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A philosophical case against euthanasia

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I. 'EUTHANASIA'

DEVISED FOR SERVICE in a rhetoric of persuasion, the term 'euthanasia' has no generally accepted and philosophically warranted core of meaning.

The Dutch medical profession and civil authorities define euthanasia as: killing at the request of the person killed. But I shall call that *voluntary euthanasia*, and distinguish it from non-voluntary euthanasia (where the person killed is not capable of either making or refusing to make such a request) and involuntary euthanasia (where the person killed is capable of making such a request but has not done so).[1] It is certain that deliberate killing of patients by Dutch medical personnel, with the more or less explicit permission of civil authority, extends well beyond cases where death has been requested by the person killed; the Dutch practice of euthanasia includes non-voluntary and perhaps some involuntary euthanasia. Rightly (as we shall see) the Dutch commonly reject as morally irrelevant the distinction sometimes drawn between 'active' and 'passive' euthanasia, i.e. between killing by use of techniques or instrumentalities for hastening death, and killing by omitting to supply sustenance and/or treatment which, but for the decision and intent to terminate life, would been have supplied.

In Nazi discourse, euthanasia was any killing carried out by medical means or medically qualified personnel, whether intended for the termination of suffering and/or of the burden or indignity of a life not worth living (*Lebensunwertes Leben*), or for some more evidently public benefit such as eugenics (racial purity *and hygiene*), *Lebensraum* (living space for

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Germans), and/or minimising the waste of resources on 'useless mouths'.

In pluralist democracies today, there is understandable reluctance to be associated with Nazi ideas and practices. Racist eugenics are condemned, though one comes across discreet allusions to the burden and futility of sustaining the severely mentally handicapped. Much more popular is the conception that some sorts of life are not worth living; life in such a state demeans the patient's dignity, and maintaining it (otherwise than at the patient's express request) insults that dignity; proper respect for the patient and the patient's best interests requires that that life be brought to an end.

Since this paper is to present a philosophical case against euthanasia, my working definition of euthanasia should satisfy two requirements. It should ensure that the type of proposal to be argued against is identified under its most attractive or tempting true description. And it should also identify the full range or set of proposals which, for the purposes of applying the relevant moral principles and norms, fall within the same morally significant type and are the subject matter of a single moral conclusion.

So I define the *central case* of *euthanasia* as the adopting and carrying out of a proposal that, as part of the medical care being given someone, his or her life be terminated on the ground that it would be better for him or her (or at least no harm) if that were done. But this definition should be taken with two related and inter-related points. The moral norms which, I shall argue, rule out the central case will rule out *every* proposal to terminate people's lives on the ground that doing so would be beneficial by alleviating human suffering or burdens, whether the proposal arises within or outside the context of medical care. And, conversely, if the central case of euthanasia is not morally ruled out, neither are proposals to terminate people's lives outside the context of medical care and/or on the ground that doing so would benefit *other people* at least by alleviating their proportionately greater burdens.

To make this last point is not to insinuate some crude 'slippery slope' argument from the anticipated bad consequences of allowing euthanasia of the paradigm sort. It is merely to indicate at the outset, proleptically, that neither the true moral principles at stake in the discussion, nor any plausible (though untrue) principles which if true would justify euthanasia of the paradigmatic type, give warrant for thinking that the conclusion of the moral argument might depend upon the medical (or non-medical) character or context of lethal conduct, or upon the identity of the person(s) for whose benefit a proposal precisely to terminate life might be adopted as a means. It is, in other words, to indicate that hereabouts one will find 'slippery slope' arguments of a valid[2] and sophisticated type, adverting not so much to predictions and attempted evaluative assessments of future consequences and

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states of affairs, but rather to the implications of consistency in judgment.

One of those valid arguments from consistency will conclude that there is no morally relevant distinction between employing deliberate omissions (or forbearances or abstentions) *in order to* terminate life ('passive euthanasia') and employing 'a deliberate intervention' for the same purpose ('active euthanasia'). So my definition even of the narrow central case of euthanasia is wider than the definition offered by those who, like the Walton Committee,[3] wish (for good reason) to oppose euthanasia but (for no detectable reason of principle) are unwilling to challenge the line between 'positive actions intended to terminate life' and 'omissions intended to terminate life' – the line drawn, for example, in *Airedale NHS Trust* v. *Bland*,[4] by Law Lords who admitted its legal misshapenness and moral irrelevance.[5]

II. HOW INTENTION COUNTS

The Select Committee on Medical Ethics (Walton Committee), which was set up by the House of Lords in the wake of the *Bland* case and reported in early 1994, unanimously rejected any proposal to 'cross the line which prohibits any *intentional* killing, a line which we think it essential to preserve'.[6] The Committee described the 'prohibition of intentional killing' as 'the cornerstone of law and of social relationships'.[7] They then showed their understanding of the nature and importance of *intention* by rejecting outright the view[8] that the rightness or wrongness of administering analgesics or sedatives, in the knowledge that the dose will both relieve pain and shorten life, depends not upon the intention with which the medication is administered and only upon the comparative value of the respective outcomes. The Committee's view was this:

> [W]e are satisfied that the professional judgment of the health-care team can be exercised to enable increasing doses of medication (whether of analgesics or sedatives) to be given *in order to* provide relief, even if this shortens life. In some cases patients may in consequence die sooner than they would otherwise have done but this is not in our view a reason for withholding treatment that would give relief, *as long as* the doctor acts in accordance with responsible medical practice *with the objective of* relieving pain or distress, and *with no intention to kill* . . . the doctor's intention, and evaluation of the pain and distress suffered by the patient, are of crucial significance in judging double effect. If this *intention* is the relief of pain or severe distress, and the treatment given is appropriate to that *end*, then the possible double effect should be no obstacle to such treatment being given. Some may suggest that intention is not

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> readily ascertainable. But juries are asked every day to assess intention in all sorts of cases.[9]

In this passage, the Committee rightly deploy some of the various synonyms which common speech deploys as alternative ways of expressing what is signified by their key general term 'intentional': 'with the intention to', 'in order to', 'with the objective of' and 'to that end'.[10]

I mention the Walton Committee's conclusions not as an appeal to authority, but as convenient evidence of a fact confirmed in many recent philosophical studies. Intention is a tough, sophisticated and serviceable concept, well worthy of its central role in moral deliberation, analysis and judgment, because it picks out the central realities of deliberation and choice: the linking of means and ends in a plan or *proposal*-for-action *adopted* by *choice* in preference to alternative proposals (including: to do nothing). What one intends is what one chooses, whether as end or as means. Included in one's intention is everything which is part of one's plan (proposal), whether as purpose or as way of effecting one's purpose(s). The parts of the plan are often picked out by phrases such as 'trying to', 'in order to', 'with the objective of', 'so as to' or, often enough, plain 'to'.

In recent years, the English courts have firmly set their face against a view widely and for many years propounded by legal academics, but most clearly put by Henry Sidgwick:

> for purposes of exact moral or jural discussion, it is best to include under the term 'intention' all the consequences of an act that are foreseen as certain or probable.[11]

It was settled by the Law Lords in *R.* v. *Moloney* (1985) and *R.* v. *Hancock* (1986) that it is a fatal misdirection to instruct a jury on Sidgwick's lines. Foresight of consequences is evidentially relevant to the question what the accused intended, but a jury can rightly hold that what one foresees as probable or even certain to result from one's action is nevertheless no part of what one intends.[12] (And 'jural discussion' about the law of murder is intended by the judges to track sound 'moral discussion'.) The 'oblique intention' of Bentham, Sidgwick, Holmes and Glanville Williams is not intention at all; it is a state of foresight and acceptance that one will cause such and such as a side-effect. These thinkers claim one *should* have the same moral responsibility for foreseen (or foreseeable?) side-effects as one has for what one intentionally brings about. But that claim depends not on a clear and realistic analysis of action but on a (highly contestable) theory about the content of true moral norms. In a sound theory of human action, the

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utilitarian construct 'oblique intention' is a mere deeming, a fiction, but the *intention* known to common sense, law and exact philosophy alike is action's central reality. It is what one forms in choosing to act on *this* proposal/plan rather than that or those. In carrying out one's intention, one *does* precisely what one intends. The primary and proper description of one's act, and thus its primary identity as a human act, morally assessable by reference to relevant moral norms, is settled by what one intends, what one means to do.

So, in common sense and law alike, there is a straightforward, non-artificial, substantive distinction between choosing to kill someone with drugs (administered over, say, three days in order not to arouse suspicion) in order to relieve them of their pain and suffering, and choosing to relieve someone of their pain by giving drugs, in a dosage determined by the drugs' capacity for pain-relief, foreseeing that the drugs in that dosage will cause death in say three days. The former choice is legally and morally murder (in mitigating circumstances); the latter is not. The latter *may* still be morally and legally culpable, not by virtue of the moral and legal norm which excludes intentionally terminating life, but by virtue of other legal and moral norms, those which apply to the causing and accepting of side-effects unfairly or in some other way unreasonably. So if the pain were in any case likely to abate, and the patient was not in any case dying, the imposition of death even as an unintended consequence (side-effect) of pain-relief would normally be grossly unfair and unreasonable, and in law a case of manslaughter though not murder.

The distinctions between what is intended as means or end and what is accepted as a side-effect do not depend upon whether the side-effect is desired or undesired, welcomed or accepted with reluctance. Provided that one in no way adjusts one's plan so as to make them more likely, side-effects may be welcomed as a 'bonus' without being intended. It can be reasonable for someone to welcome death precisely insofar as it involves an end to misery or is envisaged as the gate of heaven. Of course, such a desire for death can be or become a temptation to form an intention to terminate or secure the termination of one's life, even if only a conditional ('If things get worse, I'll . . . ') or hypothetical intention ('If I had the nerve to do it, I'd . . . '). But a desire for death need not result in the forming of such an understandable but always fundamentally different (and immoral) intention.

So the moral argument which condemns euthanasia as a kind of intentional killing does not condemn the use of drugs which cause death as a side-effect, and does not condemn the longing that some people have for death. Nor does it condemn the decision of those who decline to undergo some life-saving or life-sustaining form of treatment because they choose to avoid the burdens (e.g. pain, disfigurement or expense) imposed by such treatment, and accept

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the earlier onset of their death as a side-effect of that choice. Such decisions may be more or less immoral because lacking in fortitude and/or perseverance in reasonable commitment, or because unfair to dependents or colleagues, and so forth. But provided that they in no way involve the choice (intention) to terminate life by omission, they are not suicidal, and a similar decision made on someone's behalf is not euthanasiast.

Turn the coin over. Intentionally terminating life by omission – starving someone to death, or withholding their insulin, etc., etc. – is just as much murder as doing so by 'deliberate intervention' ('commission', 'active euthanasia'). Without squarely confronting the issue, at least a majority of the Law Lords in *Bland* slid, via a confused analysis of 'duty of care', into a position tantamount to denying this implication of the significance of intention. And the Walton Committee unfortunately so arranged their definitions and discussions that they managed to avoid even confronting the need to identify euthanasia by deliberate omission for what it is, and to distinguish it from the refusal or withholding of burdensome or futile treatment.

III. WHY INTENTION COUNTS

The distinction between what one intends (and does) and what one accepts as foreseen side-effect(s) is significant because free choice matters. There is a free choice (in the sense that matters morally) only when one is rationally motivated towards incompatible alternative possible purposes (X and Y, or X and not-X) which one considers desirable by reason of the intelligible goods (instrumental and basic) which they offer – and when nothing but one's choosing itself settles which alternative is chosen. In choosing one adopts a proposal to bring about certain states of affairs – one's instrumental and basic purposes – which are precisely those identified under the description which made them seem rationally appealing and choosable. And what one thus adopts is, so to speak, synthesised with one's will, i.e. with oneself as an acting person. Rationally motivated choice, being for reasons, is never of a sheer particular. So one *becomes* a doer of the *sort* of thing that one saw reason to do and chose and set oneself to do and accomplish – in short, one becomes the sort of person who has *such* an intention. Nothing but contrary free choice(s) can reverse this self-constitution.

Forming an intention, in choosing freely, is not a matter of having an internal feeling or impression; it is a matter of *setting oneself* to do something. (Here and hereabouts 'do' and 'act' include deliberate omissions such as starving one's children to death.) No form of voluntariness other than

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intention – e.g. the voluntariness involved in knowingly causing the side-effects one could have avoided causing by not choosing what one chose – can have the self-constituting significance of really forming an intention.

The distinction between the intended and the side-effect is *morally* significant. One who chooses (intends) to destroy, damage or impede some instantiation of a basic human good chooses and acts contrary to the practical reason constituted by that basic human good. It can never be reasonable – and hence it can never be morally acceptable – to choose contrary to a reason, unless one has reason to do so which is rationally preferable to the reason not to do so. But where the reason *not* to act is a *basic* human good, there cannot be a rationally preferable reason to choose so to act. (For the basic goods are aspects of the human persons who can participate in them, and their instantiations in particular persons cannot, as reasons for action, be rationally commensurated with one another. Indeed, if they could be, the reason which measured lower on the scale would, by that very fact, cease to be a *reason* and the higher-ranked reason, having *all* the value of the lower *and some additional value*, would be rationally unopposed; so the situation would cease to be one of morally significant choice, choice between rationally appealing alternatives. But, to repeat, because of many factors including the self-constitutive significance of free choices, reasons for action (goods and bads) involved in alternative proposals for action are not commensurable *prior* to *moral* judgment and choice. Immoral proposals, though not fully reasonable, can and often do have rational appeal and morally significant choice between right and wrong remains eminently possible.) So, one who *intends* to destroy, damage or impede some instantiation of a basic human good necessarily acts contrary not merely to a reason but to reason, i.e. immorally.

Such, in very abstract terms, is the rationale of the more concrete and traditional moral wisdom: there are means which cannot be justified by any end; do not do evil that good may come; it is better to suffer wrong than to do it – not to mention the restatement made by Kant in opposition to early utilitarianism: treat humanity in oneself and others always as an end and never as a mere means.

The exceptionless moral norms which give specificity to these principles are – and, if morality is to give coherent direction to conscientious deliberation, must be – negative norms about what is chosen and intended, not about what is caused and accepted as a side-effect. But while one can always refrain from *choosing to harm* an instance of a basic human good (i.e. from resorting to unjustifiable means, doing evil, doing wrong, treating someone's humanity as a mere means), one *cannot* avoid *causing harm* to

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some instances of human goods. For every choice and action has some more or less immediate or remote negative impact on – in some way facilitates the damaging or impeding of – some instantiation(s) of basic human good(s). And since such harm is inevitable, it cannot be excluded by reason's norms of action. For moral norms exclude irrationality over which we have some control; they do not exclude accepting the inevitable limits we face as rational agents. Accepting – knowingly causing – harm to basic human goods as side-effects will be contrary to reason only if doing so is contrary to a reason of another sort, viz., a reason which bears not on choosing/intending precisely as such but rather on acceptance, awareness and causation. As I indicated in relation to choices to administer pain-relieving drugs, or to refuse or withhold life-saving treatment, there certainly are reasons of this other sort – particularly reasons of impartiality and fairness (the Golden Rule), and reasons arising from role-responsibilities and prior commitments. Still, one can be certain that harmful side-effects are *not* such as to give reason to reject an option, if the feasible alternative option(s) involve *intending* to destroy or damage some instantiation of a basic human good such as someone's life.

IV. WHY IT IS ALWAYS WRONG TO CHOOSE TO TERMINATE THE LIFE OF THE VERY YOUNG, THE VERY ILL AND/OR THE VERY OLD

The Walton Committee, having expressed its judgment that the prohibition of intentional killing is the cornerstone of social relationships, immediately adds: 'It protects each one of us impartially, embodying the belief that *all are equal*.'[13] All who/what? The answer is evident enough: people, including the vulnerable and disadvantaged.[14]

In virtue of what (if anything) are people, with all their manifold differences, equal and so entitled to be valued and treated as – not merely *as if*! – equals? To answer that question is also to answer the question of whether and why human life is a basic good which one may never rightly choose to destroy in any of its instantiations (living human beings).

What do all human beings have in common? Their humanity. This is not a mere abstraction or nominal category; nor is it Kant's thin, rationalistic reduction of one's humanity (*Menschlichkeit*) to that aspect of one's nature which one does not share with other terrestrial creatures: one's reason and rational will. Rather, one's humanity is one's capacity to live the life, not of a carrot or a cat, but a human being. And one's having this radical capacity is, again, no mere abstraction; it is, indeed, one's very life, one's being a living

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human being. Carrots and cats, too, are alive. But human life is not partly carrot-life and partly cat-life. It is human through and through, a capacity – more or less actualised in various states of existence such as waking, sleeping, infancy, traumatic unconsciousness, decrepitude, etc. – for human metabolism, human awareness, feelings, imagination, memory, responsiveness and sexuality, and human wondering, relating and communicating, deliberating, choosing and acting. To lose one's life is to lose all these capacities, these specific forms and manifestations of one's humanness; it is to lose one's very reality as a human being.

That reality is through and through the reality of a person, a being with the radical capacity to deliberate and choose. Free choice, as I have already said, is wonderful in its freedom from inner and outer determination and its world-shaping and self-determining creativity for participating in intelligible goods. Personal life accordingly has the dignity which the tradition sought to capture with the phrase 'image of God' – a phrase which serious philosophers such as Socrates, Plato and Aristotle would not have dismissed as a mere theological flourish foreign to philosophy's reflection on the ultimate principles of everything.[15] That dignity is most fully manifested in the dispositions and activities of people and communities who think wisely, and choose and act with the integrity and justice of full reasonableness. But, once again, thinking (and thinking straight) and choosing (with the freedom of full reasonableness unfettered by deflecting emotions) are *vital* activities, life-functions, actualisations of that *one* radical, dynamic capacity which is actuated in all one's activities, metabolic, sensitive, imaginative, intellectual and volitional.

Every living human being has this radical capacity for participating in the manner of a person – intelligently and freely – in human goods. That is, every living being which results from human conception and has the epigenetic primordia (which hydatidiform moles and, even more obviously, human sperm and ova lack) of a human body normal enough to be the bodily basis of some intellectual act is truly a human being, a human person. But, to repeat again, the human being's life is not a vegetable life supplemented by an animal life supplemented by an intellectual life; it is the one life of a unitary being. So a being that once has human (and thus personal) life will remain a human person while that life (the dynamic principle for that being's integrated organic functioning) remains – i.e. until death. Where one's brain has not yet developed, or has been so damaged as to impair or even destroy one's capacity for intellectual acts, one is an immature or damaged human person.

The alternative is some sort of dualism according to which a human person

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inhabits and uses a living, organically human body while that body is in a certain state of development and health, but at other times (earlier and in many cases also later) is absent from it because the body, though living, cannot yet or can no longer support personal existence. But dualism – every such attempt to distance human bodily life from person or selfhood – has been subjected to devastating philosophical criticism. For a dualistic account of personal existence undertakes to be a theory of something but ends up unable to pick out any unified something of which to be the theory. More specifically, it sets out to be a theory of one's personal identity as a unitary and subsisting self – a self always organically living but only discontinuously conscious, and now and then inquiring and judging, deliberating and choosing, communicating, etc. – but every dualistic theory renders inexplicable the unity in complexity which one experiences in every act one consciously does. We experience this (complex) unity more intimately and thoroughly than any other unity in the world; indeed, it is for us the very paradigm of substantial unity and identity. As I write this, I am one and the same subject of my fingers hitting the keys, the sensations I feel in them, the thinking I am articulating, my commitment to write this paper, my use of the computer to express myself. Dualistic accounts, then, fail to explain *me*; they tell me about two things, other and other, one a nonbodily person and the other a nonpersonal body, neither of which I can recognise as myself, and neither of which can be recognised as me by the people with whom I communicate my perceptions, feelings, thoughts, desires and intentions by speaking, smiling, etc. Careful philosophical reflection on human existence rejects the casual, opportunistic dualism of the many bio-ethicists who want to justify the non-voluntary killing of small, weak, or otherwise impaired people but, for some ill-explained reason, are reluctant to accept that such killing puts to death persons. It also exposes the arbitrariness with which these bio-ethicists attempt to draw a line between living human beings deemed to be persons and living human beings deemed to be not yet or no longer or never persons.

In short, human bodily life is the life of a person and has the dignity of the person. Every human being is equal precisely in having that human life which is also humanity and personhood, and thus that dignity and intrinsic value. Human bodily life is not mere habitation, platform or instrument for the human person or spirit. It is therefore not a merely instrumental good, but is an intrinsic and basic human good. Human life is indeed the concrete reality of the human person. In sustaining human bodily life, in however impaired a condition, one is sustaining the person whose life it is. In refusing to choose to violate it, one respects the person in the most fundamental and indispensable way.

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In the life of the person in an irreversible coma or irreversibly persistent vegetative state, the good of human life is really but very inadequately instantiated. Respect for persons and the goods intrinsic to their well-being requires that one make no choice to violate that good by terminating their life. On the other hand, fair-minded persons may well be unwilling to impose on themselves or their families or communities the burden of expense involved in medical treatment and non-domestic care for the purpose of sustaining them in such a deprived and unhealthy state. To preserve human solidarity with such people, and to respect rather than violate the one good in which they still participate – bodily life bereft of participation in other human goods such as knowledge and friendship – the care to be provided to them need not, I think, be more than is provided (save in times of most desperate emergency) to anyone and everyone for whom one has any respect and responsibility: the food, water and cleaning that one can provide at home. To do less than that (save in desperate emergency when one must attend to more urgent responsibilities) would scarcely be intelligible save as manifesting a choice – perhaps even a choice once made by the patient and set down in some advance directive – to proceed *on the basis that* such patients and/or anyone who is responsible for caring for them would be better off if they were dead. But such a choice involves the intent to terminate life and thus violates a basic and intrinsic good of human persons, and denies such people's still subsisting equality of value and worth, and their equal right to life.

Is this to say that the autonomy of the patient or prospective patient counts for nothing? By no means. Where one does not know that the requests are suicidal in intent, one can rightly, as a health-care professional or as someone responsible for the care of people, give full effect to requests to withhold specified treatments or indeed any and all treatments, even when one considers the requests misguided and regrettable. For one is entitled and indeed ought to honour these people's autonomy, and can reasonably accept their death as a side-effect of doing so.

But suicide and requests which one understands to be requests for assistance in suicide are a very different matter. It is mere self-deception to regard the choice to kill oneself as a 'self-regarding' decision with no impact on the well-being of people to whom one has duties in justice. The point is not merely that 'the death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen'.[16] More importantly, it is this. If one is really exercising autonomy in choosing to kill oneself, or in inviting or demanding that others assist one to do so or themselves take steps to terminate one's life, one will be proceeding on one or both of two philosophically and morally erroneous judgments: (i) that human life in

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certain conditions or circumstances retains no intrinsic value and dignity; and/or (ii) that the world would be a better place if one's life were intentionally terminated. And each of these erroneous judgments has very grave implications for people who are in poor shape and/or whose existence creates serious burdens for others.

For: If one claims a right to suicide, assistance in suicide and/or euthanasia, one is making a claim which is not and rationally cannot be limited by reference to one's own particular identity and circumstances. Nor can it plausibly be restricted to cases where the person to be killed has autonomously chosen to act on one or both of the two (erroneous) judgments. For the first judgment claims that death – and thus being killed – is *no harm* (indeed may be a benefit). So it renders unintelligible any principled moral exclusion of non-voluntary and even of involuntary euthanasia. And the second judgment, too, cannot be plausibly defended by reasons such that its range of application would be limited to suicide, assisted suicide and voluntary euthanasia; its sense and its grounds alike extend to include non-voluntary euthanasia.

The moral errors underlying claims to a right to assistance in suicide or to voluntary euthanasia are errors which do the most vulnerable members of our communities the great injustice of denying, in action, the true judgments on which depend both the acknowledgment of their dignity and their right to life (and so too all their other rights).

NOTES

1 These definitions of 'voluntary', 'non-voluntary' and 'involuntary' euthanasia correspond to those employed by the House of Lords Select Committee on Medical Ethics (Walton Committee) (see House of Lords Paper 21-I of 1993–94, para. 23), and seem more serviceable than the different definitions offered in Harris, *The Value of Life* (Routledge, London, 1985), 82–83.

2 See Douglas Walton, *Slippery Slope Arguments* (Clarendon Press, Oxford, 1992).

3 Report of the Select Committee on Medical Ethics [Chairman Lord Walton], 31 January 1994 (House of Lords Paper 21-I of 1993–94), paras. 20–21.

4 [1993] Appeal Cases 789.

5 See John Finnis, '*Bland*: Crossing the Rubicon?' (1993) 109 Law Quarterly Review 329–337.

6 House of Lords Paper 21-I of 1993–94, para. 260. Here as elsewhere emphases are by me unless otherwise indicated.

7 Ibid., para. 237.

8 Expressed to the Committee by the British Humanist Association, thus: 'The doctrine of double effect seems to us a sophistry which is morally particularly damaging. When there are two outcomes of a given action, one good and one bad, the action is justified only if the good outweighs the bad in moral significance; and the moral weights of the two outcomes depend on the outcomes and the overall context, and are quite independent of the doctor's self-

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described intentions.' Ibid., para. 76.

9 Ibid., paras. 242, 243.

10 Thus the Committee make it clear that they use 'intentional' as equivalent to 'intended' or 'with intent to', and not in the weaker sense (equivalent to 'not unintentional(ly)', i.e. not accidentally or mistakenly or unexpectedly) found in some common idiom and some philosophical treatments of these issues.

11 *The Methods of Ethics* ([1874], 7th edn., London, 1907), 202.

12 See Finnis, 'Intention and side-effects' in R. G. Frey and Christopher Morris (eds.), *Liability and Responsibility* (Cambridge University Press, Cambridge, 1991) 32 at 33–35, 45–46; Lord Goff of Chieveley, 'The Mental Element in the Crime of Murder' (1988) 104 Law Quarterly Review 30 at 42–43.

13 House of Lords Paper 21-I of 1993–94, para. 237.

14 See ibid., para. 239.

15 See e.g. Aristotle, *Metaphysics* XII.7: 1072b14–30.

16 Walton Committee, House of Lords Paper 21-I of 1993–94, para. 237.

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Active and Passive Euthanasia
James Rachels

Abstract The traditional distinction between active and passive euthanasia requires critical analysis. The conventional doctrine is that there is such an important moral difference between the two that, although the latter is sometimes permissible, the former is always forbidden. This doctrine may be challenged for several reasons. First of all, active euthanasia is in many cases more humane than passive euthanasia. Secondly, the conventional doctrine leads to decisions concerning life and death on irrelevant grounds. Thirdly, the doctrine rests on a distinction between killing and letting die that itself has no moral importance. Fourthly, the most common arguments in favor of the doctrine are invalid. I therefore suggest that the American Medical Association policy statement that endorses this doctrine is unsound. (N Engl J Med 292:78-80, 1975)

The distinction between active and passive euthanasia is thought to be crucial for medical ethics. The idea is that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient. This doctrine seems to be accepted by most doctors, and it is endorsed in a statement adopted by the House of Delegates of the American Medical Association on December 4, 1973:

> The intentional termination of the life of one human being by another -mercy killing - is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.
> The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.

However, a strong case can be made against this doctrine. In what follows I will set out some of the relevant arguments, and urge doctors to reconsider their views on this matter.

To begin with a familiar type of situation, a patient who is dying of incurable cancer of the throat is in terrible pain, which can no longer be satisfactorily alleviated. He is certain to die within a few days, even if present treatment is continued, but he does not want to go on living for those days since the pain is unbearable. So he asks the doctor for an end to it, and his family joins in the request.

Suppose the doctor agrees to withhold treatment, as the conventional doctrine says he may. The justification for his doing so is that the patient is in terrible agony, and since he is going to die anyway, it would he wrong to prolong his suffering needlessly.

But now notice this. If one imply withholds treatment, it may take the patient longer to die, and so he may suffer more than he would if noire direct action were taken and a lethal injection given. This fact provides strong reason for thinking that, once the initial decision not to prolong his agony has been made active euthanasia is actually preferable to passive euthanasia, rather than the reverse. To say otherwise is to endorse the option that leads to more suffering rather than less, and is contrary to the humanitarian impulse that prompts the decision not to prolong his life in the first place.

Part of my point is that the process of being "allowed to die" can be relatively slow and painful, whereas being given a lethal injection is relatively quick and painless. Let me give a different sort of example. In the United States about one in 600 babies is born with Down's syndrome. Most of these babies are otherwise healthy -that is, with only the usual pediatric care, they will' proceed to an otherwise normal infancy. Some, however, are born with congenital defects such as intestinal obstructions that require operations if they are to live. Sometimes, the parents and the doctor will decide not to operate, and let the infant die. Anthony Shaw describes what happens then:

> ...When surgery is denied (the doctor I must try to keep the infant from suffering while natural forces sap the baby's life away. As a surgeon whose natural inclination is to use the scalpel to fight off death, standing by and watching a salvageable baby die is the most emotionally exhausting experience I know. It is easy at a conference, in a theoretical discussion, to decide that such infants should be allowed to die. It is altogether different to stand by in the nursery and watch as dehydration and infection wither a tiny being over hours and days. This is a terrible ordeal for me and the hospital staff - much more so than for the parents who never set foot in the nursery.

I can understand why some people are opposed to all euthanasia, and insist that such infants must be allowed to live. I think f can also understand why other people favor destroying these babies quickly and painlessly. But why should anyone favor letting "dehydration and infection Hither a tine being over hours and days?" The doctrine that says that a baby may be allowed to dehydrate and wither, but may not for given art injection that would end its life without suffering, seems so patently cruel as to require no further refutation. The strong language is not in. tended to offend, but only to put the point in the clearest possible way.

My second argument is that the conventional doctrine leads to decisions concerning life and death made on irrelevant grounds.

Consider again the case of the infants with Down's syndrome who need operations for congenital defects unrelated to the syndrome to live. Sometimes, there is no operation, and the baby dies, but when there is no such defect, the baby lives on. Now, an operation such as that to remove an intestinal obstruction is not prohibitively difficult. The reason why such operations are not performed in these cases is, clearly, that the child has Down's syndrome and the parents and doctor judge that because of that fact it is better for the child to die.

But notice that this situation is absurd, no matter what view one takes of the lives and potentials of such babies. 1 f the life of such an infant is worth preserving, what does it matter if it needs a simple operation? Or, if one thinks it letter that such a baby should not live on, what difference does it make that it happens to have an unobstructed intestinal tract? In either case, the matter of life and death is being decided on irrelevant grounds. It is the Down's syndrome, and not the intestines, that is the issue. The matter should be decided, if at all, on that basis, and hot be allowed to depend on the essentially irrelevant question of whether the intestinal tract is blocked.

What makes this situation possible, of course, is the idea that when there is an intestinal blockage, one can "let the baby die," but when there is no such defect there is nothing that can be done, for one must not "kill" it. The fact that this idea leads to such results as deciding life or death on irrelevant grounds is another good reason why the doctrine should be rejected.

One reason why so many people think that there is an important moral difference between active and passive euthanasia is that they think killing someone is morally worse than letting someone die. But is it? Is killing, in itself, worse than letting die? To investigate this issue, two cases may be considered that are exactly alike except that one involves killing whereas the other involves letting someone die. Then, it can be asked whether this difference makes any difference to the moral assessments. It is important that the cases be exactly alike, except for this one difference, since otherwise one cannot be confident that it is this difference and not some other that accounts for any variation in the assessments of the two cases. So, let us consider this pair of cases:

In the first, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident.

In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith. Jones sneaks in planning to drown the child in Ills bath. However, just as fie enters the bathroom Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing.

Now Smith killed the child, whereas Jones "merely" let the child die. That is the only difference between them. Did either man behave better, from a moral point of view? If the difference between killing and letting die were in itself a morally important matter, one should say that Jones's behavior was less

reprehensible than Smith's. But does one really want to say that? I think not. In the first place, both men acted from the same motive, personal gain, and both had exactly the same end in view when they acted. I t may be inferred from Smith's conduct that he is a bad man, although that judgment may be withdrawn or modified if certain further facts are learned about him - for example, that he is mentally deranged. But would not the very same thing be inferred about Jones from his conduct? And would not the same further considerations also be relevant to any modification of this judgment? Moreover, suppose Jones pleaded, in his own defense, "After all, I didn't do anything except just stand there and watch the child drown. I didn't kill him; I only let him die." Again, if letting die were in itself less bad than killing, this defense should have at least some weight. But it does not. Such a "defense" can only be regarded as a grotesque perversion of moral reasoning. Morally speaking, it is no defense at all.

Now, it may be pointed out, quite properly, that the cases of euthanasia with which doctors are concerned are not like this at all. They do not involve personal gain or the destruction of normal healthy children. Doctors are concerned only with cases in which the patient's life is of no further use to him, or in which the patient's life has become or will soon become a terrible burden. However, the point is the same in these cases: the bare difference between killing and letting die does not, in itself, make a moral difference. If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. If his decision was wrong - if, for example, the patient's illness was in fact curable -the decision would be equally regrettable no matter which method was used to carry it out. And if the doctor's decision was the right one, the method used is not in itself important.

The AMA policy statement isolates the crucial issue very well; the crucial issue is "the intentional termination of the life of one human being by another." But after identifying this issue, and forbidding "mercy killing," the statement goes on to deny that the cessation of treatment is the intentional termination of a life. This is where the mistake conies in, for what is the cessation of treatment, in these circumstances, if it is not "the intentional termination of the life of one human being by another?" Of course it is exactly that, and if it were not, there would be no point to it.

Many people will find this judgment hard to accept. One reason, I think, is that it is very easy to conflate the question of whether killing is, in it, worse than letting die, with the very different question of whether most actual cases of killing are more reprehensible than most actual cases of letting die. Most actual cases of killing are clearly terrible (think, for example, of all the murders reported in the newspapers), and one hears of such crises every day. On the other hand, one hardly ever hears of a race of letting die, except for the actions of doctors who are motivated by humanitarian reasons. So one learns to think of killing in a much worse light than of

letting die. But this does not mean that there is something about killing that makes it in itself worse than letting die. for it is not the bare difference between killing and letting die that makes the difference in these cases. Rather, the other factors - the murderer's motive of personal gain, for example, contrasted with the doctor's humanitarian motivation -account for different reactions to the different cases.

I have argued that killing is not in itself any worse than letting die; if my contention is right, it follows that active euthanasia is not any worse than passive euthanasia. What arguments can be given on the other side? The most common, I believe, is the following:

"The important difference between active and passive euthanasia is that, in passive euthanasia, the doctor does not do anything to bring about the patient's death. The doctor does nothing, and the patient dies of whatever ills already afflict him. In active euthanasia, however, the doctor does something to bring about the patient's death: he kills him. The doctor who gives the patient with cancer a lethal injection has himself caused his patient's death; whereas if he merely ceases treatment, the cancer is the cause of the death."

A number of points need to be made here. The first is that it is not exactly correct to say that in passive euthanasia the doctor does nothing, for he does do one thing that is very important: he lets the patient die. "Letting someone die" is certainly different, in some respects, from other types of action - mainly in that it is a kind of action that one may perform by way of not performing certain other actions. For example, one may let a patient die by way of not giving medication, just as one may insult someone by way of not shaking his hand. But for any purpose of moral assessment, it is a type of action nonetheless. The decision to let a patient die is subject to moral appraisal in the same way that a decision to kill him would be subject to moral appraisal: it may be assessed as wise or un rise, compassionate or sadistic, right of wrong. If a doctor deliberately let a patient die who was suffering from a routinely curable illness, the doctor would certainly be to blame for what he had done, just as he would be to blame if he had needlessly killed the patient. Charges against him would then be appropriate. If so, it would be no defense at all for him to insist that he didn't "do anything." He would have done something very serious indeed, for he let his patient die.

Fixing the cause of death may be very important from a legal point of view, for it may determine whether criminal charges are brought against the doctor. But I do not think that this notion can be used to show a moral difference between active and passive euthanasia. The reason why it is considered bad to be the cause of someone's death is that death is regarded as a great evil - and so it is. However, if it has been decided that euthanasia - even passive euthanasia - is desirable in a given case, it has also been decided that in this instance death is no greater an evil than the patient's continued existence. And if this is true, the usual reason for not wanting to be the cause of someone's death simply does not apply.

Finally, doctors may think that all of this is only of academic interest - the sort of thing that philosophers may worry about but that has no practical bearing on their own work. After all, doctors must be concerned about the legal consequences of what they do, and active euthanasia is clearly forbidden by the law. But even so, doctors should also be concerned with the fact that the law is forcing upon them a moral doctrine that may well be indefensible, and has a considerable effect on their practices. Of course, most doctors are not now in the position of being coerced in this matter, for they do not regard themselves as merely going along with what the law requires. Rather, in statements such as the AMA policy statement that I have quoted, they are endorsing this doctrine as a central point of medical ethics. In that statement, active euthanasia is condemned not merely as illegal but as "contrary to that for which the medical profession stands," whereas passive euthanasia is approved. However, the preceding considerations suggest that there is really no moral difference between the two, considered in themselves (there may be important moral differences in some cases in their *consequences,* but, as I pointed out, these differences may make active euthanasia, and not passive euthanasia, the morally preferable option). So, whereas doctors may have to discriminate between active and passive euthanasia to satisfy the law, they should not do any more than that. In particular, they should not give the distinction any added authority and weight by writing it into official statements of medical ethics.

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