began to level off, money for construction all but disappeared from congressional appropriations, the outrage of medical school administrators notwithstanding. Yet new construction continues, if at a slower pace. Where does the money come from?

From indirect costs, of course. Universities are allowed under the rules to charge to research grants a portion of the costs of constructing and financing new buildings. What this means is that institutions confident that their researchers would be well supported have been able to build buildings speculatively, knowing that the costs would eventually be requited by the indirect costs with which research grants are loaded. The results have often been dramatic. One research hospital, for example, used to charge a 30 per cent overhead rate until it built a new building, when overhead charges (on every grant, whether or not the new space was used) jumped to 70 per cent.

The system, entirely legal and above board, is now being scrutinized closely, in the wake of the more flamboyant scandals that have come to light. Several other abuses have been uncovered in the allocation of what is called the administrative overhead, which has been rising steadily over the past decade. The use of the indirect cost pool for the amortization of buildings seems to be one of the chief forces driving up the overhead rates, at some institutions now 80 per cent of the value of research grants. Yet nobody pretends that new buildings are not needed. Too many research buildings in the United States are now 40 to 50 years old, in desperate need of rejuvenation or replacement. It may be possible to start computer companies in a garage, but garages are not the place for contemporary science.

What is to be done? Congress must first understand that its pretence that it supports research, but does not build buildings, is a misconception. Having willed the projects, does it not have a responsibility for the settings in which they will be carried through? To be sure, there are advantages in insulating decisions on buildings from the geographically sectional interests rife in Congress, but none in a system that makes research seem more costly than it is and which rewards the institutions whose speculative builders are luckiest. What the US research enterprise needs is analysis of the need for research facilities in the twenty-first century and a commitment from the government to provide them. □

Death with dignity

A proposal in Washington state to legalize euthanasia has begun an important debate even though it did not become law.

THE idea that the terminally ill should be allowed to "die with dignity" has become not only a moral but a potent political issue, first in the Netherlands, now in the United States, where the sometimes mindless use of high technology to sustain otherwise lifeless bodies is all too common. That explains the voter initiative on the ballot in the state of Washington earlier this month that would have legalized euthanasia. The proposition was narrowly defeated. If it had become law, Washington would have been the first jurisdiction in the Western world to sanction physician-assisted death. Even the Dutch, long tolerant of help in dying, have not explicitly legalized euthanasia. And the failure of the Washington initiative in no way settles the matter, but merely puts it off until the next statewide election.

Even those who accept that physicians should, in certain circumstances, accede to the wishes of a terminally ill patient that he or she should die agree that the issues are complex and that the slippery-slope argument against euthanasia has force. What separates euthanasia for the truly terminally ill and mercy killing of the hopelessly sick (Alzheimer's patients, for instance)? Washington's draft law contained several prohibitions of the slippery slope. First, it would have required a determination, to the extent that medicine can judge, that the patient had less than six months to live. Second, it would have applied only to mentally competent patients, those alert enough to ask for aid in dying. Strictly kept, these provisions would have made for sound protection.

So why did the proposition not succeed? One influence, during the Washington ballot, seems to have been a last-minute television advertisement featuring a cancer patient who claimed that, had physician-assisted dying been legal when her disease was diagnosed seven years previously, she might have chosen to die. That claim, of course, overlooks the need specified by the draft legislation that a determination of imminent death should have been reached objectively. Yet the advertisement had obvious emotional appeal; it may have influenced voters whom pollsters had predicted were planning to vote YES.

The important and neglected question, which points to the reason why this debate will not go away, is why so many people are leaning towards legalized euthanasia, even in the face of religious scruples. Why, for that matter, has the Hemlock Society's book *Final Exit* become a bestseller in the United States? The answer is that modern medicine, with its devotion to respirators and other forms of high technology, has lost its bearings.

Most terminally ill people do not rush headlong into suicide. What makes it an attractive option is a deeply held fear that, when death is at hand, eager doctors armed with feeding tubes and breathing machines will fend it off — painfully, at great cost, but only for a while. It may be relevant that, in Canada and Europe, the high technology is less conspicuous, as is the likelihood that a family will bring a malpractice suit if doctors fail to use the very technology that so many patients fear. The physicians' common objection to euthanasia on the grounds that the Hippocratic oath compels them to "do no harm" overlooks the reality that, often, patients perceive modern medical technology as harm in itself. At least until the next election, Washington can be pleased to have made these issues respectable in polite conversation. □