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EUTHANASIA IN ALZHEIMER'S DISEASE?

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Ought euthanasia be practiced for persons with advanced dementia? Although the issue of euthanasia is a topic of increasingly heated social debate, already tending to polarize those who support it as voluntary "aid-in-dying" and those who reject it as medical "killing," what is said about active euthanasia on *both* sides is severely challenged by the question of euthanasia in Alzheimer's disease. Whether euthanasia may or should be practiced in Alzheimer's is not an easy moral or social-policy question to answer, as I shall try to show, even if one finds the answers to moral and policy questions about euthanasia comparatively simple in other contexts.

In showing why the question of euthanasia in Alzheimer's is so difficult to answer, I'd like to survey the three most prevalent arguments for euthanasia in general, the arguments from autonomy, from mercy, and from justice (Battin, 1987), and show what is problematic about each. All three yield indeterminate answers. Although none of these conventional arguments for euthanasia seems to be effective in the specific circumstances of Alzheimer's, the considerations they raise also fail to produce effective arguments against euthanasia. But a philosophically indeterminate position of this sort seems a luxury, given the literally millions of people potentially directly affected by social policies that might be formulated on the basis of such discussions. Given these inconclusive results, I then turn to look at what is usually the principal argument against euthanasia—the "slippery-slope" argument—and find that it gives equally disturbing results. Finally, I look briefly at the question this situation poses: How can one formulate social policy in such a sensitive matter as this, when background philosophical considerations do not seem to prove much help?

What I shall be considering here is whether *active* euthanasia may be practiced on persons with advanced Alzheimer's—that is, direct killing, performed in the paradigmatic case by a physician as a medical procedure intended to produce death. It is without question the case that in terminal illness we already often practice what philosophers (but not doctors or the general public) call passive euthanasia: the withholding or withdrawal of treatment that would otherwise prolong life, thus "allowing" the patient to die. We also often practice a form of life curtailment involving the overadministration of morphine; in these cases, it is usually argued, the intention is to relieve pain, and the respiratory suppression that results in death is a foreseen but unintended consequence. While both of these may and do occur in Alzheimer's, I shall be considering neither here: I am concerned with whether directly produced death, produced because of the Alzheimer's rather than for other reasons, is morally warranted. To be sure, any discussion of the moral issues in euthanasia rejects the categorical argument that killing or causing the death of human beings is always wrong; pointing to practices often regarded as morally acceptable, including killing in self-defense, just war, abortion, and capital punishment, such a discussion presupposes that if any of these practices are morally permissible, it must be argued, not assumed, that killing in euthanasia cannot also be so.

THE PHILOSOPHICAL ARGUMENTS CONCERNING EUTHANASIA, AS APPLIED TO ADVANCED DEMENTIA

THE ARGUMENT FROM AUTONOMY

In contemporary defenses of active euthanasia, it is often argued that the right to determine the character and timing of one's own death, wherever doing so is possible, is a basic human right, grounded in fundamental rights of self-determination and autonomy generally. Such autonomy rights include all choices that are self-respecting only and do not seriously damage the interests or violate the rights of others, and certainly include, it is argued, rights of choice in matters so profound and intimately personal as deciding whether to continue to live or to die. On this view, a course of action one knowingly and voluntarily chooses, provided it does not harm others, is one to which a person has at least one and perhaps two sorts of rights: the negative right not to be interfered with in the performance of the action and perhaps in addition the positive right to be aided in or provided with means for accomplishing the action. Of course, there may be grounds for interference with exercise of this right either when it is chosen in an irrational, impaired way or when the interests of other parties would be jeopardized (say, those of minor children who would be left unsupported), but these circumstances are typically irrelevant in choices concerning euthanasia in Alzheimer's. On the argument from autonomy, the patient who knowingly and voluntarily elects death in preference to a medical situation such as Alzheimer's ought not be interrupted in any attempt to commit suicide and may even have claim to positive aid in physician-assisted suicide or physician-performed euthanasia. By and large, suicide by the Alzheimer's patient is possible only just after diagnosis or in the comparatively early stages of the disease, when he or she is still able to form and act on a plan and is likely to have access to means of suicide; active euthanasia could of course be performed at any point, though the issue I wish to address here is euthanasia in the late stages of the disease.

But is it meaningful at all to speak of autonomous choice in Alzheimer's? Can euthanasia be voluntary, the product of informed, free choice, in Alzheimer's? Given that Alzheimer's eventually involves complete deterioration of all cognitive skills, including the capacity to conceptualize, predict, understand information, deliberate about a matter, reason, or perform any sort of planning, it would seem that an Alzheimer's patient, at least in the advanced stages of dementia, could hardly *choose* euthanasia. After all, for such a choice to be fully enough informed to count as voluntary, the person must be able to understand not only the medical procedures actually used to produce death, but also the abstract notion of the transition from life to death. But while an advanced Alzheimer's patient may exhibit some behavior that looks like choosing in certain simple contexts—using a red crayon rather than a green one when coloring, for example, or sitting down or getting up from a chair—we do not suppose that these actions involve choice in any robust way or that they are anything more than simple responses to stimuli. We certainly do not think that such actions provide real evidence of abstract choice.

On the other hand, it would seem that choices of euthanasia governing the advanced Alzheimer's patient must be recognized as voluntary if they are made by the person while still competent and recorded in an advance-directive document such as a living will. The living will provides legally valid evidence (in most U.S. states) of a person's choices about treatment after she becomes incompetent. (Feminine pronoun has been used because, statistically, most patients are female.) To be sure, living-will declarations at the current moment in the United States cannot contain provisions concerning active euthanasia; in the Netherlands, in contrast, where euthanasia is legally tolerated, at least one standard living-will form does contain a provision permitting the request of active euthanasia, and we can imagine legislation permitting such choices in this country too. Of course, the living will brings with it various problems, among them that the signer of it may not correctly foresee the range of medical problems to occur in her future, that one may fluctuate in and out of competence and hence in and out of being subject to the provisions of one's own living will, or that one can revoke one's own living will after becoming no longer competent but cannot then later reexecute it. Nevertheless, the living will, which functions by recognizing precedent autonomy, is designed to expand the range of choices a person can make about herself: It gives legal force to choices that will take effect after that person is no longer currently capable of making any choice at all. If that person knew she might develop Alzheimer's and chose—with full information, and perfectly voluntarily—to request euthanasia should that occur, it is argued, this choice ought to be respected.

But does the living will actually represent a voluntary choice of the Alzheimer's patient? After all, the person whom this choice now concerns—the one perhaps to be put to death as a result of this choice, if euthanasia has been requested—can no longer understand the choice or reenact making it; indeed, the severely demented person cannot even remember making this profoundly important choice. After all, the choice was made by a long-distant version of herself, whom she no longer even remembers being. Can we actually say that she made this choice? Since in the United States only choices resulting in earlier death by withholding or withdrawing treatment are currently recognized, not choices employing active euthanasia, and since physicians, family members, payers, and others rarely object to choices to withhold or withdraw in severe dementia, the philosophical issue of the legitimacy of the advance directive is rarely raised. Nevertheless, the same issue seems to become much more pressing in the case of a highly contentious provision like a request for active euthanasia. Is it plausible to say that this person, the one who is now severely demented and has no awareness of her previous advance directive, knowingly and voluntarily requests to be killed? If it is not plausible, is there convincing reason for recognizing such a choice?

But then, can we actually say that she did not make this choice? It was her hand that put the pen to the paper, signing it; it was she who discussed it with her lawyer and relatives; it was she who was the legal agent employing a recognized legal instrument for effecting her own choice concerning the very circumstance in which she now finds herself. Choice is *always* choice about one's own future, though the time gap between present and future may be longer or shorter and the conditions more or less different. Only by adopting a Humean or Parfitean account of the self, in which there is no genuine continuity of person over time but only a set of overlapping bundles or person-stages, can we so radically divorce the present patient from her own former self as to say it is not *her* choice. She has changed, and changed dramatically, to be sure, but it is still she, we are inclined to say, who wrote the directive. After all, if it wasn't she who executed the directive, what other person did it?

The difference between these two conceptions is what Ronald Dworkin describes as the difference in conceiving of the Alzheimer's patient as "a demented person" or as "a person who has become demented" (Dworkin, 1986, p. 4). If we employ the former view, we give primary weight to current choices, allowing them to supersede prior ones (as, for example, in revoking a living will); on the latter, we give primary weight to the choices of the previously undemented person. Dworkin favors recognizing precedent rather than current autonomy in severe dementia, primarily because the value of autonomy lies in the way "autonomy makes each of us responsible for shaping his own life according to some coherent and distinctive sense of character, conviction, and interests" (p. 8); what is essential is the integrity of a person's life plan. This may be a reasonable policy proposal, but it does not really answer the philosophical question: Ought we recognize precedent autonomy in these extreme cases where the agent can no longer recognize her former self, or is autonomy here, if possible at all, always necessarily contemporary?

Can euthanasia in advanced Alzheimer's be voluntary? This, as we said, is not an easy question to answer, and even the sophisticated legal device of the living will, intended to cover circumstances of later incompetence precisely such as these, does not decide the philosophical question.

THE ARGUMENT FROM MERCY

Even though it is not clear whether euthanasia in advanced Alzheimer's can be voluntary, can it nevertheless be a gesture of mercy? Traditional arguments for euthanasia have often been arguments from mercy: that euthanasia is morally permissible when it is the only effective way to relieve a patient's pain or suffering and to spare the patient an otherwise agonizing death. Thus, regardless of whether euthanasia in advanced Alzheimer's can be voluntary, it is still open to question whether it might be legitimized, or perhaps even morally mandated, on grounds of mercy. This is not a question of the sufferings of others, especially family members who serve as principal caregivers, but of the sufferings of the Alzheimer's victim herself.

After all, while the early Alzheimer's patient can often still function fairly well, it is a long road downhill, and the advanced Alzheimer's patient's sufferings seem to be extreme. She loses her capacities for effective function in the world; she is increasingly bewildered by her circumstances; and she loses her capacity for interaction with family and friends, even those closest to her. She cannot read, think, play any game, or converse with anyone; and she cannot, as the traditional stereotype of benign old age would have it, sit in a rocking chair sifting through her memories of youth. Hers is a world without meaning, without purpose or project, without affectional ties. This is the condition the Dutch call *entluistering*, the "effacement" or complete eclipse of human personality, and for the Dutch, *entluistering* rather than pain is a primary reason for choices of euthanasia. Worse still, in those forms of Alzheimer's which involve paranoid delusions, the patient's experience may be peopled with creatures and situations or horrendously threatening sorts, but whose patterns she cannot predict and whose terms she cannot understand well enough to escape or accept. In some cases, dementia may be a kind of ongoing nightmare, full of shadows and threats that do not vanish when one wakes. Thus it looks as though euthanasia in advanced Alzheimer's might be warranted on grounds of mercy, whether or not it is voluntarily requested, because the mental suffering it involves may be so great.

But does the argument from mercy really succeed in Alzheimer's? We are often reluctant to speak of suffering where there is no self-aware subject of experiences; if this is so, the Alzheimer's victim cannot be said to be suffering. True, as an organism with a nervous system, the Alzheimer's victim, like other persons and also like animals, can of course feel pain, but pain is not to be confused with the distinctive kind of suffering the loss of cognitive function is said to produce. But does it? Does a person whose life is void of meaningful activity or important interpersonal contact thereby suffer? Or it is rather that her sensorium merely includes isolated, unconnected, uninterpreted sensory experiences but no cognitive awareness or experience of what she is missing? But if she has no awareness of what she is missing, she cannot suffer, anymore than one's pet dog experiences suffering from being unable to talk or do arithmetic or from being unable to plan for its own future. Even the demented patient with paranoid delusions, if she no longer has any sense of self, cannot suffer, it would seem, since there is no self there to whom these awful experiences happen; they occur, but in a mental void. But if these things are true and we take the having of a sense of self—that self-awareness often counted as distinctively human and as presupposed by the very notion of person—as prerequisite for suffering, then as the deterioration of Alzheimer's advances, the potential for suffering decreases. Paradoxically, it might seem, the greater the patient's losses, the weaker her claim to euthanasia on grounds of mercy.

The traditional argument for euthanasia on grounds of mercy points to physical pain and emotional suffering, but the former is irrelevant in the case of Alzheimer's and it is not clear whether the latter can occur. It is of course true that an Alzheimer's patient might have some untreatable coexisting medical condition about which the question of euthanasia because of intractable pain might be raised, but then this is not a question of euthanasia because of Alzheimer's and would have only tangential bearing on the million persons with severe Alzheimer's; the two to three million more with milder, though progressive, Alzheimer's; and indeed the rest of us, who, if we live to age 85, stand a one in four chance of developing it. But this just raises the question all over again: Do we not fear developing Alzheimer's because we do not want to suffer in this way?

If neither considerations of choice nor considerations of mercy will decide whether euthanasia should be performed for Alzheimer's patients, how then should we develop social policy in this very difficult matter? What about the argument that to keep such people alive defies any defensible principle of distributive justice—in other words, that to keep such people alive is a waste?

THE ISSUE OF JUSTICE

It is also often popularly argued that the expenditure of funds to care for Alzheimer's victims is a "waste." This is a form of distributive argument; it is based on the assumption that there are other more defensible distributions of health care and that it would be more just to allocate these resources to other parties with stronger claims to them than to have them consumed by Alzheimer's patients who are already severely demented and will never recover. While the cruder forms of the popular argument rarely spell out what distributive arrangement ought to be considered more just, what sorts of claims to resources would outweigh those of Alzheimer's patients, or what assurances of actual redistribution would need to be made, this argument nevertheless often seems to exert considerable intuitive pull: There is something unjust, it is said, about committing large amounts of resources to people who are "already gone" while denying help to others in current need.

While it is usually considered a distinct argument, this appeal to justice nevertheless trades on the claims involved in the issues we have already discussed, those of autonomy and mercy. After all, justice in the distribution of resources presupposes that potential claimants to these resources would actually wish to have them or that the receipt of them would actually count as a benefit. If a prospective claimant would not want the resources and they would not be a benefit to him or her, then a distributive scheme allocating resources to this party is unjust if there are other claimants who would want the resources and for whom they would be a benefit. Like the proverbial "dog in the manger," there is no justice in allocating scarce resources to a party who cannot use them; similarly, there is no justice in allocating them to a party who does not want them. Yet given the indeterminate results of the preceding sketches of the issues of choice and mercy, it is by no means clear that Alzheimer's patients "want" the resources that might be allocated to them or that these resources would count as a "benefit."

It is important to note that this is not the same as the "useless eaters" argument advanced by the Nazis as grounds for the destruction of mentally retarded persons and others, though it would have been applied in some of the same cases. The "useless eaters" argument does not assert that the use of resources is not of benefit to the person in question; it asserts that this use of resources is not of benefit to others in the sense that the person in question is "useless" to society. There is no issue in the current question about whether the Alzheimer's patient is "useful" to others, but instead about whether the resources are useful to him or her. Although the two arguments are easily confused, there is in the background of the current discussion about justice in Alzheimer's the assumption that whether or not Alzheimer's patients are "useful" to others or to society in general, society is willing to provide care that is useful to them.

But this then returns us to the problem. Does the Alzheimer's patient want the resources, and are they a benefit to her? Even if claims on her behalf are pressed by a surrogate, can these claims reflect either substituted judgment or any form of best-interests test? Clearly, the more advanced the deteriorative process, the less plausible it is to speak of contemporary choice in wanting resources: The severely demented patient cannot, presumably, understand any other arrangement of things, nor can she conceptualize the distributive schema itself or the allocations it makes to her in competition with others. Nor, presumably, can the severely demented patient in any conscious sense "want" the continuing life that medical treatment and maintenance care make possible, though of course her bodily processes may continue to operate in the normal, life-continuing way; as we said, this person can no longer have any conception of what life is or of the transition from life to death. Of course, she may have had a vigorous conception of all these things prior to the onset of serious disease and may have recorded her wishes in a living will or other document; in this sense, the now-demented person still may "want" access to resources she earlier chose. She can also react favorably to situations she experiences as pleasant and react negatively to those that involve discomfort or pain; in this sense, she can "want" allocations of resources that provide her with, say, foods she prefers, a more comfortable bed, better-fitting clothing (but not more stylish clothing, since appreciating style requires cognitive abilities), and so on. But she can neither conceptualize these wants nor, except by expressions of pleasure or displeasure, articulate them.

Can the severely demented patient benefit from the allocation of resources to her care, including medical treatment, maintenance care, and whatever else is necessry to keep her alive? The answer here is clearly dependent on the argument considered earlier about mercy, and hence we cannot arrive at any clearer answer. Does she benefit from remaining alive, or would she be better off dead? There is quite a lively discussion in the philosophic and economic literature about the value of life, and how one can weigh this against death (Brueckner and Fischer, 1986; Brock, 1986), but it is not a discussion that proves decisive in the present case. Many or most of the features that are usually said to make life worth living are absent in advanced dementia—for example, the possibilities of enjoying human interaction, planning and undertaking projects, serving causes, having religious and aesthetic experience, and perhaps (as Aristotle would identify as the highest good) rational contemplation. With no surviving conceptual skills or even sense of self, it is not clear that continuing life is a continuing good, and hence not clear that allocations that make continuing life possible are really a benefit after all. Nor, however, is it clear that they are not.

What, then, is a fair distribution of resources with respect to people with Alzheimer's? It is not clear that we can even begin to answer this question, because we cannot identify either what Alzheimer's patients want or what would benefit them. Furthermore, we cannot identify wants and benefits either on subjective grounds or on objective, quality-of-life ones: We cannot approximate the severely demented person's point of view, and we cannot assess the quality of her life. Of course, to identify what various claimants want and what would be of benefit to them is not all that is involved in settling distributive issues, since many other matters (for instance, deserts, prior claims, needs for rectification) are involved; but one cannot even get off the ground in justifying a given distributive scheme without knowing whether the various claimants to the resources involved actually want and/or would benefit from them. Discussions of distributive justice uniformly assume that the various competing claimants involved all want and would benefit from the resource in question—that is, that they are all appropriately considered *claimants*—but in the case of Alzheimer's no such thing is clear. Since the amount of resources involved in the issue of

Alzheimer's is immense, the quesiton of justice is an enormous one, and to say that we simply cannot resolve it on adequate philosophical grounds is no trivial matter.

DEVELOPING POLICY CONCERNING EUTHANASIA IN ALZHEIMER'S

Of course, positions on the issue of justice are ultimately expressed in social policy, which puts into practice one or another distributive scheme allocating resources to or away from various claimants or apparent claimants for them. Needless to say, the development of social policy in the matter of allocating resources in Alzheimer's is a matter with such high stakes that it can hardly wait for philosophers to sift through these questions, especially when there is no indication that they will reach a uniform, workable answer. In the absence of firm philosophical justification, then, what form should social policy take in expressing these issues of justice?

To simplify a huge range of possibilities, there are three principal candidates for social policies distributing medical and supportive care in Alzheimer's:

1. do what is possible to maintain and supply medical and supportive treatment for Alzheimer's patients, though without heroics, until the end of their natural lives;
2. practice passive euthanasia on late-stage Alzheimer's patients: provide maintenance and support but not lifesaving medical treatment, and so allow these patients to die when infections or other potential fatal conditions arise; or
3. practice active euthanasia on late-stage Alzheimer's patients.

Current social policy, not at all well defined, wavers between alternatives #1 and #2, though #2 is never termed "euthanasia." It is #3 that raises the question under discussion here. In the absence of firm answers to the questions of choice and mercy, we must still answer the question, Should we, or should we not, practice active euthanasia for Alzheimer's patients? To refuse to address this question is already to answer it, since current social policy prohibits active euthanasia, though permitting passive euthanasia, and to refuse to raise the question is to accept the current answer. It is not clear, however, that this answer is a defensible one. But perhaps there are still other ways of looking at the issue.

THE VIEW DOWN THE SLIPPERY SLOPE

Another, more clearly consequentialist way of approaching the issues in euthanasia in Alzheimer's, or for that matter any proposed social policy, is to take a look down the "slippery slope," that is, to examine the likely highly negative outcomes of introducing the policy. The slippery-slope argument as usually employed against euthanasia predicts the spread of medical killing from a few sympathetic cases, genuinely dictated by the wishes of the patient or the demands of mercy, to more problematic medical cases, then to cases of expensive patients, then to politically undesirable cases, and finally to widespread holocaust. Regardless of whether the advanced Alzheimer's patient wants or would benefit from continuing life, it is argued, active euthanasia ought not be employed, for this would risk the spread of this practice to other persons who both want to remain alive and would benefit by doing so.

Slippery-slope arguments trade on empirical claims about likely consequences, either direct causal results of a certain policy or consequences resulting from other forces affected by the precedents set by a policy. Much of the continuing argumentation about euthanasia involves trading claims about how far the slide would go and how broad the spread of the increasingly intolerable practice would be, and it very often cites catastrophic events such as the Nazi Holocaust as evidence for its claims. When these slippery-slope arguments do so, they generally trade on assumptions about the evil motives of human beings and of physicians in particular, often making reference to the Nazi doctors and their increasing callousness about human experimentation and killing.

It is true that the Nazis' early T4 program began with medical "euthanasia" and that medical staff from this program were later transferred to the extermination camps; but this historical transition does not establish that any practice of euthanasia will always lead to holocaust or that human beings generally or physicians in particular are evil. There are apparent counterexamples: Active euthanasia is practiced in contemporary Holland without evident abuse, and it was also apparently practiced (by recommending the hemlock) in ancient Greece (Battin, 1982, p. 22). However, while the empirical issues can hardly be settled here, it is reasonable to suppose that human beings generally and physicians in particular rapidly respond to incentives of various kinds, especially legal and financial ones.

If active euthanasia in advanced Alzheimer's were legal or legally tolerated in the United States, I think we can well imagine the rapid development of cost-saving social policies that would offer fairly strong incentives for physicians to recommend euthanasia in Alzheimer's, say by reducing reimbursements for treating such persons, by limiting bed space for patients with this condition, or by reconceptualizing the practice as a humane, appropriate course of treatment in this condition.

On the other hand, since any spread of such policies beyond advanced Alzheimer's would be rapidly challenged by other groups whose own interests might be threatened, I see no reason to assume that even if active euthanasia were permitted in some sympathetic cases in advanced Alzheimer's, involuntary euthanasia would inevitably spread to wholesale slaughter of the handicapped, the racially despised, or the politically rejected.

Thus, while I do not think the broad form of slippery-slope argument—which predicts the spread of euthanasia into widespread holocaust—is plausible, at least in the contemporary United States, I can nevertheless imagine the spread of active euthanasia in Alzheimer's from some few cases to a more general policy of comparatively routine use of euthanasia in advanced dementia, and will grant this limited version of the slippery-slope claim here. Routine use of active euthanasia in advanced Alzheimer's might or might not involve solicitation of consent from family members—no doubt it often would, but in the same perfunctory way that consent for no-code orders is now often solicited—but the point is that one can imagine euthanasia as a widespread, medically customary response to severe, irreversible dementia.

Suppose, then, that most or all severely demented, advanced Alzheimer's patients—all million or so—were routinely euthanized, though this practice did not spread to any other category of patient. This is the view down the slippery slope; but the question is how we should assess the view we see. Would this be a bad thing? How are we to answer this question at all? We might try to assess the effects of such a policy on the persons involved, but given the difficulties we have just experienced in considering issues of autonomy and mercy, it is not at all clear that this will be possible to do: We have no way of approximating a subjective assessment and no way of making an objective one either (Nagel, 1986). Nor can we determine whether this widespread practice would be just or unjust. Nevertheless, there is a way of approaching an answer, by looking down the slippery slope in a rather different way.

Doing so appropriates the Rawlsian device of the original position, in which rational self-interest maximizers who are behind the veil of ignorance and thus do not know their own personal characteristics agree to principles that will govern the society of which they are members (Rawls, 1971). However, while Rawls does not discuss health policy and does not use this device for direct policy formation, specific features of the circumstances allow us to adopt it in a rather natural way. This is made possible by the fact that, with respect to the possibility of becoming a patient with Alzheimer's, we are naturally in a kind of "original position" and behind the veil of ignorance: We know the general incidence of severe dementia—about 1 percent between ages 65 to 74, rising to 7 percent between 75 and 84, and to 25 percent for those 85 and over (Office of Technology Assessment, 1987, p. 9)—but as individuals we do not know whether we will be among those affected or unaffected. This provides us with a natural way of considering what principles we would assent to, in seeking to protect our own self-interests, and hence what policies we would be willing to formulate. Thus, rather than speculate about the effects of such a policy on others, we can ask—that is, each of us can ask—whether our own worlds would be better ones for us if, should we become demented, our lives would be protected or would be terminated in euthanasia?

Clearly all the issues we have considered in reflecting on the arguments from autonomy, mercy, and justice reemerge here. However, since the slippery-slope argument is essentially an argument from fear and each potential target of the policy may in principle share this fear, let us look down the slippery slope from the point of view of a single individual who might have such fears. Thus we can ask a more personal form of the question, Would I be more afraid, or less so, in a world that practiced active euthanasia on severely demented Alzheimer's patients? To what sort of policy would I, without knowing into which category I will eventually fall, consent?

Exactly what do I fear, then, in fearing euthanasia, if the slippery-slope prediction comes true and I, like other Alzheimer's patients, may be killed? Assume that I have not previously executed a living will requesting euthanasia, or even that I have no living will indicating any treatment preferences at all. Euthanasia performed on me will be clearly nonvoluntary. This is the scene I can imagine:

> *Golden Harbor Nursing Home.* Morning. The nurses' station in the hallway, then my room. A young doctor, wearing a standard white coat and stethoscope but with steel-rimmed glasses and a slightly disordered crop of thick brown hair, flips quickly through my chart. He extracts a little plastic-coated chart labeled "Functional Criteria in Alzheimer's Disease" from his pocket, checks it, flips through the chart a little further. "I think it's time for Mrs. Battin," he says absently to the nurse, then moves to my room.
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> "Good morning, Mrs. Battin," he says cheerily, though he already knows I will not respond. "What day is it today?" I tell him a few words, though they are not days of the week. "Who is the President?" I tell him a few more words, though I do not name this fellow Bush, and the doctor makes notes in my chart. He does a variety of other tests, none of which I pass. He or the other doctors like him have done these tests every month for the past half year, and I never show any improvement; now I have failed again. As he goes out I hear him mutter, "Yes, it's time." When the nurse comes in, she is equally cheerful. "So it's time, Mrs. Battin, is it?" She also knows that I do not understand. A phone call will be made to one of my children, explaining the situation and proposing a date; this child will phone the other one, and they will agree.
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> They will both fly to this city, where the Golden Harbor Nursing Home is; and they will come here to see me for the last time. They do this even though they know I will not recognize them, and have not recognized them for some time. They will try once more to make conversation, though they know it is futile, because they do not know what else to do or how to relate to their mother. They will try to help me remember my husband, though I no longer can, and they will try to elicit even the tiniest fragment of memory. In between, they talk about the house and the arrangements with the lawyer about the estate, though they do not seem to have any particular interest in this—no, they are sad, I see a tear forming in the eyes of one of them, they both grasp my withered old hands, stroke my cheek. They rub, caress my hands and cheek as if they were trying to implant them forever in their own memories. Now they are both crying. After a little while one, then the other, bends over the bed to kiss me. "Goodbye, Mom," each of them finally says, and then they stand and leave, looking back once or twice over their shoulders.
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> The young doctor is there in the corridor. "Would you like to be with her?" he asks. He notices their own age and the early symptoms of decline: One of them is 57 already, and the other almost 60. One of them wavers a bit, but the other says no. "She wouldn't know we were there anyway," he explains, but the doctor understands why: They are not used to death, and it would be a difficult thing for them to watch. There are a few papers to sign, but that is all; no one objects to the procedure.
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> The nurse has the syringe already filled for the doctor as he returns to the room, and out of sheer habit she swabs the injection site with alcohol. I say a few more miscellaneous words, and the nurse puts her hand gently on my forehead as the doctor positions the syringe. I feel only a little prick, like so many injections I have had before, and then after that the doctor leans over my chest with his stethoscope to listen to the silence where the heartbeat had been.

So this is how it might go, in an ordinary nursing home, with an ordinary doctor, with an ordinary old lady in the later stages of progressive dementia. If the predictions of the slippery slope are correct, this is how it might go in many nursing homes, all over the country, with all sorts of doctors, with virtually all the 1.5 million patients in the late, irreversible stages of progressive dementia.

And what are my fears, as a likely victim of this spread? Pain? Loss of dignity? Being constricted by involuntary choice? The cursoriness of the visit from my children? Having my life ended without my consent by a physician I don't even know? But of course, I can have experienced none of these things, and indeed my imagined account of these events is entirely misleading: I experienced no pain, nor any loss of dignity; I could not make a choice nor know if my choices were being countervened. I heard the doctor say "it's time," but had no way of understanding what he meant. Although my children's visit was cursory, I did not recognize them as my children. That this doctor was different from the previous one could not have made any difference to me: I could not have known whether I had ever seen him before. I did not know that I had passed or failed any tests, or even that they were tests at all. What was my actual, direct experience in euthanasia? Life as usual until the very end, except for a gentle hand on my forehead and a small needle-prick in my vein. What we fear, in fearing the kind of widespread practice of euthanasia which the slippery slope predicts, are all things we can now imagine but could not then experience; in this sense, our most personal fears are completely unrealistic. This is not the comparison between subjective and objective views of the events contemplated, but between two different forms of subjective view.

What if, on the other hand, there were no euthanasia for severely demented patients, and, as in option #1 above, such patients were provided full maintenance and medical treatment?

> *Golden Harbor Nursing Home.* Morning. Same year as before, then a year later, then sometime during the following year, then at various intervals after that. The young doctor in the corridor, but a different one each time. In the first episode my activities are reassigned to a group for more demented patients, and I now spend the days sitting vacantly at a table with crayons and coloring books in a continuously monitored dayroom; in the second, I am treated for a pneumonia; in the third, I am put in restraints in a day chair; in the fourth, treated for another pneumonia and also decubiti from prolonged sitting; in the fifth, I am spoonfed. Perhaps somewhere in the series I develop paranoid delusions or undergo episodes of random aggressive behavior. By the end of the series, some ten or twelve years later, I cannot communicate at all or walk or get out of bed or feed myself or bathe or control my bladder or bowels. My children have still made a dutiful point of coming to visit me from their respective cities at least once a year, and they still pay the bills, but now they do so with a sense of sullen resignation. The end finally comes with a cardiac arrest, probably about 3 A.M., but it is not noticed until the first nursing round in the morning.

So this is how it might be in an ordinary nursing home, with an ordinary string of doctors, for an ordinary old lady with Alzheimer's. What is there to fear in this scenario? The deterioration I do not notice, since I cannot remember myself as I was nor compare previous stages to this one, nor do I recognize my children at their many visits. But I do experience some new things: I am feverish with infections, I feel the discomfort of the bedsores and, if they are not treated properly, smell their bad odor; I have foods put into my mouth, some of which I like but some I do not; I cannot move my arms out of the restraints on my day chair; I feel the irritation of sitting sometimes for hours in a diaper soiled with urine or feces. If there is any struggle at the end, I, no doubt like many of the other million Alzheimer's patients in the same condition and indeed the rest of the several million who will soon reach this condition, am alone while it happens. But it makes no difference; this nursing home, like most, does not perform CPR.

Is this a better scenario or a worse one than the scenario involving active nonvoluntary euthanasia? Clearly the effects on my children are worse, since they have had no genuine contact with me for years but continue to make their annual visits and to pay the bills; they are no longer sad, but resigned and sullen. Is it better for me? I have been alive for all these years; but I can think of no compelling reason to say I would not have been better off dead, that is, without any experience at all. Of course, there have been positive experiences—a shaft of sunlight warming my cheek through the slats of the venetian blind in my window, well-meaning hugs now and then from an indefatigable nursing staff or from visitors I do not know—but there are also the diapers, the restraints, the bedsores, and the espisodes of illness and infection which I cannot understand but for which I am treated. If my claim to care under distributive scarcity rests on the assumption that I want this continuing life or that it is a benefit to me, is my claim really secure?

But what about the apparent compromise position, #2? This is the position that represents an increasingly pervasive policy today: to take advantage of intercurrent infections or illnesses and, by refraining from providing treatment, let the patient die. This is the compromise position favoring passive euthanasia (though it is rarely called that), which rejects both indefinite extension of life and active termination. What would it be like, and could I fear it? The scene at Golden Harbor will be the same as before, except that various young doctors will not order treatment for various infections or illnesses, and I will survive a few of these, though with difficulty, until finally one of them kills me. My children will be summoned hastily, or perhaps after the fact, but will have had no general sense of where in the overall downhill course of my progressive dementia my death might occur, whether a few years earlier or perhaps a lot of years later. My sensory experiences, though shorter, will have been in one way worse than the second series above—I will have endured at least one or perhaps several episodes of illness without treatment, or with only whatever symptomatic control is possible consistent with letting the disease take its course. The difference between alternative #3, active euthanasia, and this one, #2, passive euthanasia, is that in the former the doctor killed me; in the latter, it is a disease that does the killing. When the doctor killed me, my only experience was a gentle hand and a tiny needle-prick; in alternative #2, I am "allowed to die," and this necessarily occurs only at the conclusion of a period in which I am mortally ill.

Why then should I fear the slippery slope, or let it count as a persuasive argument against euthanasia? Even if we grant that the spread that this argument predicts would actually occur and some 1.1 million currently institutionalized Alzheimer's patients would be medically killed, as well as the rest of the several million whose disease eventually progresses and in addition all new cases developing, it is not clear that *from the point of view of each of them* this would be a bad thing. Figures in the millions, of course, recall the appalling butchery of the Holocaust, but that killing viewed from the points of view of each of those victims was a catastrophically bad thing. After all, the victims of the Holocaust wanted to stay alive, in the sense discussed earlier, and would clearly have benefited from doing so. But the victims of Alzheimer's are different. After all, their points of view will be exactly like my own, accurately and not unrealistically imagined, if I should develop Alzheimer's—a point of view without a sense of self, without cognitive capacities for comparing one's past and present circumstances, without memory, without the ability to understand or predict death, and with only the capacity for current sensation. As a rational self-interest maximizer who does not yet know whether I will or will not develop Alzheimer's, can I fear euthanasia, if this is what my future may hold? Clearly the answer is no.

Of course, there may be aspects of euthanasia I could fear—for instance, that the doctor would be hasty or irresponsible in conducting the tests of functional capacity, that the nurse would be rough, that the nursing home would be callous in contacting my children. To be sure, medical personnel and institutions can be hasty, rough, and callous in all sorts of situations, but there is no special incentive for acting in this way in the case of euthanasia; on the contrary, given special legal protections, the presence of witnesses, and so on, one might expect incentives to run the other way. If I have no reason to fear euthanasia in principle and no reason to think that in practice it would be cruelly conducted, there seems to be no basis for responding to the slippery-slope argument at all. Generalizing thus from my own imagined single case behind my current veil of ignorance to that of severely demented persons generally, it looks, on the contrary, as though alternative #3, a world of routine active euthanasia, rather than passive euthanasia or continuing treatment, would better protect my self-interests; hence it is the policy to which I would agree.

DEVELOPING SOCIAL POLICY

Philosophical reflection seems to produce no compelling argument against euthanasia in advanced Alzheimer's and no sound reason why we should fear it. Should we then, as a matter of social policy, practice nonvoluntary active euthanasia on advanced Alzheimer's patients, developing a set of guidelines for functional status which would serve to determine the appropriate timing—guidelines that the physician could, like the young doctor in the Golden Harbor Nursing Home, carry around in his pocket on a little laminated card? If this seems a disturbing suggestion, reopening all the fears the slippery slope points to, it is important to be clear about what the problem is.

The problem in developing policy, I think, arises from the difference in the perceptions the public is likely to have of this issue and what philosophic reflection produces. Ordinary—that is, precritical, nonreflective, nonphilosophical—perceptions of the prospect of nonvoluntary euthanasia are likely to take the form in which our little scenarios here have been described; it is the way most of us see this issue most of the time. We tend to see the issue from the point of view of a conscious, self-aware person (ourselves now) capable of remembering and comparing circumstances and engaging in human relationships, not from the point of view of those persons actually affected by the practice, namely those persons who are severely demented (ourselves in a possible future). In reflecting on the nature of euthanasia and the possibility of the slippery slope, we do not readily assume the perspective of the persons most directly affected, but rather our own *current* view. This is why the little imagined descriptions presented earlier are so misleading: They presuppose the wrong point of view. They are fictions in the fullest sense, even though they purport to describe a possible future. The imaginary account of euthanasia in the Golden

Harbor Nursing Home involves a narrated personal experience—the doctor enters *my* room, looks at *my* chart, asks *me* questions that provide a diagnostic test, listens to the garbled answers *I* tell him, prepares to inject the euthanaticum into *my* vein. This little story is narrated in a temporal sequence as seen from an individual point of view, that of the self to whom it would happen; but of course this is a misleading description of the experience of a severely demented person. This is not what will happen to me, not because it will not happen, but because if I am severely demented, it cannot happen to *me*.

But while imaginary narratives of this sort—developed as a way of employing a natural version of the Rawlsian device for selecting principles and at the same time as a way of looking down the slippery slope—are misleading in one way, they are enormously useful in another. For they also provide a way of foreseeing what problems certain social policies might cause. In this sense, fiction serves as forecast. If it is correct that, as ordinary human beings, not philosophers, we are more likely to view the prospect of widespread involuntary euthanasia from our own current perspective than from the perspective of ourselves in the future, a policy permitting involuntary euthanasia of millions of advanced Alzheimer's victims might well produce considerable anxiety, even anguish, for most of us, depending on how these stories are interpreted. Of course, it is anxiety to persons *before*, though not after, they contract Alzheimer's; but it is still a kind of anxiety to be considered in developing social policy. Indeed, anxiety before, rather than after, developing advanced Alzheimer's is the only kind of anxiety which can be experienced, insofar as it is anxiety about what will happen in the future to oneself and hence presupposes the cognitive capacity both to anticipate the future and to entertain a conception of oneself.

Furthermore, philosophic reflection can also produce anxiety of another sort for possible future Alzheimer's patients: the anxiety of recognizing that the prevailing policies #1 and #2, favoring continuing treatment or allowing to die, are really much less defensible than they may seem. The anxiety results from knowing that these policies are unlikely to change, and that if one does develop Alzheimer's, these indefensible policies will govern how one is treated. Furthermore, this anxiety is compounded by knowing that once one is in the circumstances in question, one can no longer do anything to change them and can no longer protect oneself from being governed by them, say by executing a directive stipulating exactly how one wishes to be treated.

Thus, in thinking about social policy and on what basis it is to be formulated, we see we are faced with two kinds of anxiety: that produced by ordinary, unreflective attitudes about euthanasia in Alzheimer's, and that resulting from considered, philosophical reflection at odds with the ordinary view. These are two forms of subjective view, as I've mentioned earlier, not a subjective and an objective one, and neither has clear pride of place. The real question here is whether social policy ought to be formulated on the basis of one rather than the other, and if so, which one—for they will produce very different policies indeed. Basing policy on the ordinary view will be a vote for the status quo; basing it on the considered, philosophical view will support policies endorsing nonvoluntary active euthanasia in advanced dementia. Permitting active euthanasia only in conjunction with an antecedently executed living will or personal directive requesting it is probably the best policy compromise, since this appears to protect against unreflective fears of nonvoluntary euthanasia but protects those who make antecedent choices on more philosophical grounds. Yet even this compromise policy provides little guarantee that, as we formulate social policies that will determine our own possible futures whether or not we contract Alzheimer's, we will be able to keep considerations based on fiction distinct from those based on philosophy.

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