WHILE I WAS ON A CLERKSHIP IN THE INTENSIVE CARE UNIT (ICU), A FRIEND drew my attention to a chapter in Robert Zussman's book, *Intensive Care*. In this chapter, an intern on an ICU rotation reports a bizarre dream in which he finds penguins in a basement. In order to save one of these penguins, who can only survive in a cold environment, he puts it in a blender with some ice and turns the blender on.¹

For me, the enduring lesson of my time in the ICU was that bad things can sometimes happen to people in the hospital. Sometimes a treatment can be worse than the disease itself. Sometimes our efforts seem only to prolong a patient's suffering.

Many medical students have had a similar ICU experience at some point in their training; from this, it requires no great leap of reasoning to reconsider the role of the physician in addressing pain and suffering. Should unwilling patients be allowed to forgo life-sustaining therapy? Most systems of law concede this right. But this raises a more difficult question: Should physicians assist certain patients—perhaps those who meet some predefined criteria for measuring distress—in ending their own lives? Within the medical profession and among ethicists there are strong opinions, but there is no widely agreed-upon answer.

Perhaps mirroring or perhaps causing this conflicted thinking, lawmakers in our country are similarly divided. In 1997, the US Supreme Court ruled that the Constitution neither explicitly permits nor prohibits physician-assisted suicide. Since then, the states have been free to consider on their own the question of legalizing the practice of assisted suicide. Measures to legalize physician-assisted suicide have been proposed and defeated in eight state legislatures—bringing the number of states outlawing its practice to 38. Oregon, which held a popular referendum on this issue in 1994, became the only state to legalize assisted suicide by implementing its Death With Dignity Act in 1997.²

In this issue of MSJAMA, Juan Carlos Batlle clarifies terminology in recounting the legal and historical differences among assisted suicide, euthanasia, and the withdrawal of life support. Joanne Lynn and Karl Lorenz examine some of the ethical problems that physicians might face in responding to a patient's request for assisted suicide and draw attention to the failure of the US health care system to provide reliable supportive and palliative care for the dying. Larry Palmer sizes up the legal struggle between the US attorney general and the state of Oregon over that state's assisted suicide law. All of these authors challenge us to think about this issue, which yields no easy answers.

REFERENCES