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## **Peter Singer and the Lessons of the German Euthanasia Program**

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*Abstract:* If the German euthanasia program developed from that nation's intellectual culture, then the Nazi extension of it was not a unique horror and might be a relevant analogy for modern euthanasia debates. In this context, the case of Peter Singer (an advocate of euthanasia) and his criticisms of the Nazi analogy are particularly worthy of consideration. This article argues that Singer's criticisms fail, and that the analogy does in fact have contemporary relevance.

### **Introduction**

**BETWEEN 1939 AND THE END OF WORLD WAR II**, German doctors systematically killed more than 100,000 children and adult patients in hospitals and institutions throughout the country.<sup>1</sup> This program had wide support among physicians and intellectuals. Our question is simple: does this German euthanasia program have anything to teach us about the prospects for permitting euthanasia today? Some writers suggest that it cannot. They say that the Nazi experience was a unique horror so distinct from present social conditions that we cannot draw from it any useful parallels. Others point to Germany's preeminent position in the cultural and intellectual life of Europe at the turn of the century. If such horrors were possible there, they say, then they are possible anywhere and we must learn from this example. I want to explore this question in three distinct ways. First, I will examine the intellectual roots of this program. If the German euthanasia program was a natural development of the nation's intellectual culture, then we cannot plausibly say that it was a unique, non-reproducible horror derived from Nazi distortions. In that case, the German euthanasia experience might be a relevant analogy for modern developments. Second, I will consider the

case of Peter Singer and his criticisms of the Nazi analogy. I claim that the failure of these criticisms will show that the analogy does have contemporary relevance. Finally, I will draw out a few of the lessons the Nazi euthanasia experience might provide for contemporary issues.

## I

Dr. Leo Alexander, a young Harvard-trained doctor, served as an advisor for the prosecution at the Nuremberg Medical Trials. He later argued that Nazi ideology had produced a perversion of the medical profession in Germany (1980). Alexander used a metaphor from the historian Arnold Toynbee to illustrate his argument that German medicine had traveled down a slippery slope. He attributes to Toynbee the “law of the fall of civilizations.” This law borrows three terms from the Greek historians to outline a process leading from *koros* (excess, or surfeit), to *hubris* (pride), and finally, to *ate* (disaster). Alexander identifies *koros* in our time as modernity’s overwhelming scientific and technical progress. He suggests that this can lead to *hubris*, the overweening pride, which in the German case, led doctors to abandon traditional values and understandings, claiming they had become outdated. He concluded, “moral and physical disaster (*ate*) is the inevitable consequence” (p. 590). Alexander then went on to identify Nazi propaganda, which was “highly effective in perverting public opinion and public conscience in a remarkably short time,” as the engine driving these developments (p. 571). Within the medical profession, the crucial step leading toward this disastrous end was the “barrage against the useless, incurably sick” (p. 39).

Alexander’s essay was the first systematic application of the Nazi analogy to medical ethics. However, in blaming Nazi propaganda as the chief cause of the ensuing “disaster,” Alexander understated the continuous developments in German intellectual life that led toward the euthanasia program and its ultimate excesses. The process that ended at Auschwitz had its roots in some intrinsic developments within the German learned professions. Let me trace a few strands of that history.

The first important strand is eugenics. Charles Darwin’s *The Origin of Species*, written in 1859, fundamentally altered our ways of thinking about the relation between human beings and the wider living world. Although Darwin was primarily concerned about non-human animals, the application of his work to human life was inevitable. Many scientists accepted Darwin’s notion that species change and evolve through natural selection. They also rejected the competing Lamarckian theory, which held that acquired characteristics are inheritable. While Lamarck’s theory is congenial to social reform-

ers who argue that improving humanity is possible by education and cultivation, Darwin's, in contrast, favors the conclusion that breeding is the only way to improve humanity. British biologist Frances Dalton coined the term *eugenics* in 1881 for a scientific program that aimed to improve human racial stock through selective scientific breeding. This program became a social movement which advocated many specific reforms including the development of birth control to limit reproduction by the lower classes and the "unfit" and sterilization for those who were genetically undesirable (Sanger, 1932, pp. 107-108). In the United States, the "eugenics movement" had powerful and persuasive advocates, and it succeeded in creating eugenically based programs for voluntary—and even involuntary—sterilization in several states.<sup>2</sup> German medicine closely studied and even emulated these ideas. Originally developed as a descriptive scientific study, eugenics in Germany eventually came to be associated with Alfred Plötz's ideas about Nordic racial superiority (Friedlander, 1995, pp. 10ff). For the majority of German eugenicists, improving the race by breeding came to mean preserving and fostering the Nordic heritage against contamination by so-called foreign elements. Thus, German racialist ideology received strong support from a well-respected segment of the scientific community. It was not solely the product of Nazi party ideology.

A second important thread in Germany was an ongoing discussion of the "the right to die," and "death with dignity." As nearly as I have been able to determine, Alfred Jost started the discussion in his monograph "Das Recht auf den Tod" published in 1895. Jost referred to the fact that Hume and Rambach each wrote "serious and unprejudiced" works about "the question of suicide's permissibility under some conditions" (2000, p. 1). Nevertheless, Jost seemed to claim that he himself initiated serious discussion of the question regarding a universal "right to die."<sup>3</sup> Jost appealed to a "scientific" ethics, rather than one based on "outmoded theological ideas" and claimed that incurably ill people have a right to self-determination.<sup>4</sup> In particular, he granted them a right to end their lives when they had nothing more in view except pain and limitation. More dangerously, Jost also invoked social utility as sometimes a permissible reason for granting "a merciful death." He weighed the benefit to society of "granting death" to the incurably ill against the small advantages one might expect from contributions by those very few who might miraculously recover. Jost was willing to draw the conclusion that even patients whose condition prevents them from requesting euthanasia can permissibly be killed, either "in their own best interest" or for the good of society. Nevertheless, Jost's immediate proposal was limited to granting a right

to die for incurable patients who request death voluntarily and without constraint. Jost's arguments found a willing audience. Others who followed continued to take up his suggestions and to argue for a social policy of permitting euthanasia, mostly for reasons of our "right of self-determination."<sup>5</sup>

The politics and policy proposals implicit in the eugenics and right-to-die movements join forces in the influential 1920 publication *Die Freigabe der Vernichtung lebensunwerten Lebens: Ihr Mass und Form* by Karl Binding and Alfred Hoche (1992). Binding was the most distinguished legal scholar of his time, and the author of many important books.<sup>6</sup> Hoche was a professor of medicine at Freiburg who did physiologically-based research on the nervous system and opposed Freud's psychoanalysis. The book contains separate essays by each author. Both works support the idea that, under certain conditions, physicians should be permitted to take the lives of their patients.

Binding made a careful, legally-detailed analysis of the question across several related cases. He discussed issues such as suicide, assisting in a suicide, responding to a request for death from a terminally ill patient, killing a mentally ill person at the request of family members, and so on. He made important distinctions while maintaining clear boundaries around the specific cases of killing he proposed to categorize as "not legally forbidden." Hence, for example, while he regarded suicide as "not legally forbidden," he thought that assisting in a suicide is actually the killing of a third party. In this case, the consent of the victim does not remove the assisting person's legal liability.

However, Binding also introduced an innovation. He claimed that "terminally ill or fatally wounded people" represent a new category. "Here there clearly appears the idea that such a life no longer merits strict legal protection." There are, he thought, three distinct cases of "lives not worth living." The first group consists of "those irretrievably lost as a result of illness or injury, who, fully understanding their situation, possess and have somehow expressed their urgent wish for release." Binding believed we have "a duty of legal mercy" that requires us to kill such people. His primary example was the case of a fatally injured comrade on a battlefield or a mountaineering expedition. Binding's second group of "lives not worth living" included only one group, the "incurable idiots" (Binding and Hoche, 1992, p. 247). Such persons have the will neither to live nor to die. Here again, Professor Binding found "no grounds—legally, socially, ethically, or religiously—for not permitting the killing of these people who are the fearsome counter image of true humanity, and who arouse horror in nearly everyone who meets them" (p. 249).<sup>7</sup> He restricted the right of application to the family caring for the

handicapped patient or to the guardian. The third class of lives whose termination Binding defined as “not legally forbidden” consists of mentally sound people who “through some event like a very severe, doubtless fatal wound” have become comatose. Binding had no blanket rule for this last group of cases, but he did offer a general guideline:

[O]nly those persons are candidates for having their deaths permitted who are terminally ill and who, in addition to being beyond help, have either requested death or consented to dying, or else would have requested or consented, had they not fallen into unconsciousness at the critical time or if they had been able to achieve awareness of the situation.<sup>8</sup> (p. 250)

Binding also stated another constraint. “Every unforbidden killing of a third person must be experienced as a release, at least by the victim; otherwise allowing it is self-evidently ruled out” (p. 250). He then proposed a panel of three experts to review all cases, with requirements for explicit reporting. Only a qualified applicant—the patient, the patient’s physician, or someone to whom the patient has entrusted this authority—may file requests, and the board, after gathering evidence and hearing witnesses, issues a decree that:

may only say that, after thorough investigation on the basis of current scientific opinion, the patient seems beyond help; that there is no reason to doubt the sincerity of his consent; that accordingly no impediment stands in the way of killing the patient; and that the petitioner is entrusted with bringing about the patient’s release in the most expedient way. (pp. 251-252)

Binding extended doctors’ rights by allowing the physician to kill before a case is reviewed if circumstances make a review too difficult to obtain in time. However, the doctor then must report the episode and establish that the case meets the criteria, or he will be liable for criminal penalties.

Hoche’s essay, in contrast, addressed three themes, discussing them only briefly. First, he discussed the general relation of physicians to killing and injuring patients. Here he mentioned the conduct of dangerous surgery with a statistical likelihood of fatal outcomes, the injury done by surgery itself, and the necessary killing of babies to save mothers. Second, Hoche argued that medicine has no explicitly defined ethical standards. Medical ethics depend instead on peer opinion, which holds that “[p]hysicians are obligated to

observe the universal ethical norms, and (as additional obligations) to heal the sick, eliminate or mitigate pain, and preserve and prolong life as much as possible” (p. 256).

However, these “rigid basic principles of medical ethics” conflict with “the demands of a higher conception of life’s value” (Binding and Hoche, 2000, p. 257). Hoche claimed that the physician’s commitment to preserve life is “merely relative, alterable under new conditions” and “always open to question” (p. 257). Third, Hoche dealt with the concept of “mental death.” When people, either naturally from birth or later as a result of accident or disease, have an absence of self-consciousness, lack productive relationships or accomplishments, have no clear ideas, feelings, or acts of will, they are *mentally dead*. They can make no claim to life and so killing them cannot be wrong. When society is struggling under heavy economic burdens, as Germany was at that time, killing such patients “is no crime, no immoral act, no emotional cruelty, but is rather a permissible and useful act” (p. 262).

Their contemporaries discussed Binding’s and Hoche’s arguments extensively. In fact, their work helped create a climate in the German medical profession that permitted physicians to accept the *idea* of killing their patients. Many physicians adopted their views and brought forward proposals for enacting them. After the war, participants in the T4 program appealed to Binding’s and Hoche’s ideas to justify their actions. Clearly, Alexander was wrong to attribute the euthanasia program solely to Nazi propagandizing. Rather, the killing began because *doctors* wanted to do it. However, this result was not in contradiction with Alexander’s eventual conclusion. He wrote:

Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they started from very small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, and finally all non-Germans. But it is important to realize that the infinitely small, wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick. (1980, p. 584)

This is a slippery-slope argument. Once doctors accept the idea that there

*actually are* “lives not worthy to be lived,” it is possible to justify ending such lives. The basic category of “lives not worthy to be lived” is sufficiently vague to allow for a gradual extension to new and less clear cases once the basic principle has been granted. In Germany, the kinds of lives regarded as “not worth living” multiplied, and the killing followed. For Alexander, only an absolute prohibition on medical killing prevents such a development. Only the “stake in the ground” of an absolute commitment to life prevents the journey to the bottom. That the impetus toward killing comes from German medicine’s eugenic tendencies rather than Nazi propaganda does not change the fundamental logic of Alexander’s analysis.

Indeed, Alexander clearly understood that Nazi ideology was not the only possible engine for a progression to wider killing. Looking at his own time, Alexander saw that the increasing importance of economic criteria in medical decision making represented the seed for a similar slide. (Indeed, one may add that our time, fifty years later, shows similar worrisome signs.) He writes: “The killing center is the *reductio ad absurdum* of all health planning based only on rational principles and economy and not on human compassion and divine law” (1980, p. 46).

Alexander’s point here is not speculative, as we can see from Varda Burstyn’s chilling discussion of German critical responses to the new reproductive technologies (1993). She cites molecular biologist Paula Bradish who reminds us that “the pressures of the market are as forceful and destructive, if not more so, than what we have had in the past” (p. 16). If my analysis here is plausible, then we can say with confidence that the German euthanasia program was not the result of Nazi fanaticism or a lack of respect for rationality. It was not a unique, non-reproducible horror. Rather, this program was a direct and logical result of European intellectual culture in the early twentieth century, and its relevance for contemporary ethical discussions cannot be simply excluded.

## II

Establishing the possibility that the German euthanasia program might be relevant to thinking about contemporary ethical problems does not mean that it actually is so. One good way to engage the question of relevance is to look at what contemporary critics have actually said against the analogy.

Consider the case of Peter Singer. For at least two decades now, Peter Singer has been one of our most influential (and controversial) English-speaking applied ethicists, serving until recently as the Director of the Center for Human Bioethics at Monash University in Melbourne, Australia. Singer played

a very important role in the early animal-rights movement by arguing for extending moral status to non-human creatures based on their ability to experience pain. In his important first paper, he argued that each citizen of an affluent society (certainly including nearly all readers of this journal) has a fundamental moral obligation to sacrifice his or her own resources to alleviate the problem of world hunger. Singer's personal conduct has generally been broadly consistent with his intellectual views.<sup>9</sup> He gives twenty percent of his annual income to famine relief, and he has been a persistent advocate for the relief of suffering. Singer's philosophizing tends to be analytic, utilitarian, and influential. More than once, however, he has become a lightning-rod for very public and very vocal protest.

First, in February 1988, Singer accepted an invitation to a European Symposium on Bioengineering, Ethics, and Mental Disability to be held in Marburg, West Germany. Two advocacy organizations for handicapped people jointly organized this conference, and it was held under the auspices of two more.<sup>10</sup> The program was to have included the German Minister of Family Affairs and a wide range of scientists, theologians, and philosophers. Singer let colleagues know that he would be in Europe that spring, and so he received an additional invitation from Dr. Christolph Anstötz, a professor of special education at the University of Dortmund. Singer's topic for that lecture was to have been, "Do severely disabled newborn infants have a right to life?"

Singer had made his position on such questions very clear. His book *Practical Ethics* (1979), which included discussions of these matters, had recently appeared in a German translation. In *Practical Ethics*, Singer argued that infants lack self-consciousness, rationality, and autonomy and therefore have a less strong claim to life than do others who possess these characteristics. He also claimed that we should permit active euthanasia of severely disabled newborns at the parents' request. He draws a strong conclusion: "[K]illing a defective infant is not morally equivalent to killing a person. Very often it is not wrong at all" (1979, p. 138). Singer's talks at the conference and the Dortmund lecture would almost certainly have explained, developed, and applied these views.

To set the context of this crisis even more specifically, we should note that serious philosophical work on normative questions about modern medicine and biotechnology came later to Germany than to the United States. In the early 1980s, there were some discussions about appropriate protection for animals used in research, *in vitro* fertilization, and human embryo research. The first of these topics is one to which Singer's early work on animal rights



was especially germane. According to Bettina Schöne-Seifert and Klaus Rippe (1991), the late 1980s saw an increasing interest in applied ethics. There were meetings and lectures on these topics. Institutions established ethics boards to review human experimentation and, among other institutes, the Akademie für Ethik in der Medizin was established in 1986 as a “forum for research, discussion, and teaching in medical ethics” (p. 20). Graduate students worked in this field, and university jobs in applied ethics were on the horizon. Singer’s talks were to take place within this active and fertile academic movement, which was still new and largely unknown to the educated public.

When the news spread about Singer’s invitations, a coalition of activist groups from both the left and the right came together to oppose his talks. Handicapped Students Organization, the Federal Association of Handicapped, Initiatives for Cripples (a self-ascribed term adopted by some handicapped activists), women’s groups, university professors, church organizations, and the German Society for Social Psychiatry, among others, voiced their protests. These groups held public meetings, wrote angry letters to the organizers and institutions, and published statements and fliers. All of them demanded the cancellation of Singer’s appearances. Some went on to attack the institutions that invited Singer, even calling for Professor Anstötz’s removal. The two most obvious outcomes were the cancellation of Singer’s appearance and a fierce debate on the appropriate balance between free speech and the protection of vulnerable individuals and groups. One handicapped representative for the protesting groups said, “We cannot tolerate that people should speak about whether we may live or not” (Singer, 1990, p. 35).<sup>11</sup> Schöne-Seifert and Rippe cite “anti-bioethicist” Oliver Tolmein, who described Singer’s views as “deny[ing] the right to life of the disabled” (1991, p. 21). Tolmein also introduced the Nazi analogy, claiming that debating Singer’s views would be “as senseless as to debate a theory arguing for the superiority of the Aryan race. In both cases it is the cognitive will at the theory’s foundation that must be attacked” (Schöne-Seifert and Rippe, 1991, p. 21). Singer responded, claiming that his views were being misrepresented and misunderstood. He went further to say that “the protesters have themselves shown the kind of fanaticism and lack of respect for rational debate that was a necessary precondition of the Nazi atrocities” (Singer, 1990, p. 42).<sup>12</sup>

A second, similar episode occurred in Spring 1998. When Princeton University appointed Singer to a position at its Institute for Human Values, pro-life and disability advocates again organized a mail campaign against this appointment, as well as threatening to picket Singer’s classrooms. Many pub-

lications, including the *New York Times*, reported this conflict, with strong editorial positions appearing on both sides.<sup>13</sup>

In these two cases, the issues were essentially the same. That Singer wished simultaneously (1) to do everything possible to protect animals from suffering, and (2) to permit the killing of profoundly retarded and handicapped children, seemed (and still seems) to his opponents to be callous and inhumane.<sup>14</sup> Singer's utilitarianism, his claim that there can be such a thing as human "lives that are not worth living," and in particular his proposal to begin with "defective" children, were (and are) for the disability advocates, ominously similar to the rhetoric and practice which led to Nazi death camps and genocide. In the case of Singer's canceled invitations in Germany, at least he and his defenders responded with a similar invocation of the Nazi period to characterize the behavior and views of his opponents.

Clearly, for many contemporary Germans, the excesses of their recent history are very much alive in current thinking about public policy questions. In their view we need to learn from the Nazi experience by rejecting social policies that permit killing citizens because their lives are regarded as not worth living. However, have they gone too far?

One might say *yes*. Indeed, a very attractive and popular response to the use of the Nazi analogy is to discount it altogether. As Courtney Campbell says, "[The analogy's] occasional indiscriminate invocation constitutes a cheapening or trivializing of moral discourse. . . . [T]o characterize an opponent as a 'Nazi' or to accuse a person of advocating Nazi-like proposals represents a radical indictment or even a denial of his or her humanity" (1992, p. 25). Many utilitarian thinkers like Singer, for example James Rachels and Joseph Fletcher, have tended to discount the Nazi experience as a unique horror that is no longer relevant and has nothing to teach us today. Singer denies that what the Nazis did was a euthanasia program at all.<sup>15</sup> However, such responses fail to address the conditions under which this analogy might succeed. Nor do they investigate the extent to which these conditions might be satisfied in the German case. Until they do so, their uncritical acceptance is premature. We must evaluate Alexander's argument before we simply reject it.

In *Practical Ethics*, Singer attempts such an evaluation. He rejects Alexander's notion that admitting the existence of lives not worthy to be lived is the essential step toward Nazi killing. He says: "A life of physical suffering, unredeemed by any form of pleasure or by a minimal level of self-consciousness, is not worth living" (1979, p. 214). He also rejects Alexander's idea that only an absolute prohibition of medical killing can stop the disaster.

Singer says that we can set criteria for deciding when a life is not worth living and that we may permissibly take it. In no case, he thinks, will this include already born people who are aware that they exist or who are capable of thinking about their situations. In no case will it lead to the disaster that Alexander has predicted. Thus, he holds that the links in Alexander's analysis are questionable, that we have not sufficiently established the historical story, and that the concept of "lives not worth living" can be defined in a way that prevents bad consequences.

Singer goes on to cite the example in Holland, where euthanasia is illegal but still widely practiced. After listing the guidelines that Dutch courts have developed, he asserts that:

Euthanasia in these circumstances is strongly supported by the Royal Dutch Medical Association, and by the general public in the Netherlands. The guidelines make murder in the guise of euthanasia rather far-fetched, and there is no evidence of an increase in the murder rate in the Netherlands.<sup>16</sup> (1979, p. 197)

Singer asserts that the Dutch experience of permitting euthanasia supports the claim that the German experience was a unique, one-time occurrence and not a precedent for the future. Although Singer does not say so, one might also note that these same Dutch physicians only a few decades earlier had most courageously resisted any participation in the Nazi euthanasia program. If they now support the practice, surely there must be a discontinuity between the two situations.

Placing so much weight on the Dutch experience is a risky strategy. True, Singer is right that euthanasia is popular in Holland. He is also right that no equivalent to the Nazi Holocaust has happened there. However, his citation of the murder rate is just rhetoric. No statistics of this kind would include even dubious medical killings (should there be such); and how we should think about these killings is exactly the question at issue. Moreover, when we examine the details, this example actually works against Singer's view.

During the last two decades in Holland, the categories of patients for whom physician-assisted dying was "not legally forbidden" (to use Binding's phrase) have been extended beyond the initial guidelines.<sup>17</sup> The 1981 Rotterdam decision established the basic rules. Among others, they included the following factors: (1) the patient must be conscious and experiencing unbearable pain; (2) there must be no other reasonable solutions; and (3) the patient must make a well-informed, entirely voluntary, and durable request for death. Fur-

ther, (4) the doctor must consult with an independent professional and this person must concur. Today, however, the situation has evolved. Cases of permitted killing have been extended to include transient, psychological as well as persistent physical distress, chronic as well as terminal illness, and involuntary as well as voluntary euthanasia. In each case, these extensions are supported by the argument that it would be discriminatory and unfair to allow euthanasia for some, and to deny it to other closely similar cases. This is just the kind of slippage that Alexander predicted, should his “peg” be removed.

The Dutch government, supported by the Royal Dutch Medical Association, has conducted two formal studies of their euthanasia program (1990 and 1995). In each case, researchers promised that participating physicians would be immune from prosecution for anything they revealed. Both reports documented the prevalence of involuntary euthanasia, as well as the fact that doctors, rather than patients, are increasingly making end-of-life decisions in Holland. Although the investigators presented their results as showing that the euthanasia program was a *success*, a number of disturbing facts emerged in the two reports. Herbert Hendlin (1997) summarizes the points as follows:

1. According to the 1990 report, 2,300 people who requested it were killed by doctors.
2. Additionally, doctors killed 1040 people who did not know or consent to what was happening. Fourteen percent of these were fully competent, and 72 percent had never given any indication that they would want their lives terminated.
3. Sixty percent of euthanasia cases in Holland go unreported. In these cases, doctors intentionally falsified death certificates to show death by natural causes. Of course, such falsifications make regulation of euthanasia impossible.
4. In the 1995 studies, physicians indicated that they consulted another physician in only 11 percent of unreported cases.
5. Almost 20 percent of unreported cases in that report involved ending a life without the patient’s consent.
6. Twenty-five percent of physicians reported that they had “terminated the lives of patients without an explicit request” from the patient to do so.
7. Although the Dutch investigators claimed that such cases decreased between 1990 and 1995, they reached this result by citing only the number of “without explicit request” cases. They ignored another

category on the list, cases in which physicians gave pain medication with the explicit intent of ending a patient's life. These cases increased from 1350 to nearly 1900. In more than 80 percent of these cases, there was no request for death. If we view such deaths as non-voluntary, then there has been an increase in the number of cases terminated without request. (pp. 22-23)

While Holland has not experienced mass killings on the scale of the Holocaust, these facts suggest that the practice of euthanasia in the Netherlands has escaped its initially tight controls and evolved toward wider, less regulated, and sometimes almost certainly undesirable killing. The guidelines of the Dutch court called explicitly for a persistent and repeated request by patients as one condition of permitting their deaths; but, in many hundreds of cases, doctors are ignoring this requirement with impunity. Instead of increasing patient autonomy, permitting physician-assisted death has actually reduced it in Holland. An increasing number of Dutch citizens are undergoing euthanasia without having requested death. Thus, the Dutch experience too provides evidence for the idea that, once permitted, the rate of killing will increase. This independent, contemporary example supports the argument that what happened in Germany may not be a unique and exceptional circumstance. Evidently, there are lessons to learn from these experiences for contemporary debates about physician-assisted death.

### III

What admonitions may we draw from the German and Dutch experiences to inform contemporary discussions of physician-assisted death? By way of concluding, I will suggest three. The first concerns the role of the physician as a healer. As several others have argued, it is wrong for doctors intentionally to kill their patients.<sup>18</sup> Doing so not only violates the Hippocratic Oath, it also undermines patient trust. We can see this from another Dutch study. In 1993, the Protestant Christian Elderly Society in Holland conducted a survey on general health-care issues, with no special mention of euthanasia. They received responses from several thousand elders. Still, ten percent of the respondents reported being afraid that they would be killed without their consent. Hans Holmans, director of the Society, offered this explanation: "They are afraid that at a certain moment, on the basis of age, a treatment will be considered no longer economically viable, and an early end to their lives will be made" (Elderly Dutch afraid, 1993). When physicians begin to kill, it causes confusion and uncertainty. The resulting distrust can undermine phy-

sicians' abilities to function in their appropriate role as healers. The first admonition, therefore, is that we be very careful before breaching the fundamental premise of medical ethics, that preserving the health and life of the patient is a physician's controlling duty.

In the second place, we must look carefully at the frequently invoked idea that "quality of life" can be used as a measure to decide who should live and who should die. This idea has always permeated discussions of euthanasia. However, euthanasia advocates, from Jost to Singer, often miss the fact that "quality of life" is not a simple property inherent in individuals. It is rather a relational property describing how we as a society care for one another, especially the most vulnerable among us. The low quality of life ascribed to many people with differences is less a result of clinical medical facts than of social attitudes and policies towards these people.<sup>19</sup> In the United States, given the concern for reducing health-care expenditures and the large numbers of uninsured and under-insured people, invocations of the patients' "right to choose" inevitably seems dangerously hollow. The second admonition is this. Until every seriously ill or disabled person has a right to the health care and support services necessary to provide a good quality of life, talk about their "right to die" is dangerous, discriminatory, and unjust.<sup>20</sup>

Finally, simply, and most importantly, the examples of Germany and Holland should remind us that it *can* happen here. Neither education and culture nor scientific progress and social wealth confer immunity from wrongdoing. In the early decades of the twentieth century, Germans had the most advanced medical science on the earth. They were leaders in all aspects of intellectual and cultural life. By the midpoint of that century, they had become the icon for totalitarian barbarism. Not for the first time, the "best and brightest" became agents for the "stupidest and worst." As Leo Alexander wrote, "the first step to disaster is overweening pride" (1980, p. 46). The final admonition, then, is that we never forget our common humanity. What human beings have done before can be done again, both for good and for ill. We must not imagine that we are different.

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## Notes

1. Friedlander estimates 70,000 deaths during the official “T4” euthanasia program and at least that many again during the “wild euthanasia” program following Hitler’s “stop order” in 1941. The last victim, four-year-old Richard Jenne, was killed 21 days after Germany’s unconditional surrender (1995, p. 163).
2. “In 1907 Indiana passed the first laws allowing sterilization of the mentally ill and criminally insane . . . . By 1939 more than 30,000 people in twenty-nine American states had been sterilized on eugenic grounds; nearly half of the operations (12,941) were carried out in California” (Proctor, 1988, p. 97).
3. Jost says nothing about Seneca or other early writers who deal with this question.
4. Jost’s choice of “incurability” as a critical criterion is both striking and peculiar. Many “incurable” diseases are not immediately or constantly painful and are compatible with long, comfortable, and productive life. This is typical of a lack of care about important details that characterizes Jost’s entire discussion.
5. Three such works are mentioned by Karl Binding: the “legally weak” essay by Hiller, *Das Recht über sich Selbst* (1908); the “legally inadequate ‘criminal study’” by Elizabeth Rupp, also entitled *Das Recht auf den Tod* (1913); and Alfred Hoche’s lecture *Von Sterben* (n.d.). I have not yet examined any of these texts. Hoche’s lecture is available in a few U.S. libraries, but they have so far proven unwilling to circulate or copy it. From the references to it in Binding’s essay, he and Hoche do not seem to depend on the argument from self-determination as heavily as do Hiller and Rupp.
6. These include a four volume series (1872-1920) *Die Normen und ihre Übertretung* (*Norms and Their Transgression*); and *Lehrbuch des gemeinen deutschen Strafrechts* (*A Textbook of Common German Criminal Law*) (1902-1905).
7. While one might think that no one would ever actually assign moral status based on the outward appearance of the entity under consideration, Binding is not alone in doing so. This consideration also surfaced in American discussions of eugenics.
8. Patrick Derr pointed out to me in conversation that this, in effect, is allowing euthanasia by what we would call “substituted judgment.” He notes ironically that this is a very “advanced” idea indeed.
9. A recent profile in *New Yorker*, by Michael Specter (1999), includes several examples of serious inconsistencies between Singer’s beliefs and actions in the context of a very interesting discussion of Singer’s life, person, and activities.
10. According to Singer, the organizers were Lebenshilfe and the Bishop Bekkers Institute, respectively German and Dutch organizations for the parents of cognitively disabled children. The groups under whose auspices the Conference was to be held were the International League of Societies for Persons with Mental Handicaps and the International Association for the Scientific Study of Mental Deficiency.
11. As a result of the conflicts around Singer’s proposed visit, universities were pressured to curtail activities in this field. While a variety of new ventures in medical and biomedical ethics were undertaken, Germany had remained quite conservative in its approach to bioethical questions. The German high court has always referred to the Nazi era in justifying its reluctance to accept lethal social activities. Likewise, the

recently established journal, *Biomedical Ethics, Newsletter of the European Network for Biomedical Ethics*, has approached questions of euthanasia and medical killing very carefully and thoughtfully but always with a strong tendency against such possibilities.

12. Bioethics remains a very sensitive issue in Germany. See Alison Abbott (1997). One point I have been attempting to make is that fanaticism and a lack of respect for rational debate are *not* preconditions for the occurrence of atrocities. See Walter Wright (2000).

13. For various advocacy positions also see Katha Pollitt (1999, p. 10); Terry Golway (1998, p. 4); and Francis Canavan (1999) among many.

14. Proctor detects a similar confluence of views in the thought of Nazi medical theorists in the 1930s. "Nazi philosophers also commonly expressed concerns about cruelty toward animals. In early 1933, Nazi representatives in the Prussian parliament called for legislation banning vivisection" (1988, p. 277).

15. "In fact the Nazis did not have a euthanasia program, in the proper sense of the word. Their so-called euthanasia program was not motivated by concern for the suffering of those killed" (Singer, 1979, p. 215). While true, this begs the question as to whether, first, the discussion and subsequently, the general approval of the idea of euthanasia in the proper sense helped create an environment in which the Nazis' later involuntary killing became possible. This latter is the point made by Friedlander and others.

16. Euthanasia and physician-assisted suicide are permitted under guidelines developed in a series of court cases. The controlling precedent is from the Court of Rotterdam (1 December 1981). See J. K. M. Gevers (1996).

17. The statistics that follow are cited from Hendlin (1997), although the essential points are available in many places.

18. See Leon Kass (1989) and Edmund Pellegrino (1992).

19. This is a point that Tom Koch has made repeatedly in his writings.

20. The other modern example is the state of Oregon, which permits physicians to prescribe lethal drug doses under certain conditions. This law has been in place a very short time, and the results are inconclusive. However, advocates point to the small number of such prescriptions written since the law was enacted and the fact that one-third of them remains unused. They fail to mention that Oregon is also the only U.S. state that will not pay for antiviral drug treatment for AIDS patients. Apparently, the two-year median survival rate of these patients is not judged to be worth the social cost of providing treatment.

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