experts on swimming safety writing:

... all but two of us ... believe that it is not immoral for a lifeguard to assist in the deliberate drowning of certain swimmers. However, we recognize that such an act represents a departure from the principle of continuous attention to swimming safety that we have presented.

Deciding that, if we institute a practice of euthanasia or assisted suicide, doctors are the professionals who should be authorized to carry out or oversee the killing, is logically indistinguishable from deciding that, *if we ever legalize deliberate drownings, lifeguards are the ones who should carry out the drownings*.

The constitutive rules which define the central core of medicine and have remained fixed and stable over millennia bind the physician to the good of the patient in precisely specified ways. The physician is not given an airborne injunction to promote the patient's well-being, which leaves it up to the physician or the patient to decide in what that well-being consists. Rather, there is a requirement of strict patient confidentiality, a requirement that the patient be protected from sexual overtures of any kind, a strict requirement that the physician is never to decide that the patient would be better off if destroyed, a requirement never to aim at injury or death, never to engage in euthanasia or assisted suicide. These central clauses define the heart of medicine, the inner nature of the practice. It is logically possible

46. Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, *NEW ENG. J. MED.*, March 30, 1989.

for an individual physician to disseminate information about his or her patients, and by concealing the violations, also to remain licensed to practice. If the proper authorities discover the misconduct they will act and their actions could include stripping the individual of standing as a physician, but the individual may remain a physician even after the authorities have acted on the violation of patient confidentiality. In contrast, it is logically impossible to have a *practice* in which "physicians" are authorized to engage in freely disseminating information about their patients, because whatever else would be true of that practice, it would, of logical necessity, not be a practice of medicine and the practitioners would not be "physicians." Similarly, an individual physician may out of mercy or malice engage in the deliberate killing of a patient, and, by escaping detection, retain standing as a physician. It is *impossible*, however, to have a practice under which "physicians" are authorized deliberately to kill patients. Logically impossible.

When we redesign the office of firefighter to authorize deliberate arson by firefighters, when we revise the office of attorney to permit attorneys to incriminate and even prosecute their clients, when we revise the office of lifeguard to allow lifeguards to carry out deliberate drownings, the time will have come to give serious thought to establishing a practice of physician-assisted suicide.

Logical impossibility has a power which renders other objections otiose. And, as we saw at the outset, other objections to a practice of physician-assisted suicide and euthanasia exist in abundance. Thus, for example, to enter an objection omitted from the earlier list: Deliberately killing patients whose cases are difficult will, among other things, rob us of the knowledge to be gained by treating such cases. Many of the cases now treated as routine are routine simply because, in the past, devoted physicians, nurses, scientists, patients, and families battled on against hopeless odds, usually losing, but in the process gaining hard-won scraps of valuable information about how to cope with a particular illness or injury and, gradually building up a body of knowledge which gave rise to today's routine treatments. Thus, a practice of assisted suicide would do more than kill certain patients, it would kill the growth of our medical knowledge and prevent us from ever reaching a point at which currently hopeless conditions can be treated routinely. And to repeat an important objection noted in the earlier list, a practice of assisted suicide would inevitably lead to the deaths of many individuals suffering from clinical depression. A fact encapsulated in a pertinent bit of folk wisdom: "Suicide is a permanent solution for a temporary problem." It can also be said against a practice of

euthanasia and assisted suicide that it contravenes the dictates of justice, violates the principle on which the legitimacy of state authority rests,⁴⁷ destroys traditional protections of the vulnerable, treads with contempt upon the most fundamental tenets of our moral heritage, deranges the medical profession,⁴⁸ and violates the dictates of common sense and common decency. These objections, however, profound though the principles they invoke may be, have the status of quibbles when set beside the difficulty established here.

If Ballot Measure 16 goes into effect in Oregon or the badly confused rulings of two recent circuit courts are permitted to dictate future practice anywhere else, it is unlikely that many physicians will rush to avail themselves of the lethal power which would be placed in their hands. A tradition as vast and deep and powerful as the tradition of Hippocratic medicine is not easily destroyed; its huge momentum would push us on for decades. Such an immense cultural force is not extinguished by the passage of a legislative initiative, a couple of resolutions by some professional organizations, or the disordered rulings of a few courts.

But suppose our practice of medicine and our laws transformed as the advocates of physician-assisted suicide would have them transformed. Then the United States will have been the birthplace for something never seen in this hemisphere: a practice of "medicine" which resembles medicine as closely as ants resemble antelopes. The new "physicians" may inherit from the practice of medicine certain costumes and a particular vocabulary and a preoccupation with human illness, but they will no more be practicing medicine than are actors in stage plays who portray doctors. To be sure, we would still have men and women donning white coats and wearing stethoscopes. These people could further elaborate their costumes by wearing name tags with the initials "M.D." after their names. They could occupy offices and clinics and hospitals which were once the work-places of physicians. They could adopt the practice of calling the people who came to them for help "patients." (And some of those unfor-

47. In her paper, *On the Source of the Authority of the State*, G.E.M. Anscombe argues persuasively that the source of the State's authority and the basis of its exclusive right to wield deadly force is its assumption of a particular task, namely, the protection of the innocent from unjust attack. This leads her to conclude that, "[t]here is one consideration here which has something like the position of absolute zero or the velocity of light in current physics. It cannot possibly be an exercise of civic authority deliberately to kill or mutilate innocent subjects." G.E.M. Anscombe, *Ethics, Religion, and Politics*, 3 *THE COLLECTED PHILOSOPHICAL PAPERS OF G.E.M. ANSCOMBE* 155, (1981).

48. If the thesis of the present article is correct, the derangement amounts to the actual destruction of medicine.

tunate people would be under the delusion that they were consulting real doctors.) To make the masquerade complete, the new breed of biological workers could even affect bad handwriting, take to playing golf on Wednesdays, and insist that others address them "Doctor." But, we would no longer have physicians. The killers would not be doctors; they could not be doctors.

The consensus of all our laws and institutions and of the moral tradition which has for several thousand years nourished those laws and institutions is that a private citizen cannot carry out homicide or perform acts of assisted suicide. These acts denied the private citizen both by law and by morality are denied the physician by an even stricter necessity: that of logic itself.

