23: SUICIDOLOGY AND THE RIGHT TO DIE

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As suicidology reflects on the issue of the right to die, it can make no bigger mistake than by seeing suicide and suicidal behavior in short-sighted isolation, without reference to the cultural context within which it occurs. Two kinds of myopia currently afflict us in particularly constricting ways: the refusal to see issues of suicide in the context of larger issues about how we die, and the failure to notice substantial cultural differences in how we think about dying and the choices we make about dying. I think suicidology can profit considerably from examining different end-of-life practices in cultures otherwise closely related to our own, and it is for this reason that I'd like to look here at differences in end-of-life practices and their conceptual backgrounds in three otherwise rather similar countries: the Netherlands, Germany, and the United States. Much of what we say about suicide and suicidal behavior in our own culture may look very different in the light of such contrasts, and much of what we do in studying and preventing suicide may be called into question in this way.

DEALING WITH DYING IN THREE ADVANCED NATIONS

The Netherlands, Germany, and the United States are all advanced industrial democracies. They all have sophisticated medical establishments and life expectancies over 70 years of age; their populations are all characterized by an

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increasing proportion of older persons. They are all in what has been called the fourth stage of the epidemiologic transition (Olshansky and Ault 1986)—that stage of societal development in which it is no longer the case that most people die of acute parasitic or infectious diseases. In this stage, most people do not die of diseases with rapid, unpredictable onsets and sharp fatality curves; rather, the majority of the population—as much as perhaps 70–80 percent—dies of degenerative diseases, especially delayed degenerative diseases, that are characterized by late, slow onset and extended decline. Most people in highly industrialized countries die from cancer, atherosclerosis, heart disease (by no means always suddenly fatal), chronic obstructive pulmonary disease, liver, kidney or other organ disease, or degenerative neurological disorders. Thus, all three of these countries are alike in facing a common problem: how to deal with the characteristic new ways in which we die.

DEALING WITH DYING IN THE UNITED STATES

In the United States, we have come to recognize that the maximal extension of life-prolonging treatment in these late-life degenerative conditions is often inappropriate. Although we could keep the machines and tubes—the respirators, intravenous lines, feeding tubes—hooked up for extended periods, we recognize that this is inhumane, pointless, and financially impossible. Instead, as a society we have developed a number of mechanisms for dealing with these hopeless situations, all of which involve withholding or withdrawing various forms of treatment.

Some mechanisms for withholding or withdrawing treatment are exercised by the patient who is confronted by such a situation or who anticipates it; these include refusal of treatment, the patient-executed DNR order, the living will, and the durable power of attorney. Others are mechanisms for decision by second parties about a patient who is no longer competent or never was competent. The latter are reflected in a long series of court cases. These are cases that attempt to delineate the precise circumstances under which it is appropriate to withhold or withdraw various forms of therapy, including respiratory support, chemotherapy, antibiotics in intercurrent infections, and artificial nutrition and hydration. Thus, during the past 15 years or so, we have developed an impressive body of case law and state statute that protects, permits, and facilitates our characteristic American strategy of dealing with end-of-life situations. These cases provide a framework for withholding or withdrawing treatment when we believe there is no medical or moral point in going on. This is sometimes termed passive euthanasia; more often, it is simply called allowing to die, and is ubiquitous in the United States.

For example, a recent study by Miles and Gomez (1988) indicates that some 85 percent of deaths in the United States occur in health-care institutions, including hospitals, nursing homes, and other facilities, and of these, about 70 percent involve electively withholding some form of life-sustaining treatment. A

1989 study cited in the *Journal of the American Medical Association* claims that 85–90 percent of critical care professionals state that they are withholding and withdrawing life-sustaining treatments from patients who are "deemed to have irreversible disease and are terminally ill" (Sprung 1990 p. 2213). Still another study identified some 115 patients in two intensive-care units from whom care was withheld or withdrawn; 110 were already incompetent by the time the decision to limit care was made. The 89 who died while still in the intensive care unit accounted for 45 percent of all deaths there (Smedira 1990). It is estimated that 1.3 million American deaths a year follow decisions to withhold life support; this is a majority of the just over two million American deaths per year. Withholding and withdrawing treatment is the way we in the USA go about dealing with dying, and indeed "allowing to die" is the only legally protected alternative to maximal treatment recognized in the United States. We do not legally permit ourselves actively to cause death.

DEALING WITH DYING IN HOLLAND

In the Netherlands, voluntary active euthanasia is also an available response to end-of-life situations. Although active euthanasia remains prohibited by statutory law, it is protected by a series of lower and supreme court decisions and is widely regarded as legal, or, more precisely, *gedogen,* legally tolerated. These court decisions have the effect of protecting the physician who performs euthanasia from prosecution, provided the physician meets a rigorous set of guidelines.

These guidelines, variously stated, contain five central provisions:

1. that the patient's request be voluntary;
2. that the patient be undergoing intolerable suffering;
3. that all alternatives acceptable to the patient for relieving the suffering have been tried;
4. that the patient have full information;
5. that the physician have consulted with a second physician whose judgment can be expected to be independent.

Of these criteria, it is the first which is central: euthanasia may be performed only at the voluntary request of the patient. This criterion is also understood to require that the patient's request be a stable, enduring, reflective one—not the product of a transitory impulse. Every attempt is to be made to rule out depression, psychopathology, pressures from family members, unrealistic fears, and other factors compromising voluntariness. In general, pain is not the principal basis for euthanasia, since pain can, in most cases, be effectively treated; "intolerable suffering," understood to mean suffering that is in the patient's (rather than the physician's) view intolerable, may also include fear of or unwillingness to endure *entluisterung,* or that gradual effacement and loss of personal identity that characterizes the end stages of many terminal illnesses. It is also required that euthanasia be performed only by a physician; it may not be performed by a nurse, family member, or other party.

Putting an end to years of inflammatory discussion in which speculation about the frequency of euthanasia had run as high as twenty thousand cases a year, a comprehensive study requested by the Dutch government was published in 1991.[1] This study, popularly known as the Remmelink Commission report, showed that about 1.8 percent of deaths in the Netherlands are the result of euthanasia at the explicit request of the patient with some form of physician involvement and about 0.3 percent of deaths involve physician-assisted suicide. The report of another 0.8 percent of cases of life-terminating acts without the explicit and persistent request of the patient has stirred enormous controversy in the United States, where it is often claimed that this shows that one thousand patients were put to death against their wishes; but what the Remmelink Commission in fact reports is that in these cases, although the strict criteria for euthanasia were not fulfilled, in more than half, euthanasia had been previously discussed with the patient or the patient had expressed in a previous phase of the disease a wish for euthanasia if his or her suffering became unbearable, and in virtually all the remaining cases the patients were near to death and clearly suffering grievously, yet verbal contact had become impossible. Of the total deaths in the Netherlands, the Remmelink Commission found that about 17.5 percent involved decisions to withhold or withdraw treatment although continuing treatment would probably have prolonged life, another 17.5 percent involved the use of opioids to relieve pain but in dosages probably sufficient to shorten life (a practice ubiquitous in the U.S.), and a total of approximately 2.9 percent involved euthanasia and related practices.

Thus, euthanasia is comparatively rare in the Netherlands, even in a medical climate in which, as in the U.S., medical decisions about dying are common; physician-assisted suicide is even rarer. Nevertheless, euthanasia is a conspicuous alternative to terminal illness well known to both physicians and the general public. Surveys of public opinion in the Netherlands show growing public support for a liberal euthanasia policy (increasing from 40 percent in 1966 to 81 percent in 1988) (Borst-Eilers 1991), and whereas there is a vocal minority opposed to the practice (including a group of about one thousand physicians), it is apparent that both the majority of the population in Holland and the majority of Holland's physicians support it. The Remmelink Commission found that 54 percent of physicians had performed euthanasia or assisted in suicide (though the percentage is highest [62 percent] among general practitioners and lowest [12 percent] among nursing home physicians), and an additional 34 percent said that although they had not practiced euthanasia or assisted in suicide, they could conceive of situations in which they would be prepared to do so. The

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[1] A summary of the findings is available in English in P. J. van der Maas, J. J. M. van Delden, L. Pijnenborg, and C. W. N. Looman, "Euthanasia and Other Medical Decisions Concerning the End of Life," *The Lancet* 338 (14 September 1991): pp. 669–74.

Commission commented, "a large majority of physicians in the Netherlands see euthanasia as an accepted element of medical practice under certain circumstances," (van der Maas et al. 1991) though these circumstances are comparatively rare.

In Holland, many hospitals now have protocols for the performance of euthanasia; these serve to ensure that the court-established guidelines have been met. However, it is believed that most euthanasia is practiced in the patient's home, typically by the *huisarts,* or general practitioner, who is the patient's long-term family physician. Euthanasia is usually performed after aggressive hospital treatment has failed to arrest the patient's terminal illness; the patient has come home to die, and the family physician is prepared to ease this passing. Whether practiced at home or in the hospital, it is believed that euthanasia usually takes place in the presence of the family members, perhaps the visiting nurse, and often, the patient's pastor or priest. Many doctors say that performing euthanasia is never easy, but that it is something they believe a doctor ought to do for his or her patient when nothing else can help.

Thus, in Holland, a patient facing the end of life has an option not openly practiced in the United States: to ask the physician to bring his or her life to an end. Although not everyone does so—indeed, of people who die in a given year, at least 97 percent do not—it is a choice widely understood as available.

FACING DEATH IN GERMANY

In part because of its very painful history of Nazism, Germany appears to believe that doctors should have no role in causing death. Although societal generalizations are always risky, it is fair, I think, to say that there is vigorous and nearly universal opposition in Germany to the notion of active euthanasia. Euthanasia is viewed as always wrong, and the Germans view the Dutch as stepping out on a dangerously slippery slope.

However, it is an artifact of German law that, whereas killing on request (including voluntary euthanasia) is prohibited, assisting suicide—where the person committing suicide is determined to do so—is not a violation of the law. Taking advantage of this situation, there has developed a private organization, the *Deutsche Gesellschaft für Humanes Sterben* (DGHS), or German Society for Humane Dying, which provides support to its very extensive membership in choosing suicide as an alternative to terminal illness.

Founded in 1980, by September 1991 the DGHS had grown to some fifty thousand members, and has been adding new members at the rate of one thousand per month. Many of its members are already elderly or terminally ill. After a person has been a member of the organization for at least a year, he or she may request a copy of DGHS's booklet *Menschenwürdiges und selbstverantwortliches Sterben,* or "Dignified and Responsible Death," which is not commercially available. The DGHS does not charge for this booklet. The booklet itself includes a statement of the conditions under which it is obtainable—including the requirement that the member has not received medical or psychotherapeutic treatment for depression or other psychiatric illness during the last 2 years. Each copy is numbered; the member is urged to keep track of it, not to give it to third parties, and not to make public its contents in any other way. The booklet is to be returned to DGHS after the member's death. The DGHS reports approximately two thousand to three thousand suicides per year among its members.

The specific advice provided in the DGHS's booklet contains, among other things, a list of ten drugs available by prescription in Germany, mostly barbiturates and chloroquines, together with the specific dosages necessary for producing a painless, nonviolent death. (Although the DGHS was originally associated with the provision of cyanide, it no longer publicly recommends this.) In addition to the drugs that will produce death, the booklet lists companion drugs for preventing vomiting and for inducing sedation. It also lists drugs available without prescription in other European countries (some just a few hours drive from parts of Germany), including France, Italy, Spain, Portugal, and Greece. DGHS recommends that the member approach a physician for a prescription for the drug of choice, asking, for example, for a barbiturate to help with sleeping or chloroquine for protection against malaria on a trip to India. Where this deception is difficult or impossible, the DGHS may also arrange for someone to obtain drugs from a country where they are available without prescription. In unusual cases, it will also provide what it calls *Sterbebegleitung,* or accompaniment in dying: this is provided by a companion who will remain with the person during the time that is required for the lethal drug to take full effect, often as much as 10 to 12 hours or longer. However, the DGHS now urges that family members or friends, rather than DGHS staff or members, provide accompaniment, and has recently inaugurated an *Akademie der Sterbebegleitung,* or Academy of Accompaniment in Dying, to train such persons in what to expect and how to be supportive.

DGHS also supports refusal of treatment, where that is what the patient wishes, and in general attempts to protect a broad range of patients' rights. It provides members with a series of forms, including copies of Germany's version of the living will and durable power of attorney. In the format provided by the DGHS, both of these forms not only stipulate health care choices or persons empowered to make them on behalf of a no-longer-competent patient, but they also include provisions authorizing the DGHS to take legal action against any person or organization (that is, any physician or hospital) that refuses to honor the patient's antecedently stipulated wishes. For those who choose suicide as a way of bringing their lives to an end, the DGHS also provides a form intended to provide clear evidence both of the considered nature of that choice and to dispel any suspicion of foul play. The form—printed on a single sheet of distinctive pink paper—is to be signed once when the person joins the DGHS, asserting that he or she is a member of the organization and that he or she wishes to exercise the right to determine the time of his or her death; the same form is to be signed again at the time of the suicide—presumably, at least a year later—and to be left beside the body.

DGHS also relies heavily on its network of regional bureaus to encourage and facilitate feedback. Since assisting suicide is not illegal in Germany, there is no legal risk for an individual in soliciting information about suicide or in that person's family reporting back information about methods of suicide attempted or used. DGHS attempts to keep very careful track of its members' experiences with the information it provides, and uses this feedback to revise and update its drug recommendations. To facilitate this, the drug information provided in its booklet is printed on a separate sheet inserted in a slip pocket inside the back cover, and this list of current recommendations is revised and updated on a monthly basis. DGHS thus claims to be able to do what is much riskier in countries where assisting suicide is illegal: to make extensive use of feedback about actual methods of suicide. In mid-1991, when the Hemlock Society's president Derek Humphry's book *Final Exit* (1991) hit the top of the *New York Times* how-to best-seller list, DGHS president Hans Henning Atrott complained that the American book's information wasn't fully reliable: it was based, Atrott claimed, on published toxicological information, or information about what drug doses might prove sufficiently toxic to cause death, and not on empirical information about what drug doses would be certain to cause death. Because of the quite different legal situation in Germany, DGHS is able to collect reports about its own members' suicides and thus to adjust its drug recommendations on the basis of actual experience. Humphry replied that he gets just as much information from the forty seven thousand members of the Hemlock Society, including explicit information about suicide deaths from patients' families, from doctors, and even occasionally from patients whose suicide attempts were not fatal, but it is clear that such information is collected in a very different climate in the U.S. Fearing that they would be subpoenaed, the Hemlock Society was forced several years ago to burn first-person reports from a sizable number of physicians of cases of euthanasia they had performed or suicide in which they had assisted.

Even though assistance in suicide is not illegal in Germany, the DGHS remains controversial, though criticism is often directed against the person of its founder and not against the principle of assistance in suicide itself. Late in 1991, Hans Henning Atrott was accused of selling cyanide to an attorney hospitalized for mental illness, and in May 1992 police raided his office, finding capsules of cyanide, barbiturates, and a large amount of cash. What the outcome of this scandal will be remains, at this writing, to be seen, though the point of criticism clearly has to do with Atrott's alleged profiteering and assisting a mentally ill person, rather than with the DGHS's practice of assisting competent terminally ill individuals in suicide.

The existence of the DGHS is made possible by a distinctive feature of German law, a feature in which German law differs from that of England, the

U.S., the Netherlands, and most of Europe. During the Middle Ages in most of Europe suicide was a felony punishable by desecration of the corpse, burial at a crossroads, forfeiture of the decedent's estate to the crown, and, in some instances, execution if the suicide attempt was not fatal. Suicide was decriminalized in England and Wales only in 1961, primarily for the purpose of permitting medical and psychiatric treatment without criminal onus for those who had attempted suicide. In contrast, suicide was decriminalized in Germany by Frederick the Great in 1751. Assisting suicide is not a crime in Germany either, provided that the person about to commit suicide is *tatherrschaftsfähig,* that is, capable of exercising control over his or her actions, and also that he or she acts out of *freiverantwortliche Wille,* or freely responsible choice.[2] Thus, while assisting the suicide of a disturbed, depressed, or demented person, or a person coerced by external forces, would not be permitted under German law, it is permitted to aid an informed, voluntary suicide, including what we might be tempted to call a rational suicide. However, killing upon request—the act involved in euthanasia—is prohibited under German law.

To be sure, the details of German law on these points have been receiving extended discussion, especially with respect to the apparent conflict between the fact that assisted suicide is not illegal but that there may be a duty to rescue a suicide in progress. Like U.S. law, German law imposes an obligation to rescue upon specific parties standing in certain professional or personal relationships to other persons; this is the basis of the physician's legal duty to rescue his or her patient. Thus, as one widely prevalent interpretation of the legal situation holds, although the physician is not prohibited from giving a lethal drug to a patient, once that patient has taken the drug and becomes unconscious, the physician incurs a duty to resuscitate him or her.[3]

These provisions of German law—all currently highly controversial—have the effect of curtailing the role of German physicians in suicide, and tend to insulate the patient from physician aid. Thus, German law reinforces a posture that might also seem to be a product of fear of euthanasia and suspicion of authoritarian physicians: in Germany, taking death into one's own hands in these contexts is an individual, private matter, to be conducted outside the medical establishment and largely without its help. This is not to say that the provisions of German law are the product of studied judicial deliberation or current political consensus; they are often viewed as an artifact of earlier times. In any case, although it apparently would not be illegal for physicians to assist in the

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[2] See Volker Krey, "Tötung durch Zulassen eines Selbstmordes" [Killing by allowing a suicide to occur], *Strafrecht Besonderer Teil,* vol. 1, 7th edition (Stuttgart: Verlag W. Kohlhammer, 1972, 1989), pp. 35-37.

[3] See Volker Krey, "Euthanasie nach deutschem Strafrecht—Strafrechtlich Probleme der Sterbehilfe für unheilbar Erkrankte" [Euthanasia according to the German criminal law: the problem of aid-in-dying for the terminally ill], in 5. Europäischer Kongress für humanes Sterben, (Augsburg: Deutsche Gesellschaft für humanes Sterben e.V., 1985), pp. 145-50, and also the previously cited work.

initiation of their patients' suicides, as a matter of practice they do not do so. There is some move to suggest that the obligation to rescue extends beyond the physician to a spouse, friend, or any person with knowledge of a suicide in progress, but this is currently an extremely controversial issue in German law.

That neither suicide nor assisted suicide are illegal under German law does not mean that there can be no attempts to prevent suicide. Indeed, Germany has an active organization for suicide prevention, the *Deutsche Gesellschaft für Suizidprävention* (the German Society for Suicide Prevention), which directs its attention in particular to recognizing suicidal tendencies in disturbed, depressed, or demented persons—that is, persons who cannot be said to be in control of their actions and who are not exhibiting freely responsible choice. Since, of course, it is not always possible to determine in advance whether a given person's suicide might count as in control or not in control, or as the product or not the product of freely responsible choice, in practice Germany's suicide prevention efforts look very much like those elsewhere, and are generally directed across the board at preventing suicide.[4]

To be sure, assisted suicide is not the only option open to the terminally ill in Germany; nor is it, apparently, particularly frequent. There is increasing emphasis on help in dying that does not involve direct termination, and organizations like Omega, offering hospice-style care and an extensive program of companionship, are attracting increasing attention. Nevertheless, the DGHS is a conspicuous organization, and many Germans appear to be aware that this alternative is available even if they do not use it.

OBJECTIONS TO THE THREE MODELS OF DYING

In response to the dilemmas raised by the new circumstances of death, in which the majority of the population in each of the advanced industrial nations dies of degenerative diseases after an extended period of terminal deterioration, different countries develop different practices. The United States legally permits only withholding and withdrawal of treatment, though of course active euthanasia and assisted suicide do occur. Holland also permits voluntary active euthanasia, and although Germany rejects euthanasia, it tolerates assisted suicide. But there are serious moral objections to be made to each of these practices, objections to be considered before resolving the issue of which practice our own culture ought to adopt.

Objections to the German Practice

German law does not prohibit assisting suicide, but postwar German culture discourages physicians from taking any active role in death. This gives rise to

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[4] See, however, Hermann Pohlmeier, *Selbstmord und Selbstmordverhütung* [Suicide and suicide prevention] (Munich: Urban & Schwartzenberg, 1983) for a discussion of suicide and suicide prevention that also considers the relationship of suicide prevention to issues about freedom to choose suicide; a briefer statement can be found in his editorial, "Suicide and Euthanasia—Special Types of Partner Relationships," *Suicide and Life-Threatening Behavior,* 15, no. 2(1985):117–123.

distinctive moral problems in Germany's practices. For one thing, it appears that there is little professional help or review provided for patients' choices about suicide; because the patient makes this choice essentially outside the medical establishment, medical professionals are not in a position to detect or treat impaired judgment on the part of the patient, especially judgment impaired by depression. Similarly, if the patient must commit suicide assisted only by persons outside the medical profession, there are risks that the patient's diagnosis and prognosis are inadequately confirmed, that the means chosen for suicide will be unreliable or inappropriately used, that the means used for suicide will fall into the hands of other persons, and that the patient will fail to recognize or be able to resist intrafamilial pressures and manipulation. The DGHS policy for providing assistance requires that the patient be terminally ill and have been a member of the DGHS for at least one year in order to make use of its services, the latter requirement apparently intended to provide evidence of the stability of such a choice, but these minimal requirements are hardly sufficient to answer the charge that suicide decisions, which are made for medical reasons but must be made without medical help, may be rendered under less than ideally informed and voluntary conditions.

Whether Germany's different cultural and linguistic climate, as we shall explore in a moment, protects these decisions in other ways remains to be seen.

Objections to the Dutch Practice

The Dutch practice of physician-performed active voluntary euthanasia also raises a number of ethical issues, many of which have been discussed vigorously both in the Dutch press and in commentary on the Dutch practices from abroad. For one thing, it is sometimes said that the availability of physician-performed euthanasia creates a disincentive for providing good terminal care. I have seen no evidence that this is the case; on the contrary, Peter Admiraal, the anesthesiologist who is perhaps Holland's most vocal proponent of voluntary active euthanasia, insists that pain should rarely or never be the case for euthanasia, since pain (in contrast to suffering) is comparatively easily treated (Admiraal 1990). Instead, it is a refusal to endure the final stages of deterioration, both mental and physical, that motivates requests.

It is also sometimes said that active euthanasia violates the Hippocratic Oath. Indeed, it is true that the original Greek version of the Oath prohibits the physician from giving a deadly drug, even when asked for it; but the original version also prohibits performing surgery and taking fees for teaching medicine, neither of which prohibitions has survived into contemporary medical practice. Dutch physicians often say that they see performing euthanasia—where it is genuinely requested by the patient and nothing else can be done to relieve the patient's suffering—as part of their duty to the patient, not as a violation of it.

The Dutch are also often said to be at risk of starting down the slippery slope, that is, that the practice of voluntary active euthanasia for patients who meet the criteria will erode into practicing less-than-voluntary euthanasia on patients whose problems are not irremediable, and perhaps by gradual degrees develop into terminating the lives of people who are elderly, chronically ill, handicapped, mentally retarded, or otherwise regarded as undesirable. This risk is often expressed in vivid claims of widespread fear and wholesale slaughter, claims that are repeated in the right-to-life press in both Holland and the USA; however, these claims are simply not true and as we have seen, the vast majority of the Dutch favor current practices. However, it is true that the Dutch are now beginning to agonize over the problems of the incompetent patient, the mentally ill patient, the newborn with serious deficits, and other patients who cannot make voluntary choices, though these are largely understood as issues about withholding or withdrawing treatment, not about direct termination (Ten Have 1990). In the rare cases where direct termination is practiced, these are not understood as euthanasia, but as a distinct form of *levensbeëindigend handelen,* or life-ending treatment.

What is not often understood is that this new and acutely painful area of reflection for the Dutch—withholding and withdrawing treatment from incompetent patients—has already led in the United States to the development of a vast, highly developed body of law: the series of cases beginning with *Quinlan* and culminating in *Cruzan.* Americans have been discussing these issues for a long time, and have developed a broad set of practices that are regarded as routine in withholding and withdrawing treatment. The Dutch see Americans as much further out on the slippery slope than they are, because Americans have already become accustomed to second-party choices. Issues involving second-party choices are painful to the Dutch in a way they are not to us precisely because voluntariness is so central in the Dutch understanding of choices about dying. Concomitantly, the Dutch see the Americans' squeamishness about first-party choices—voluntary euthanasia, assisted suicide—as evidence that we are not genuinely committed to recognizing voluntary choice after all. For this reason, many Dutch commentators believe that the Americans are at a much greater risk of sliding down the slippery slope into involuntary killing than they are. I fear, I must add, that they are right about this.

Objections to the American Practice

There may be moral problems raised by the German and the Dutch practices, but there are also moral problems raised by the American practice of relying on withholding and withdrawal of treatment in end-of-life situations. The German, Dutch, and American practices all occur within similar conditions—in industrialized nations with highly developed medical systems, where a majority of the population dies of illnesses exhibiting characteristically extended downhill courses—but the issues raised by our own response to this situation may be even more disturbing than those of the Dutch or the Germans. We often assume that our approach is safer because it involves only letting someone die, not killing him or her; but it too raises very troubling questions.

The first of these issues is a function of the fact that withdrawing and especially withholding treatment are typically less conspicuous, less pronounced, less evident kinds of actions than direct killing, even though they can equally well lead to death. Decisions about nontreatment have an invisibility that decisions about directly causing death do not have, even though they may have the same result, and hence there is a much wider range of occasions in which such decisions can be made. One can decline to treat a patient in many different ways, at many different times—by not providing oxygen, by not instituting dialysis, by not correcting electrolyte imbalances, and so on—all of which will cause the patient's death; open medical killing also brings about death, but is a much more overt, conspicuous procedure. Consequently, letting die also invites many fewer protections. In contrast to the earlier slippery slope argument, which sees killing as riskier than letting die, the slippery slope argument here warns that because our culture relies primarily on decisions about nontreatment, grave decisions about living or dying are not as open to scrutiny as they are under more direct life-terminating practices, and hence, are more open to abuse.

Second, and closely related, reliance on withholding and withdrawal of treatment invites rationing in an extremely strong way, in part because of the comparative invisibility of these decisions. When a health-care provider does not offer a specific sort of care, it is not always possible to discern the motivation; the line between believing that it would not provide benefit to the patient and that it would not provide benefit worth the investment of resources in the patient can be very thin. This is a particular problem where health-care financing is highly decentralized, as in the United States, and where rationing decisions without benefit of principle are not always available for easy review.

Third, relying on withholding and withdrawal of treatment can often be cruel. It requires that the patient who is dying from one of the diseases that exhibits a characteristic extended, downhill course (as the majority of patients in Holland, Germany, and the U.S. do) must in effect wait to die until the absence of a certain treatment will cause death. For instance, the cancer patient who forgoes chemotherapy or surgery does not simply die from this choice; he or she continues to endure the downhill course of the cancer until the tumor finally destroys some crucial bodily function or organ. The patient with amyotrophic lateral sclerosis who decides in advance to decline respiratory support does not die at the time this choice is made, but continues to endure increasing paralysis until breathing is impaired and suffocation occurs. We often try to ameliorate these situations by administering pain medication or symptom control at the same time we are withholding treatment, but these are all ways of disguising the fact that we are letting the disease kill the patient rather than directly bringing about death. But the ways diseases kill people are far more cruel than the ways physicians kill patients when performing euthanasia or assisting in suicide.

LANGUAGE AND CONCEPTUAL DIFFERENCES IN THE WAY WE DIE

But to describe difference in end-of-life practices in three otherwise similar cultures is not yet to show why these differences are possible. To understand how these cultures can variously accept or reject active euthanasia, assistance in suicide, and withdrawing and withholding of treatment, it is necessary to see several conceptual distinctions at the root of these practices.

Differing Senses of the Term Euthanasia

In attempting to disentangle disagreement about the issues in euthanasia, and to explain how it can be so broadly accepted in one European culture, the Netherlands, so strongly rejected in an immediately neighboring one, Germany, and viewed with such ambivalence in American culture, it is essential to see that the term is used in two quite different senses. On the one hand, there is the sense, based heavily on the Greek etymology, *eu-thanatos,* or good death, that euthanasia is in the interests of the person whose death it is; it is better than the death this person would otherwise meet. In the Netherlands, euthanasia is understood in this way, but there is an additional component: it is understood that the wish of the patient is central, and that a death cannot be a good one which is not in concert with the wish of the patient. Hence, in the Netherlands, euthanasia is understood to mean, by definition, *voluntary* euthanasia—or, as the authors of the Remmelink Commission report put it, "the intentional termination of life by somebody other than the person concerned at his or her request" (p. 669).

In Germany, in contrast, the term euthanasia is characteristically understood in a way associated with the abuses by the Nazis: here, euthanasia has nothing to do with good death or death that is in the interests of the person concerned and preferable in that person's eyes to the death he or she might otherwise meet, but an ostensibly medical procedure performed for ulterior, nonmedical ends. The corruption of the term euthanasia began with the infamous T4 program, begun by Hitler in 1939, in which chronically ill, retarded, and handicapped Aryans were selected for this "benefit" though they were neither already dying nor had made any request to die (Lifton 1986). The T4 program increasingly moved to the involuntary selection of those determined unfit for work or who failed other tests of function. The T4 program was discontinued at the protests of both the Catholic and Protestant churches in 1941, but the personnel from this program were reassigned to the newly opened concentration camps, where they continued to perform killings of persons deemed unfit for various reasons. With the T4 personnel went not only their technology but the term "euthanasia," and it became firmly associated with Nazi medical experimentation and genocide. In Germany today, the term still retains this association with Nazi brutality and the involuntary killing of people for wholly nonmedical reasons. Indeed, so strong is the stink of the word "euthanasia" that protest groups have organized to suppress the discussion of it even in settings like academic bioethics conferences.[5]

Thus, we can identify two distinct, wholly different senses of the term euthanasia, and note that they are used in these quite opposite ways in two adjoining European countries. While the Dutch accept euthanasia in the voluntary, self-benefitting sense they have in mind, the Germans reject euthanasia in the involuntary, politically motivated, essentially Nazi sense they have in mind. Meanwhile, in the United States, discussions of the issues in euthanasia shift back and forth between these two quite distinct senses. The result is a general failure to communicate and, consequently, continuing political friction.

Multiple Senses of Suicide

Background conceptual issues are even more apparent in the matter of the language we use for self-caused death, and failure to understand the differences among different cultures may produce even more confusion.

In current usage, English provides one principal term to denote self-caused death: suicide. In contrast to English's primary reliance on a single term, German employs several distinct ones: the traditional terms *Selbstmord* and *Selbsttötung,* the scientific term *Suizid,* and the literary *Freitod. Selbstmord* and *Selbsttötung* are the analogues of the English terms *self-murder* (also *self-murther*) and *self-killing,* which were in widespread use in English during the seventeenth and eighteenth centuries; in English these terms were eventually supplanted by the Latinate *suicide* and have virtually disappeared from contemporary use. The German terms both remain current. The German *Selbstmord,* the term most frequently used in ordinary spoken and written discourse, carries extremely negative connotations, no doubt associated with its literal meaning, self-murder, including the implication of moral wrong. In partial contrast, *Selbsttötung,* literally self-killing, has connotations that are comparatively neutral in their factual quality but still decidedly negative, just as *killing* is neutral in English compared to murder but still decidedly negative. *Selbsttötung* is used primarily in bureaucratic and legal contexts. The German term *Suizid,* linguistically analogous to the English term, also literally means self-killing, but is comparatively neutral in its moral connotations; it conveys an implication of psychiatric pathology and is the technical term characteristically used by clinicians and researchers. While these terms are primarily found in their conversational,

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[5] See Peter Singer, "On Being Silenced in Germany," *The New York Review of Books,* 15 August 1991, pp. 36–42, and Bettina Schöne-Seifert and Klaus-Peter Rippe, "Silencing the Singer: Antibioethics in Germany," *Hastings Center Report* 21 no. 6 (1991):20–27, for accounts of responses to discussion of euthanasia and other topics. Also see the more comprehensive volume *Zur Debatte über Euthanasie* [On the debate over euthanasia], ed. Rainer Hegselmann and Reinhard Merkel (Frankfurt: Suhrkamp Verlag 1991), containing much of the discussion as well as responses to it. An example of the opposition is to be found in Christian Stadler, *Sterbehilfe—gestern und heute* [Aid-in-dying: yesterday and today] (Bonn: Psychiatrie-Verlag, 1991).

bureaucratic, and clinical applications respectively, they are also sometimes used interchangeably.

German's fourth term for self-caused death, however, is quite another matter. *Freitod* (literally free death or voluntary death) is a positive term, free from connotations of either moral wrongness or pathology; it also avoids the drabness of bureaucratic facticity. It is associated with voluntary individual choice and the expression of basic, strongly held personal values or ideals, especially those running counter to conventional societal norms, and suggests the triumph of personal integrity in the face of threat or shame. *Freitod* has an archaic flavor, often associated with Romanticism, and would not generally be used in ordinary conversation; however, it is readily recognizable to most speakers. But while the most common term for suicide, *Selbstmord,* and the comparatively uncommon literary one, *Freitod,* both refer to the act of bringing about one's own death, they have very different connotations and describe what are understood to be quite different sorts of acts. *Selbstmord* is taken to involve a generally repugnant, tragic act, generally associated with despair, anger, or depression; *Freitod,* in contrast, is seen as expressing voluntary, idealistic choice. Even the verbs used with the different German terms for suicide reinforce their semantic differences: one "commits" *Selbstmord (man begeht Selbstmord),* but one "chooses" *Freitod (man wählt den Freitod).* It is not grammatically possible to speak either of "choosing" *Selbstmord* or of "committing" *Freitod.*

To be sure, both English and German also offer a variety of peripheral terms to refer to suicide—for example, English's *self-destruction* and the archaic *self-slaughter;* German's *Selbstentleibung* (literally, self-disembodiment), all terms with strong connotations of violence, as well as an assortment of verbal expressions, many of which appear in similar forms in both English and German, *sich das Leben nehmen* (take one's own life), and often make reference to the means of death employed: *sich erhängen* (hang oneself), *sich erschiessen* (shoot oneself), *sich ertränken* (drown oneself), and so on. But the central contrast lies in the difference between English's current reliance on a single principal term—suicide—and German's routine use of several different terms, especially *Selbstmord, Selbsttötung, Suizid,* and *Freitod.* Despite its comparative archaism and infrequent usage, this last term, *Freitod,* plays an especially significant role and is crucial to understanding the nature of institutionalized assisted-suicide practices in contemporary Germany.

The term *Freitod* is often thought by educated Germans to date from the eighteenth century, emerging around the same time that Frederick the Great was decriminalizing suicide. The term seems particularly associated with the *Sturm und Drang,* or storm and stress, movement in German literature, especially the plays of Goethe and Schiller—plays read, of course, by German students during their high-school years. Perhaps the most familiar, celebrated example of *Freitod* in German literature would be said to be the death of Goethe's character Werther, the hero of his 1774 novella *The Sorrows of Young Werther.* In this compelling tale, a projection of Goethe's own ill-fated love affair with Charlotte

Buff, Werther chooses to end his own life rather than sink from a condition of extraordinary sensitivity and sensibility into the respectable tedium of everyday life.[6]

Curiously, however, etymological sources do not actually trace the word *Freitod* as far back as Goethe; rather, they find that it originates with the title of Section 22 of Nietzsche's *Also Sprach Zarathustra* (1883), *Vom Freien Tode* (variously translated "On free death" or "On voluntary death").[7] In this work, Nietzsche develops the notion of *Übermensch,* or superman, a concept later misunderstood and appropriated by National Socialism, and asserts a central teaching of Zarathustra: "Die at the right time." *Meinen Tod lobe ich euch, den freien Tod, der mir kommt, weil ich will,* says Zarathustra—"My death, praise I unto me because *I* want it" (p. 75). The death to be avoided is the "common, withered, patient death" of those who are "like sour apples": their lot is to "wait until the last day of autumn: and at the same time they become ripe, yellow, and shrivelled" (p. 75). The death that Zarathustra preaches is an active, extraordinary, heroic death, an earlier, self-willed death of which the ordinary man is hardly capable.

Perhaps because of the association of Nietzsche's *Übermensch* with Nazism, *Freitod,* with its quite positive connotations, is rarely thought to originate there, and is instead attributed, erroneously, to the pre-Romantic ideal. But the term is not found in either Goethe or Schiller, and, indeed, the single term, *Freitod,* is not even found in Nietzsche, though it originates from Nietzsche's two-word phrase.[8] Yet, however problematic its actual origins, the term does have a distinctive, well-recognized sense in contemporary German: although it refers to the act of bringing about one's own death, it does not convey the very negative moral connotations associated with *Selbstmord,* the factual but still negative connotations of *Selbsttötung,* or the pathological ones associated with *Suizid.* On the contrary, the connotations of the term *Freitod* are wholly positive: achieving this kind of death is an admirable, heroic—if very difficult—thing to do.

There is no analogous term in English. While there have been recent attempts at coinages in English (for example, *self-deliverance*) to describe suicide

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[6] Considerable critical discussion has been devoted to the issue of whether Werther's death—depicted as resulting a dozen hours after a self-inflicted gunshot wound to the head, clearly involving considerable suffering, is really intended by Goethe as a pure example of *Freitod,* or whether, on the contrary, it is a parody of it or warning against it. The publication of *The Sorrows of Young Werther* did lead to a rash of copycat suicides among young men, many of whom were dressed in clothing similar to Werther's—a blue waistcoat and a yellow vest.

[7] Friedrich Kluge, *Etymologisches Wörterbuch der deutschen Sprache* [Etymological dictionary of the German language], (Berlin: DeGruyter, 1989), p. 231. See also Karl Baumann's remarkable dissertation on the development of the terms Selbstmord and Freitod: *Selbstmord und Freitod in sprachlicher und geistesgeschichtlicher Beleuchtung* [suicide and free death as illuminated by linguistic and intellectual history] (Giessen: Dissertationsdruckerei und Verlag Konrad Triltsch, 1934), which includes extensive personal reflections from other linguists and over one hundred responses to a questionnaire about usage of these two terms.

[8] The first known occurrence of the single word *Freitod* is dated 1906, some 23 years after Nietzsche's *Zarathustra.* See Baumann, *Selbstmord und Freitod,* p. 13.

but avoid that term's negative connotations, there is no widely recognized, familiar English term with long historical resonances of the sort that *Freitod* seems to have. The only other English terms for suicide that do not have negative connotations carry either pronounced religious associations or the implication that the suicide serves the interest of some other person or cause: there are terms like *self-sacrifice* and *martyrdom.* The very concept of *Freitod*—a notion without religious, altruistic overtones and without negative moral or psychological implications, but which celebrates the voluntary choice of death as a personal expression of principled idealism—is, in short, linguistically unfamiliar to English speakers. Language is crucial in shaping attitudes about end-of-life practices, and because of the very different lexical resources of English and German, it is clear that English speakers cannot straightforwardly understand the very different German conception of these matters. Even in situations of terminal illness, the very concept of voluntary death resonates differently for the German speaker who conceives of it as *Freitod* than it does for the English-speaker who conceives of it as suicide.

Thus, while one sees in both Germany and the United States the development of notions of what is often called rational suicide and the conception that this may be a reasonable choice in terminal illness, they occur in very different cultural climates. In an English-speaking country like the United States, there is no tradition that recognizes a distinctive sort of suicide, different from immoral or pathological suicide, and no tradition of legal or other protection for it. Nor is there a similar tradition in the Netherlands. Not even among the English Romantics is there a literary model quite like Werther, whose death could readily be described as *Freitod.* The sense of the German term *Freitod* is simply not to be found in any single term in English, or in Dutch. Furthermore, it could be constructed in English only with comparatively clumsy circumlocutions: "suicide that is self-centered but without the negative connotations of either suicide or self-centered; "self-deliverance but with long, positive historical resonances," and so on, but these paraphrases would hardly capture the rich connotative field that has developed around the term *Freitod.* This is not to say that German speakers are always actively aware of the history and connotations of *Freitod,* but that the German language provides resources for thinking about, expressing, and experiencing choices about suicide in terminal illness in a way that English and Dutch do not.

Indeed, the DGHS deliberately exploits the conception of ending one's life in terminal illness as *Freitod* rather than *Selbstmord.* The distinctive pink form, mentioned earlier, to be signed when joining the DGHS and to be signed again at the time of one's final act, does not refer to that act as suicide, but as free death: it is labelled *Freitod-Verfügung,* or free death directive. On the line just prior to the space for the second signature, the form reads: *Ich habe heute meinen Freitod eingeleitet*—"I have brought about my free death today." This is the form that will be found beside the body. The terms *Selbstmord* and *Suizid* appear nowhere in this document, and the bureaucratic term *Selbsttötung* appears only in the reverse side in the language of quotations from German law about the legal status of suicide.

It is tempting to say, then, that choices about ending life may be rather different for the German speaker than for the English or the Dutch speaker. If so, it is also plausible to suppose that choices of suicide in terminal illness, protected not only by legal but also by linguistic and hence conceptual supports, may be much easier to make in Germany than they are in the United States, where legal, linguistic, and conceptual structures all militate against them, and perhaps easier than in the Netherlands, where euthanasia is widely accepted but suicide seems less so. Furthermore, presumably, not only may these choices to suicide be easier for the German speaker to make, they may also be easier for survivors to accept and for the culture as a whole to acknowledge. Of course, there are factors in German culture that militate against suicide as well—religious sanctions, for example; but the picture may nevertheless be rather different from the one we see in the Netherlands and the United States, and it may be a picture that is difficult for outsiders to perceive or understand.

THE PROBLEM: A CHOICE OF CULTURES

Thus we see three similar cultures and countries and three similar sets of circumstances, but three quite different basic practices in approaching death. All three of these practices generate moral problems; none of them, nor any others we might devise, is free of moral difficulty. But the questions that face us are this: which of these practices are best, and what consequences would they have for altering our attitudes as suicidologists?

It is not possible to answer this question in a less-than-ideal world without some attention to the specific characteristics and deficiencies of the society in question. In asking which of these practices is best, we must ask which is best *for us*. That we currently employ one set of these practices rather than others does not prove that it is best for us; the question is, would practices developed in other cultures or those not yet widespread in any be better for our own culture than that which has developed here? Thus, it is necessary to consider which differences between our own society and these European cultures have real bearing on the model of approach to dying we ought to adopt.

First, notice that different cultures exhibit different degrees of closeness between physicians and patients—different patterns of contact and involvement. The German physician is sometimes said to be more distant and more authoritarian than the American physician. For example, although empirical data have yet to be published, a large study currently in progress at the University of Göttingen is exploring a number of hypotheses that are often said to characterize medical decision making.[9] These center around the claim that

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[9] Personal communication, Karl-Heinz Wehkamp, Director, Sozial-medizinisch-psychologisches Institute der Evangelisch-Lutherischen Landeskirche Hannovers. Dr. Wehkamp is currently involved with the study at the University of Göttingen, "Ärztliche Entscheidungen in Konfliktsitua-

decision making remains largely in the hands of the physician; while consent by the patient is legally required, and indeed consent forms for major procedures are routinely signed, neither patient understanding nor consent is much emphasized. In circumstances in which the patient faces oncoming death, according to the hypotheses of the Göttingen study, it is the physician who makes decisions about the initiation or withdrawal of life-sustaining therapy. In these decisions, the evaluations and views of nurses and other caregivers play a considerable role and consent is for the most part sought from the patient's relatives; however, in most cases the patient, who is often no longer competent, is not included in decision making. For the most part, patients in the system of hospital care do not demand or achieve self-determination in matters of dying.

On the other hand, the Dutch physician is sometimes said to be closer to his or her patients than either the American or the German is. In the Netherlands, basic primary care is provided by the *huisarts,* the general practitioner or family physician, who typically lives in the neighborhood, makes house calls frequently, and maintains an office in his or her own home. The *huisarts* is usually the physician for the other members of the patient's family, and will remain the family's physician throughout his or her practice. Thus, the patient for whom euthanasia becomes an issue—say, the terminal cancer patient who has been hospitalized in the past but who has returned home to die—will be cared for by the trusted family physician on a regular basis. Indeed, for a patient in severe distress, the physician, supported by the visiting nurse, may make house calls as often as once or twice a day, or more (after all, it is right in the neighborhood), and is in continuous contact with the family. In contrast, the traditional American institution of the family doctor who makes house calls is rapidly becoming a thing of the past, and whereas some patients who die at home have access to hospice services and house calls from their long-term physician, many have no such long-term care and receive most of it from staff at a clinic or housestaff rotating through the services of a hospital. The degree of continuing contact the patient can have with a familiar, trusted physician clearly influences the nature of his or her dying, and also plays a role in whether physician-performed active euthanasia, assisted suicide, and/or withholding and withdrawing treatment is appropriate.

Second, the United States has a much more volatile legal climate than either the Netherlands or Germany; our medical system is increasingly litigious, much more so than that of any other country in the world. Fears of malpractice action or criminal prosecution color much of what physicians do in managing the dying of their patients. We also tend to evolve public policy through court decisions, and to assume that the existence of a policy puts an end to any moral issue. A delicate legal and moral balance over the issue of euthanasia, as is the case in the Netherlands, would not be possible here.

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tionen" [Physician decision-making in situations of conflict], which is directed by Hannes Friedrich, Eva Hampel, Klaus Held, Bettina Schöne-Seifert, and Jürgen Wilhelm.

Third, we in the United States have a very different financial climate in which to do our dying. Both the Netherlands and Germany, as well as every other industrialized nation except South Africa, have systems of national health insurance or national health care. Thus the patient is not directly responsible for the costs of treatment, and consequently the patient's choices about terminal care and/or euthanasia need not take personal financial considerations into account. Even for the patient who does have health insurance in the United States, many kinds of services are not covered, whereas the national health care or health insurance programs of many other countries variously provide many sorts of relevant services, including at-home physician care, home-nursing care, home-respite care, care in a nursing-home or other long-term facility, dietician care, rehabilitation care, physical therapy, psychological counseling, and so on. The patient in the United States needs to attend to the financial aspects of dying in a way that patients in many other countries do not, and in this country both the patient's choices and the recommendations of the physician are very often shaped by financial considerations.

There are many other differences between the United States on the one hand and the Netherlands and Germany, with their different models of dying, on the other. There are differences in degrees of paternalism in the medical establishment and in racism, sexism, and ageism in the general culture, as well as awareness of a problematic historical past, especially Nazism. All of these and the previous factors influence the appropriateness or inappropriateness of practices such as active euthanasia and assisted suicide. For instance, the Netherlands' tradition of close physician–patient contact, its absence of malpractice-motivated medicine, and its provision of comprehensive health insurance, together with its comparative lack of racism and ageism and its experience in resistance to Nazism, suggest that this culture is able to permit the practice of voluntary active euthanasia, performed by physicians without risking abuse. On the other hand, it is sometimes said that Germany still does not trust its physicians, remembering the example of Nazi experimentation, and given a comparatively authoritarian medical climate in which the contact between physician and patient is quite distanced, the population could not be comfortable with the practice of active euthanasia. There, only a wholly patient-controlled response to terminal situations, as in non-physician-assisted suicide, is a reasonable and prudent practice.

But what about the United States? This is a country where 1) sustained contact with a personal physician is decreasing, 2) the risk of malpractice action is increasing, 3) much medical care is not insured, 4) many medical decisions are financial decisions as well, 5) racism is on the rise, and 6) the public is naive about direct contact with Nazism or similar totalitarian movements. Thus, the United States is in many respects an untrustworthy candidate for practicing active euthanasia. Given the pressures on individuals in an often atomized society, encouraging solo suicide, assisted if at all only by nonprofessionals, might well be open to considerable abuse, too.

What, then, is appropriate for our own cultural situation? Physician-performed euthanasia, though not in itself morally wrong, is morally jeopardized where the legal, time allotment, and especially financial pressures on both patients and physicians are severe; thus, it is morally problematic in our culture in a way that it is not in the Netherlands. Solo suicide outside the institution of medicine (as in Germany) is problematic in a culture (like the United States) that is increasingly alienated, offers deteriorating and uneven social services, is increasingly racist, and in other ways imposes unusual pressures on individuals. Reliance only on withholding and withdrawing treatment (as in the United States) can be, as we've seen, cruel, and its comparative invisibility invites erosion under cost containment and other pressures. These are the three principal alternatives we've considered; but none of them seems wholly suited to our actual situation for dealing with the new fact that most of us die of extended-decline, deteriorative diseases. However, permitting physicians to supply patients with the means for ending their own lives still grants physicians some control over the circumstances in which this can happen—only, for example, when the prognosis is genuinely grim and the alternatives for symptom control are poor—but leaves the fundamental decision about whether to use these means to the patient alone. It is up to the patient then, and his or her advisors, including family, clergy, physician, other health-care providers, and perhaps a raft of self-counseling books, to be clear about whether he or she really wants to use these means or not. Thus, the physician is involved, but not directly; and it is the patient's choice, but the patient is not alone in making it. We live in a quite imperfect world, but, of the alternatives for facing death—which we all eventually must—I think that the practice of permitting physician-assisted suicide is the one most nearly suited to the current state of our own quite flawed society. This is a model not yet central in any of the three countries examined here—the Netherlands, Germany, or the United States—but it is the one I think suits us best.

Contemporary suicidology must, I think, come to terms with these realities. It must observe that different choices and background assumptions about dying characterize different cultures, and it must use these facts to reexamine the background assumptions of our own culture and the choices we permit and reject. The question of one's own role in one's own death will become, I think, *the* major social issue of the next decade, as we consider legalizing assisted suicide, physician-assisted suicide, and physician-performed voluntary active euthanasia; and if contemporary suicidology is to remain the enormously important field it has become, it must be capable of responding openly to these issues.

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