

Taking Life: Humans

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In dealing with an objection to the view of abortion presented in Chapter 6, we have already looked beyond abortion to infanticide. In so doing we will have confirmed the suspicion of supporters of the sanctity of human life that once abortion is accepted, euthanasia lurks around the next comer - and for them, euthanasia is an unequivocal evil. It has, they point out, been rejected by doctors since the fifth century B.C., when physicians first took the Oath of Hippocrates and swore 'to give no deadly medicine to anyone if asked, nor suggest any such counsel'. Moreover, they argue, the Nazi extermination programme is a recent and terrible example of what can happen once we give the state the power to MI innocent human beings.

I do not deny that if one accepts abortion on the grounds provided in Chapter 6, the case for killing other human beings, in certain circumstances, is strong. As I shall try to show in this chapter, however, this is not something to be regarded with horror, and the use of the Nazi analogy is utterly misleading. On the contrary, once we abandon those doctrines about the sanctity of human life that - as we saw in Chapter 4 - collapse as soon as they are questioned, it is the refusal to accept killing that, in some cases, is horrific.

'Euthanasia' means, according to the dictionary, 'a gentle and easy death', but it is now used to refer to the killing of those who are incurably ill and in great pain or distress, for the sake of those killed, and in order to spare them further suffering or distress. This is the main topic of this chapter. I shall also consider, however, some cases in which, though killing is not contrary to the wishes of the human who is killed, it is also not carried out specifically for the sake of that being. As we shall see, some cases involving newborn infants fall into this category. Such cases may not be 'euthanasia' within the strict meaning of the term, but they can usefully be included within the same general discussion, as long as we are clear about the relevant differences.

Within the usual definition of euthanasia there are three different types, each of which raises distinctive ethical issues. It will help our discussion if we begin by setting out this threefold distinction and then assess the justifiability of each type.

TYPES OF EUTHANASIA

Voluntary Euthanasia

Most of the groups currently campaigning for changes in the law to allow euthanasia are campaigning for voluntary euthanasia - that is, euthanasia carried out at the request of the person killed.

Sometimes voluntary euthanasia is scarcely distinguishable from assisted suicide. In Jean's Way, Derek Humphry has told how his wife Jean, when dying of cancer, asked him to provide her with the means to end her life swiftly and without pain. They had seen the situation coming and discussed it beforehand. Derek obtained some tablets and gave them to Jean, who took them and died soon afterwards.

Dr Jack Kevorkian, a Michigan pathologist, went one step further when he built a 'suicide machine' to help terminally ill people commit suicide. His machine consisted of a metal pole with three different

bottles attached to a tube of the kind used to provide an intravenous drip. The doctor inserts the tube in the patient's vein, but at this stage only a harmless saline solution can pass through it. The patient may then flip a switch, which will allow a coma-inducing drug to come through the tube; this is automatically followed by a lethal drug contained in the third bottle. Dr Kevorkian announced that he was prepared to make the machine available to any terminally ill patient who wished to use it. (Assisting suicide is not against the law in Michigan.) In June 1990, Janet Adkins, who was suffering from Alzheimer's disease, but still competent to make the decision to end her life, contacted Dr Kevorkian and told him of her wish to die, rather than go through the slow and progressive deterioration that the disease involves. Dr Kevorkian was in attendance while she made use of his machine, and then reported Janet Adkins's death to the police. He was subsequently charged with murder, but the judge refused to allow the charge to proceed to trial, on the grounds that Janet Adkins had caused her own death. The following year Dr Kevorkian made his device available to two other people, who used it in order to end their lives.

In other cases, people wanting to die may be unable to kill themselves. In 1973 George Zygmanski was injured in a motorcycle accident near his home in New Jersey. He was taken to hospital, where he was found to be totally paralysed from the neck down. He was also in considerable pain. He told his doctor and his brother, Lester, that he did not want to live in this condition. He begged them both to kill him. Lester questioned the doctor and hospital staff about George's prospects of recovery: he was told that they were nil. He then smuggled a gun into the hospital, and said to his brother: 'I am here to end your pain, George. Is it all right with you?' George, who was now unable to speak because of an operation to assist his breathing, nodded affirmatively. Lester shot him through the temple.

The Zygmanski case appears to be a clear instance of voluntary euthanasia, although without some of the procedural safeguards that advocates of the legalisation of voluntary euthanasia propose. For instance, medical opinions about the patient's prospects of recovery were obtained only in an informal manner. Nor was there a careful attempt to establish, before independent witnesses, that George's desire for death was of a fixed and rational kind, based on the best available information about his situation. The killing was not carried out by a doctor. An injection would have been less distressing to others than shooting. But these choices were not open to Lester Zygmanski, for the law in New Jersey, as in most other places, regards mercy killing as murder, and if he had made his plans known, he would not have been able to carry them out.

Euthanasia can be voluntary even if a person is not able, as Jean Humphry, Janet Adkins, and George Zygmanski were able, to indicate the wish to die right up to the moment the tablets are swallowed, the switch thrown, or the trigger pulled. A person may, while in good health, make a written request for euthanasia if, through accident or illness, she should come to be incapable of making or expressing a decision to die, in pain, or without the use of her mental faculties, and there is no reasonable hope of recovery. In killing a person who has made such a request, who has re-affirmed it from time to time, and who is now in one of the states described, one could truly claim to be acting with her consent.

There is now one country in which doctors can openly help their patients to die in a peaceful and dignified way. In the Netherlands, a series of court cases during the 1980s upheld a doctor's right to assist a patient to die, even if that assistance amounted to giving the patient a lethal injection. Doctors in the Netherlands who comply with certain guidelines (which will be described later in this chapter) can now quite openly carry out euthanasia and can report this on the death certificate without fear of prosecution. It has been estimated that about 2,300 deaths each year result from euthanasia carried out in this way.

Involuntary Euthanasia

I shall regard euthanasia as involuntary when the person killed is capable of consenting to her own death, but does not do so, either because she is not asked, or because she is asked and chooses to go on living. Admittedly this definition lumps two different cases under one heading. There is a significant difference between killing someone who chooses to go on living and killing someone who has not consented to being killed, but if asked, would have consented. In practice, though, it is hard to imagine cases in which a person is capable of consenting and would have consented if asked, but was not asked. For why not ask? Only in the most bizarre situations could one conceive of a reason for not obtaining the consent of a person both able and willing to consent.

Killing someone who has not consented to being killed can properly be regarded as euthanasia only when the motive for killing is the desire to prevent unbearable suffering on the part of the person killed. It is, of course, odd that anyone acting from this motive should disregard the wishes of the person for whose sake the action is done. Genuine cases of involuntary euthanasia appear to be very rare.

Non-voluntary Euthanasia

These two definitions leave room for a third kind of euthanasia. If a human being is not capable of understanding the choice between life and death, euthanasia would be neither voluntary nor involuntary, but non-voluntary. Those unable to give consent would include incurably ill or severely disabled infants, and people who through accident, illness, or old age have permanently lost the capacity to understand the issue involved, without having previously requested or rejected euthanasia in these circumstances.

Several cases of non-voluntary euthanasia have reached the courts and the popular press. Here is one example. Louis Repouille had a son who was described as 'incurably imbecile', had been bed-ridden since infancy and blind for five years. According to Repouille: 'He was just like dead all the time.... He couldn't walk, he couldn't talk, he couldn't do anything.' in the end Repouille killed his son with chloroform.

In 1988 a case arose that well illustrates the way in which modern medical technology forces us to make life and death decisions. Samuel Linares, an infant, swallowed a small object that stuck in his windpipe, causing a loss of oxygen to the brain. He was admitted to a Chicago hospital in a coma and placed on a respirator. Eight months later he was still comatose, still on the respirator, and the hospital was planning to move Samuel to a long-term care unit. Shortly before the move, Samuel's parents visited him in the hospital. His mother left the room, while his father produced a pistol and told the nurse to keep away. He then disconnected Samuel from the respirator, and cradled the baby in his arms until he died. When he was sure Samuel was dead, he gave up his pistol and surrendered to police. He was charged with murder, but the grand jury refused to issue a homicide indictment, and he subsequently received a suspended sentence on a minor charge arising from the use of the pistol. Obviously, such cases raise different issues from those raised by voluntary euthanasia. There is no desire to die on the part of the infant. It may also be questioned whether, in such cases, the death is carried out for the sake of the infant, or for the sake of the family as a whole. If Louis Repouille's son was 'just like dead all the time', then he may have been so profoundly brain-damaged that he was not capable of suffering at all. That is also likely to have been true of the comatose Samuel Linares. In that case, while caring for him would have been a great and no doubt futile burden for the family, and in the Linares case, a drain on the state's limited medical resources as well, the infants were not suffering, and death could not be said to be in, or contrary to, their interests. It is therefore not euthanasia, strictly

speaking, as I have defined the term. it might nevertheless be a justifiable ending of a human life.

Since cases of infanticide and non-voluntary euthanasia are the kind of case most nearly akin to our previous discussions of the status of animals and the human fetus, we shall consider them first.

JUSTIFYING INFANTICIDE AND NON-VOLUNTARY EUTHANASIA

As we have seen, euthanasia is non-voluntary when the subject has never had the capacity to choose to live or die. This is the situation of the severely disabled infant or the older human being who has been profoundly intellectually disabled since birth. Euthanasia or other forms of killing are also non-voluntary when the subject is not now but once was capable of making the crucial choice, and did not then express any preference relevant to her present condition.

The case of someone who has never been capable of choosing to live or die is a little more straightforward than that of a person who had, but has now lost, the capacity to make such a decision. We shall, once again, separate the two cases and take the more straightforward one first. For simplicity, I shall concentrate on infants, although everything I say about them would apply to older children or adults whose mental age is and has always been that of an infant.

Life and Death Decisions for Disabled Infants

If we were to approach the issue of life or death for a seriously disabled human infant without any prior discussion of the ethics of killing in general, we might be unable to resolve the conflict between the widely accepted obligation to protect the sanctity of human life, and the goal of reducing suffering. Some say that such decisions are 'subjective', or that life and death questions must be left to God and Nature. Our previous discussions have, however, prepared the ground, and the principles established and applied in the preceding three chapters make the issue much less baffling than most take it to be.

In Chapter 4 we saw that the fact that a being is a human being, in the sense of a member of the species *Homo sapiens*, is not relevant to the wrongness of killing it; it is, rather, characteristics like rationality, autonomy, and self-consciousness that make a difference. Infants lack these characteristics. Killing them, therefore, cannot be equated with killing normal human beings, or any other self-conscious beings. This conclusion is not limited to infants who, because of irreversible intellectual disabilities, will never be rational, self-conscious beings. We saw in our discussion of abortion that the potential of a fetus to become a rational, self-conscious being cannot count against killing it at a stage when it lacks these characteristics - not, that is, unless we are also prepared to count the value of rational self-conscious life as a reason against contraception and celibacy. No infant - disabled or not - has as strong a claim to life as beings capable of seeing themselves as distinct entities, existing over time.

The difference between killing disabled and normal infants lies not in any supposed right to life that the latter has and the former lacks, but in other considerations about killing. Most obviously there is the difference that often exists in the attitudes of the parents. The birth of a child is usually a happy event for the parents. They have, nowadays, often planned for the child. The mother has carried it for nine months. From birth, a natural affection begins to bind the parents to it. So one important reason why it is normally a terrible thing to kill an infant is the effect the killing will have on its parents.

It is different when the infant is born with a serious disability. Birth abnormalities vary, of course. Some are trivial and have little effect on the child or its parents; but others turn the normally joyful event of birth into a threat to the happiness of the parents, and any other children they may have.

Parents may, with good reason, regret that a disabled child was ever born. In that event the effect that the death of the child will have on its parents can be a reason for, rather than against killing it. Some parents want even the most gravely disabled infant to live as long as possible, and this desire would then be a reason against killing the infant. But what if this is not the case? in the discussion that follows I shall assume that the parents do not want the disabled child to live. I shall also assume that the disability is so serious that - again in contrast to the situation of an unwanted but normal child today - there are no other couples keen to adopt the infant. This is a realistic assumption even in a society in which there is a long waiting- list of couples wishing to adopt normal babies. It is true that from time to time cases of infants who are severely disabled and are being allowed to die have reached the courts in a glare of publicity, and this has led to couples offering to adopt the child. Unfortunately such offers are the product of the highly publicised dramatic life-and-death situation, and do not extend to the less publicised but far more common situations in which parents feel themselves unable to look after a severely disabled child, and the child then languishes in an institution.

Infants are sentient beings who are neither rational nor self- conscious. So if we turn to consider the infants in themselves, independently of the attitudes of their parents, since their species is not relevant to their moral status, the principles that govern the wrongness of killing non-human animals who are sentient but not rational or self-conscious must apply here too. As we saw, the most plausible arguments for attributing a right to life to a being apply only if there is some awareness of oneself as a being existing over time, or as a continuing mental self. Nor can respect for autonomy apply where there is no capacity for autonomy. The remaining principles identified in Chapter 4 are utilitarian. Hence the quality of life that the infant can be expected to have is important.

One relatively common birth disability is a faulty development of the spine known as spina bifida. Its prevalence, varies in different countries, but it can affect as many as one in five hundred live births. In the more severe cases, the child will be permanently paralysed from the waistdown and lack control of bowels or bladder. Often excess fluid accumulates in the brain, a condition known as hydrocephalus, which can result in intellectual disabilities. Though some forms of treatment exist, if the child is badly affected at birth, the paralysis, incontinence, and intellectual disability cannot be overcome.

Some doctors closely connected with children suffering from severe spina bifida believe that the lives of the worst affected children are so miserable that it is wrong to resort to surgery to keep them alive. Published descriptions of the lives of these children support the judgment that these worst affected children will have lives filled with pain and discomfort. They need repeated major surgery to prevent curvature of the spine, due to the paralysis, and to correct other abnormalities. Some children with spina bifida have had forty major operations before they reach their teenage years.

When the life of an infant will be so miserable as not to be worth living, from the internal perspective of the being who will lead that life, both the 'prior existence' and the 'total' version of utilitarianism entail that, if there are no 'extrinsic' reasons for keeping the infant alive - like the feelings of the parents - it is better that the child should be helped to die without further suffering. A more difficult problem arises - and the convergence between the two views ends - when we consider disabilities that make the child's life prospects significantly less promising than those of a normal child, but not so bleak as to make the child's life not worth living. Haemophilia is probably in this category. The haemophiliac lacks the element in normal blood that makes it clot and thus risks prolonged bleeding, especially internal bleeding, from the slightest injury. If allowed to continue, this bleeding leads to permanent crippling and eventually death. The bleeding is very painful and although improved treatments have eliminated the need for constant blood transfusions, haemophiliacs still have to spend a lot of time in hospital.

They are unable to play most sports and live constantly on the edge of crisis. Nevertheless, haemophiliacs do not appear to spend their time wondering whether to end it all; most find life definitely worth living, despite the difficulties they face.

Given these facts, suppose that a newborn baby is diagnosed as a haemophiliac. The parents, daunted by the prospect of bringing up a child with this condition, are not anxious for him to live. Could euthanasia be defended here? Our first reaction may well be a firm 'no', for the infant can be expected to have a life that is worth living, even if not quite as good as that of a normal baby. The 'prior existence' version of utilitarianism supports this judgment. The infant exists. His life can be expected to contain a positive balance of happiness over misery. To kill him would deprive him of this positive balance of happiness. Therefore it would be wrong.

On the 'total' version of utilitarianism, however, we cannot reach a decision on the basis of this information alone. The total view makes it necessary to ask whether the death of the haemophiliac infant would lead to the creation of another being who would not otherwise have existed. In other words, if the haemophiliac child is killed, will his parents have another child whom they would not have if the haemophiliac child lives? If they would, is the second child likely to have a better life than the one killed?

Often it will be possible to answer both these questions affirmatively. A woman may plan to have two children. If one dies while she is of child-bearing age, she may conceive another in its place. Suppose a woman planning to have two children has one normal child, and then gives birth to a haemophiliac child. The burden of caring for that child may make it impossible for her to cope with a third child; but if the disabled child were to die, she would have another. It is also plausible to suppose that the prospects of a happy life are better for a normal child than for a haemophiliac.

When the death of a disabled infant will lead to the birth of another infant with better prospects of a happy life, the total amount of happiness will be greater if the disabled infant is killed. The loss of happy life for the first infant is outweighed by the gain of a happier life for the second. Therefore, if killing the haemophiliac infant has no adverse effect on others, it would, according to the total view, be right to kill him.

The total view treats infants as replaceable, in much the same way as it treats non-self-conscious animals (as we saw in Chapter 5). Many will think that the replaceability argument cannot be applied to human infants. The direct killing of even the most hopelessly disabled infant is still officially regarded as murder; how then could the killing of infants with far less serious problems, like haemophilia, be accepted? Yet on further reflection, the implications of the replaceability argument do not seem quite so bizarre. For there are disabled members of our species whom we now deal with exactly as the argument suggests we should. These cases closely resemble the ones we have been discussing. There is only one difference, and that is a difference of timing - the timing of the discovery of the problem, and the consequent killing of the disabled being.

Prenatal diagnosis is now a routine procedure for pregnant women. There are various medical techniques for obtaining information about the fetus during the early months of pregnancy. At one stage in the development of these procedures, it was possible to discover the sex of the fetus, but not whether the fetus would suffer from haemophilia. Haemophilia is a sex-linked genetic defect, from which only males suffer; females can carry the gene and pass it on to their male offspring without themselves being affected. So a woman who knew that she carried the gene for haemophilia could, at that stage, avoid giving birth to a haemophiliac child only by finding out the sex of the fetus, and aborting all males

fetuses. Statistically, only half of these male children of women who carried the defective gene would have suffered from haemophilia, but there was then no way to find out to which half a particular fetus belonged. Therefore twice as many fetuses were being killed as necessary, in order to avoid the birth of children with haemophilia. This practice was widespread in many countries, and yet did not cause any great outcry. Now that we have techniques for identifying haemophilia before birth, we can be more selective, but the principle is the same: women are offered, and usually accept, abortions in order to avoid giving birth to children with haemophilia.

The same can be said about some other conditions that can be detected before birth. Down's syndrome, formerly known as mongolism, is one of these. Children with this condition have intellectual disabilities and most will never be able to live independently, but their lives, like those of small children, can be joyful. The risk of having a Down's syndrome child increases sharply with the age of the mother, and for this reason prenatal diagnosis is routinely offered to pregnant women over 35. Again, undergoing the procedure implies that if the test for Down's syndrome is positive, the woman will consider aborting the fetus and, if she still wishes to have another child, will start another pregnancy, which has a good chance of being normal.

Prenatal diagnosis, followed by abortion in selected cases, is common practice in countries with liberal abortion laws and advanced medical techniques. I think this is as it should be. As the arguments of Chapter 6 indicate, I believe that abortion can be justified. Note, however, that neither haemophilia nor Down's syndrome is so crippling as to make life not worth living, from the inner perspective of the person with the condition. To abort a fetus with one of these disabilities, intending to have another child who will not be disabled, is to treat fetuses as interchangeable or replaceable. If the mother has previously decided to have a certain number of children, say two, then what she is doing, in effect, is rejecting one potential child in favour of another. She could, in defence of her actions, say: the loss of life of the aborted fetus is outweighed by the gain of a better life for the normal child who will be conceived only if the disabled one dies.

When death occurs before birth, replaceability does not conflict with generally accepted moral convictions. That a fetus is known to be disabled is widely accepted as a ground for abortion. Yet in discussing abortion, we saw that birth does not mark a morally significant dividing line. I cannot see how one could defend the view that fetuses may be 'replaced' before birth, but newborn infants may not be. Nor is there any other point, such as viability, that does a better job of dividing the fetus from the infant. Self-consciousness, which could provide a basis for holding that it is wrong to kill one being and replace it with another, is not to be found in either the fetus or the newborn infant. Neither the fetus nor the newborn infant is an individual capable of regarding itself as a distinct entity with a life of its own to lead, and it is only for newborn infants, or for still earlier stages of human life, that replaceability should be considered to be an ethically acceptable option.

It may still be objected that to replace either a fetus or a newborn infant is wrong because it suggests to disabled people living today that their lives are less worth living than the lives of people who are not disabled. Yet it is surely flying in the face of reality to deny that, on average, this is so. That is the only way to make sense of actions that we all take for granted. Recall thalidomide: this drug, when taken by pregnant women, caused many children to be born without arms or legs. Once the cause of the abnormal births was discovered, the drug was taken off the market, and the company responsible had to pay compensation. If we really believed that there is no reason to think of the life of a disabled person as likely to be any worse than that of a normal person, we would not have regarded this as a tragedy. No compensation would have been sought, or awarded by the courts. The children would merely have been 'different'. We could even have left the drug on the market, so that women who found it a useful

sleeping pill during pregnancy could continue to take it. If this sounds grotesque, that is only because we are all in no doubt at all that it is better to be born with limbs than without them. To believe this involves no disrespect at all for those who are lacking limbs; it simply recognises the reality of the difficulties they face.

In any case, the position taken here does not imply that it would be better that no people born with severe disabilities should survive; it implies only that the parents of such infants should be able to make this decision. Nor does this imply lack of respect or equal consideration for people with disabilities who are now living their own lives in accordance with their own wishes. As we saw at the end of Chapter 2, the principle of equal consideration of interests rejects any discounting of the interests of people on grounds of disability.

Even those who reject abortion and the idea that the fetus is replaceable are likely to regard possible people as replaceable. Recall the second woman in Parfit's case of the two women, described in Chapter 5. She was told by her doctor that if she went ahead with her plan to become pregnant immediately, her child would have a disability (it could have been haemophilia); but if she waited three months her child would not have the disability. If we think she would do wrong not to wait, it can only be because we are comparing the two possible lives and judging one to have better prospects than the other. Of course, at this stage no life has begun; but the question is, when does a life, in the morally significant sense, really begin? in Chapters 4 and 5 we saw several reasons for saying that life only begins in the morally significant sense when there is awareness of one's existence over time. The metaphor of life as a journey also provides a reason for holding that in infancy, life's voyage has scarcely begun.

Regarding newborn infants as replaceable, as we now regard fetuses, would have considerable advantages over prenatal diagnosis followed by abortion. Prenatal diagnosis still cannot detect all major disabilities. Some disabilities, in fact, are not present before birth; they may be the result of extremely pre- mature birth, or of something going wrong in the birth process itself. At present parents can choose to keep or destroy their disabled offspring only if the disability happens to be detected during pregnancy. There is no logical basis for restricting parents' choice to these particular disabilities. If disabled newborn infants were not regarded as having a right to life until, say, a week or a month after birth it would allow parents, in consultation with their doctors, to choose on the basis of far greater knowledge of the infant's condition than is possible before birth.

All these remarks have been concerned with the wrongness of ending the life of the infant, considered in itself rather than for its effects on others. When we take effects on others into account, the picture may alter. Obviously, to go through the whole of pregnancy and labour, only to give birth to a child who one decides should not live, would be a difficult, perhaps heartbreaking, experience. For this reason many women would prefer prenatal diagnosis and abortion rather than live birth with the possibility of infanticide; but if the latter is not morally worse than the former, this would seem to be a choice that the woman herself should be allowed to make.

Another factor to take into account is the possibility of adoption. When there are more couples wishing to adopt than normal children available for adoption, a childless couple may be prepared to adopt a haemophiliac. This would relieve the mother of the burden of bringing up a haemophiliac child, and enable her to have another child, if she wished. Then the replaceability argument could not justify infanticide, for bringing the other child into existence would not be dependent on the death of the haemophiliac. The death of the haemophiliac would then be a straightforward loss of a life of positive quality, not outweighed by the creation of another being with a better life.

So the issue of ending life for disabled newborn infants is not without complications, which we do not have the space to discuss adequately. Nevertheless the main point is clear: killing a disabled infant is not morally equivalent to killing a person. Very often it is not wrong at all.

Other Non-voluntary Life and Death Decisions

In the preceding section we discussed justifiable killing for beings who have never been capable of choosing to live or die. Ending a life without consent may also be considered in the case of those who were once persons capable of choosing to live or die, but now, through accident or old age, have permanently lost this capacity, and did not, prior to losing it, express any views about whether they wished to go on living in such circumstances. These cases are not rare. Many hospitals care for motor accident victims whose brains have been damaged beyond all possible recovery. They may survive, in a coma, or perhaps barely conscious, for several years. In 1991, the *Lancet* reported that Rita Greene, a nurse, had been a patient at D.C. General Hospital in Washington for thirty-nine years without knowing it. Now aged sixty-three, she had been in a vegetative state since undergoing open heart surgery in 1952. The report stated that at any given time, between 5,000 and 10,000 Americans are surviving in a vegetative state. In other developed countries, where life-prolonging technology is not used so aggressively, there are far fewer long-term patients in this condition.

In most respects, these human beings do not differ importantly from disabled infants. They are not self-conscious, rational, or autonomous, and so considerations of a right to life or of respecting autonomy do not apply. If they have no experiences at all, and can never have any again, their lives have no intrinsic value. Their life's journey has come to an end. They are biologically alive, but not biographically. (If this verdict seems harsh, ask yourself whether there is anything to choose between the following options: (a) instant death or (b) instant coma, followed by death, without recovery, in ten years' time. I can see no advantage in survival in a comatose state, if death without recovery is certain.) The lives of those who are not in a coma and are conscious but not self-conscious have value if such beings experience more pleasure than pain, or have preferences that can be satisfied; but it is difficult to see the point of keeping such human beings alive if their life is, on the whole, miserable.

There is one important respect in which these cases differ from disabled infants. In discussing infanticide in the final section of Chapter 6, I cited Bentham's comment that infanticide need not 'give the slightest inquietude to the most timid imagination'. This is because those old enough to be aware of the killing of disabled infants are necessarily outside the scope of the policy. This cannot be said of euthanasia applied to those who once were rational and self-conscious. So a possible objection to this form of euthanasia would be that it will lead to insecurity and fear among those who are not now, but might come to be, within its scope. For instance, elderly people, knowing that non-voluntary euthanasia is sometimes applied to senile elderly patients, bedridden, suffering, and lacking the capacity to accept or reject death, might fear that every injection or tablet will be lethal. This fear might be quite irrational, but it would be difficult to convince people of this, particularly if old age really had affected their memory or powers of reasoning.

This objection might be met by a procedure allowing those who do not wish to be subjected to non-voluntary euthanasia under any circumstances to register their refusal. Perhaps this would suffice; but perhaps it would not provide enough reassurance. If not, non-voluntary euthanasia would be justifiable only for those never capable of choosing to live or die.

JUSTIFYING VOLUNTARY EUTHANASIA

Under existing laws in most countries, people suffering unrelievable pain or distress from an incurable illness who beg their doctors to end their lives are asking their doctors to risk a murder charge. Although juries are extremely reluctant to convict in cases of this kind the law is clear that neither the request, nor the degree of suffering, nor the incurable condition of the person killed, is a defence to a charge of murder. Advocates of voluntary euthanasia propose that this law be changed so that a doctor could legally act on a patient's desire to die without further suffering. Doctors have been able to do this quite openly in the Netherlands, as a result of a series of court decisions during the 1980s, as long as they comply with certain conditions. In Germany, doctors may provide a patient with the means to end her life, but they may not administer the substance to her.

The case for voluntary euthanasia has some common ground with the case for non-voluntary euthanasia, in that death is a benefit for the one killed. The two kinds of euthanasia differ, however, in that voluntary euthanasia involves the killing of a person, a rational and self-conscious being and not a merely conscious being. (To be strictly accurate it must be said that this is not always so, because although only rational and self-conscious beings can consent to their own deaths, they may not be rational and self-conscious at the time euthanasia is contemplated - the doctor may, for instance, be acting on a prior written request for euthanasia if, through accident or illness, one's rational faculties should be irretrievably lost. For simplicity we shall, henceforth, disregard this complication.)

We have seen that it is possible to justify ending the life of a human being who lacks the capacity to consent. We must now ask in what way the ethical issues are different when the being is capable of consenting, and does in fact consent.

Let us return to the general principles about killing proposed in Chapter 4. I argued there that killing a self-conscious being is a more serious matter than killing a merely conscious being. I gave four distinct grounds on which this could be argued:

1. The classical utilitarian claim that since self-conscious beings are capable of fearing their own death, killing them has worse effects on others.
2. The preference utilitarian calculation that counts the thwarting of the victim's desire to go on living as an important reason against killing.
3. A theory of rights according to which to have a right one must have the ability to desire that to which one has a right, so that to have a right to life one must be able to desire one's own continued existence.
4. Respect for the autonomous decisions of rational agents.

Now suppose we have a situation in which a person suffering from a painful and incurable disease wishes to die. If the individual were not a person - not rational or self-conscious - euthanasia would, as I have said, be justifiable. Do any of the four grounds for holding that it is normally worse to kill a person provide reasons against killing when the individual is a person who wants to die?

The classical utilitarian objection does not apply to killing that takes place only with the genuine consent of the person killed. That people are killed under these conditions would have no tendency to spread fear or insecurity, since we have no cause to be fearful of being killed with our own genuine consent. If we do not wish to be killed, we simply do not consent. In fact, the argument from fear points in favour of voluntary euthanasia, for if voluntary euthanasia is not permitted we may, with good cause, be fearful that our deaths will be unnecessarily drawn out and distressing. In the Netherlands, a nationwide study commissioned by the government found that 'Many patients want an assurance that their doctor will assist them to die should suffering become unbearable.' Often, having received this assurance, no persistent request for euthanasia eventuated. The availability of euthanasia brought

comfort without euthanasia having to be provided.

Preference utilitarianism also points in favour of, not against, voluntary euthanasia. Just as preference utilitarianism must count a desire to go on living as a reason against killing, so it must count a desire to die as a reason for killing.

Next, according to the theory of rights we have considered, it is an essential feature of a right that one can waive one's rights if one so chooses. I may have a right to privacy; but I can, if I wish, film every detail of my daily life and invite the neighbours to my home movies. Neighbours sufficiently intrigued to accept my invitation could do so without violating my right to privacy, since the right has on this occasion been waived. Similarly, to say that I have a right to life is not to say that it would be wrong for my doctor to end my life, if she does so at my request. In making this request I waive my right to life.

Lastly, the principle of respect for autonomy tells us to allow rational agents to live their own lives according to their own autonomous decisions, free from coercion or interference; but if rational agents should autonomously choose to die, then respect for autonomy will lead us to assist them to do as they choose.

So, although there are reasons for thinking that killing a self-conscious being is normally worse than killing any other kind of being, in the special case of voluntary euthanasia most of these reasons count for euthanasia rather than against. Surprising as this result might at first seem, it really does no more than reflect the fact that what is special about self-conscious beings is that they can know that they exist over time and will, unless they die, continue to exist. Normally this continued existence is fervently desired; when the foreseeable continued existence is dreaded rather than desired however, the desire to die may take the place of the normal desire to live, reversing the reasons against killing based on the desire to live. Thus the case for voluntary euthanasia is arguably much stronger than the case for non-voluntary euthanasia.

Some opponents of the legalisation of voluntary euthanasia might concede that all this follows, if we have a genuinely free and rational decision to die: but, they add, we can never be sure that a request to be killed is the result of a free and rational decision. Will not the sick and elderly be pressured by their relatives to end their lives quickly? Will it not be possible to commit outright murder by pretending that a person has requested euthanasia? And even if there is no pressure of falsification, can anyone who is ill, suffering pain, and very probably in a drugged and confused state of mind, make a rational decision about whether to live or die?

These questions raise technical difficulties for the legalisation of voluntary euthanasia, rather than objections to the underlying ethical principles; but they are serious difficulties nonetheless. The guidelines developed by the courts in the Netherlands have sought to meet them by proposing that euthanasia is acceptable only if

It is carried out by a physician.

The patient has explicitly requested euthanasia in a manner that leaves no doubt of the patient's desire to die.

The patient's decision is well-informed, free, and durable.

The patient has an irreversible condition causing protracted physical or mental suffering that the patient finds unbearable.

There is no reasonable alternative (reasonable from the patient's point of view) to alleviate the patient's suffering.

The doctor has consulted another independent professional who agrees with his or her judgment. 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.

It is often said, in debates about euthanasia, that doctors can be mistaken. In rare instances patients diagnosed by two competent doctors as suffering from an incurable condition have survived and enjoyed years of good health. Possibly the legalisation of voluntary euthanasia would, over the years, mean the deaths of a few people who would otherwise have recovered from their immediate illness and lived for some extra years. This is not, however, the knockdown argument against euthanasia that some imagine it to be. Against a very small number of unnecessary deaths that might occur if euthanasia is legalised we must place the very large amount of pain and distress that will be suffered if euthanasia is not legalised, by patients who really are terminally ill. Longer life is not such a supreme good that it outweighs all other considerations. (if it were, there would be many more effective ways of saving life - such as a ban on smoking, or a reduction of speed limits to 40 kilometres per hour - than prohibiting voluntary euthanasia.) The possibility that two doctors may make a mistake means that the person who opts for euthanasia is deciding on the balance of probabilities and giving up a very slight chance of survival in order to avoid suffering that will almost certainly end in death. This may be a perfectly rational choice. Probability is the guide of life, and of death, too. Against this, some will reply that improved care for the terminally ill has eliminated pain and made voluntary euthanasia unnecessary. Elisabeth Kubler-Ross, whose *On Death and Dying* is perhaps the best-known book on care for the dying, has claimed that none of her patients request euthanasia. Given personal attention and the right medication, she says, people come to accept their deaths and die peacefully without pain.

Kubler-Ross may be right. It may be possible, now, to eliminate pain. In almost all cases, it may even be possible to do it in a way that leaves patients in possession of their rational faculties and free from vomiting, nausea, or other distressing side-effects. Unfortunately only a minority of dying patients now receive this kind of care. Nor is physical pain the only problem. There can also be other distressing conditions, like bones so fragile they fracture at sudden movements, uncontrollable nausea and vomiting, slow starvation due to a cancerous growth, inability to control one's bowels or bladder, difficulty in breathing, and so on.

Dr Timothy Quill, a doctor from Rochester, New York, has described how he prescribed barbiturate sleeping pills for 'Diane', a patient with a severe form of leukaemia, knowing that she wanted the tablets in order to be able to end her life. Dr Quill had known Diane for many years, and admired her courage in dealing with previous serious illnesses. In an article in the *New England Journal of Medicine*, Dr Quill wrote:

It was extraordinarily important to Diane to maintain control of herself and her own dignity during the time remaining to her. When this was no longer possible, she clearly wanted to die. As a former director of a hospice program, I know how to use pain medicines to keep patients comfortable and lessen suffering. I explained the philosophy of comfort care, which I strongly believe in. Although Diane understood and appreciated this, she had known of people lingering in what was called relative comfort, and she wanted no part of it. When the time came, she wanted to take her life in the least painful way possible. Knowing of her desire for independence and her decision to stay in control, I thought this request made perfect sense.... In our discussion it became clear that preoccupation with her fear of a lingering death would interfere with Diane's getting the most out of the time she had left until she found a safe way to ensure her death.

Not all dying patients who wish to die are fortunate enough to have a doctor like Timothy Quill. Betty Rollin has described, in her moving book *Last Wish*, how her mother developed ovarian cancer that spread to other parts of her body. One morning her mother said to her:

I've had a wonderful life, but now it's over, or it should be. I'm not afraid to die, but I am afraid of this illness, what it's doing to me.... There's never any relief from it now. Nothing but nausea and this pain.... There won't be any more chemotherapy. There's no treatment anymore. So what happens to me now? I know what happens. I'll die slowly I don't want that Who does it benefit if I die slowly? if it benefits my children I'd be willing. But it's not going to do you any good There's no point in a slow death, none. I've never liked doing things with no point. I've got to end this.

Betty Rollin found it very difficult to help her mother to carry out her desire: 'Physician after physician turned down our pleas for help (How many pills? What kind?).' After her book about her mother's death was published, she received hundreds of letters, many from people, or close relatives of people, who had tried to die, failed, and suffered even more. Many of these people were denied help from doctors, because although suicide is legal in most jurisdictions, assisted suicide is not.

Perhaps one day it will be possible to treat all terminally ill and incurable patients in such a way that no one requests euthanasia and the subject becomes a non-issue; but this is now just a utopian ideal, and no reason at all to deny euthanasia to those who must live and die in far less comfortable conditions. It is, in any case, highly paternalistic to tell dying patients that they are now so well looked after that they need not be offered the option of euthanasia. It would be more in keeping with respect for individual freedom and autonomy to legalise euthanasia and let patients decide whether their situation is bearable.

Do these arguments for voluntary euthanasia perhaps give too much weight to individual freedom and autonomy? After all, we do not allow people free choices on matters like, for instance, the taking of heroin. This is a restriction of freedom but, in the view of many, one that can be justified on paternalistic grounds. If preventing people from becoming heroin addicts is justifiable paternalism, why isn't preventing people from having themselves killed?

The question is a reasonable one, because respect for individual freedom can be carded too far. John Stuart Mill thought that the state should never interfere with the individual except to prevent harm to others. The individual's own good, Mill thought, is not a proper reason for state intervention. But Mill may have had too high an opinion of the rationality of a human being. It may occasionally be right to prevent people from making choices that are obviously not rationally based and that we can be sure they will later regret. The prohibition of voluntary euthanasia cannot be justified on paternalistic grounds, how- ever, for voluntary euthanasia is an act for which good reasons exist. Voluntary euthanasia occurs only when, to the best of medical knowledge, a person is suffering from an incurable and painful or extremely distressing condition. In these circumstances one cannot say that to choose to die quickly is obviously irrational. The strength of the case for voluntary euthanasia lies in this combination of respect for the preferences, or autonomy, of those who decide for euthanasia; and the clear rational basis of the decision itself.

NOT JUSTIFYING INVOLUNTARY EUTHANASIA

Involuntary euthanasia resembles voluntary euthanasia in that it involves the killing of those capable of consenting to their own death. It differs in that they do not consent. This difference is crucial, as the argument of the preceding section shows. All the four reasons against killing self-conscious beings apply when the person killed does not choose to die.

Would it ever be possible to justify involuntary euthanasia on paternalistic grounds, to save someone extreme agony? It might be possible to imagine a case in which the agony was so great, and so certain, that the weight of utilitarian considerations favouring euthanasia override all four reasons against killing self-conscious beings. Yet to make this decision one would have to be confident that one can judge when a person's life is so bad as to be not worth living, better than that person can judge herself it is not clear that we are ever justified in having much confidence in our judgments about whether the life of another person is, to that person, worth living. That the other person wishes to go on living is good evidence that her life is worth living. What better evidence could there be?

The only kind of case in which the paternalistic argument is at all plausible is one in which the person to be killed does not realise what agony she will suffer in future, and if she is not killed now she will have to live through to the very end. On these grounds one might kill a person who has - though she does not yet realise it - fallen into the hands of homicidal sadists who will torture her to death. These cases are, fortunately, more commonly encountered in fiction than reality.

If in real life we are unlikely ever to encounter a case of justifiable involuntary euthanasia, then it may be best to dismiss from our minds the fanciful cases in which one might imagine defending it, and treat the rule against involuntary euthanasia as, for all practical purposes, absolute. Here [R. M.] Hare's distinction between critical and intuitive levels of moral reasoning (see Chapter 4), is again relevant. The case described in the preceding paragraph is one in which, if we were reasoning at the critical level, we might consider involuntary euthanasia justifiable; but at the intuitive level, the level of moral reasoning we apply in our daily lives, we can simply say that euthanasia is only justifiable if those killed either

1. lack the ability to consent to death, because they lack the capacity to understand the choice between their own continued existence or non-existence; or
2. have the capacity to choose between their own continued life or death and to make an informed, voluntary, and settled decision to die.

ACTIVE AND PASSIVE EUTHANASIA

The conclusions we have reached in this chapter will shock a large number of readers, for they violate one of the most fundamental tenets of Western ethics - the wrongness of killing innocent human beings. I have already made one attempt to show that my conclusions are, at least in the area of disabled infants, a less radical departure from existing practice than one might suppose. I pointed out that many societies allow a pregnant woman to Ml a fetus at a late stage of pregnancy if there is a significant risk of it being disabled; and since the line between a developed fetus and a newborn infant is not a crucial moral divide, it is difficult to see why it is worse to kill a newborn infant known to be disabled. In this section I shall argue that there is another area of accepted medical practice that is not intrinsically different from the practices that the arguments of this chapter would allow.

I have already referred to the birth defect known as spina bifida, in which the infant is born with an opening in the back, exposing the spinal cord. Until 1957, most of these infants died young, but in that year doctors began using a new kind of valve, to drain off the excess fluid that otherwise accumulates in the head with this condition. In some hospitals it then became standard practice to make vigorous efforts to save every spina bifida infant. The result was that few such infants died - but of those who survived, many were severely disabled, with gross paralysis, multiple deformities of the legs and spine, and no control of bowel or bladder. Intellectual disabilities were also common. In short, the existence of

these children caused great difficulty for their families and was often a misery for the children themselves.

After studying the results of this policy of active treatment a British doctor, John Lorber, proposed that instead of treating all cases of spina bifida, only those who have the defect in a mild form should be selected for treatment. (He proposed that the final decision should be up to the parents, but parents nearly always accept the recommendations of the doctors.) This principle of selective treatment has now been widely accepted in many countries and in Britain has been recognised as legitimate by the Department of Health and Social Security. The result is that fewer spina bifida children survive beyond infancy, but those who do survive are, by and large, the ones whose physical and mental disabilities are relatively minor.

The policy of selection, then, appears to be a desirable one: but what happens to those disabled infants not selected for treatment? Lorber does not disguise the fact that in these cases the hope is that the infant will die soon and without suffering. It is to achieve this objective that surgical operations and other forms of active treatment are not undertaken, although pain and discomfort are as far as possible relieved. If the infant happens to get an infection, the kind of infection that in a normal infant would be swiftly cleared up with antibiotics, no antibiotics are given. Since the survival of the infant is not desired, no steps are taken to prevent a condition, easily curable by ordinary medical techniques, proving fatal.

All this is, as I have said, accepted medical practice. In articles in medical journals, doctors have described cases in which they have allowed infants to die. These cases are not limited to spina bifida, but include, for instance, babies born with Down's syndrome and other complications. In 1982, the 'Baby Doe' case brought this practice to the attention of the American public. 'Baby Doe' was the legal pseudonym of a baby born in Bloomington, Indiana, with Down's syndrome and some additional problems. The most serious of these was that the passage from the mouth to the stomach - the oesophagus - was not properly formed. This meant that Baby Doe could not receive nourishment by mouth. The problem could have been repaired by surgery - but in this case the parents, after discussing the situation with their obstetrician, refused permission for surgery. Without surgery, Baby Doe would soon die. Baby Doe's father later said that as a schoolteacher he had worked closely with Down syndrome children, and that he and his wife had decided that it was in the best interests of Baby Doe, and of their family as a whole (they had two other children), to refuse consent for the operation. The hospital authorities, uncertain of their legal position, took the matter to court. Both the local county court and the Indiana State Supreme Court upheld the parents' right to refuse consent to surgery. The case attracted national media attention, and an attempt was made to take it to the U.S. Supreme Court, but before this could happen, Baby Doe died.

One result of the Baby Doe case was that the U.S. government headed at the time by President Ronald Reagan, who had come to power with the backing of the right-wing religious 'Moral Majority', issued a regulation directing that all infants are to be given necessary life-saving treatment, irrespective of disability. But the new regulations were strongly resisted by the American Medical Association and the American Academy of Pediatrics. In court hearings on the regulations, even Dr C. Everett Koop, Reagan's surgeon-general and the driving force behind the attempt to ensure that all infants should be treated, had to admit that there were some cases in which he would not provide life-sustaining treatment. Dr Koop mentioned three conditions in which, he said, life-sustaining treatment was not appropriate: anencephalic infants (infants born without a brain); infants who had, usually as a result of extreme prematurity, suffered such severe bleeding in the brain that they would never be able to breathe without a respirator and would never be able even to recognise another person; and infants lacking a

major part of their digestive tract, who could only be kept alive by means of a drip providing nourishment directly into the bloodstream.

The regulations were eventually accepted only in a watered down form, allowing some flexibility to doctors. Even so, a subsequent survey of American paediatricians specialising in the care of newborn infants showed that 76 percent thought that the regulations were not necessary, 66 percent considered the regulations interfered with parents' right to determine what course of action was in the best interests of their children, and 60 percent believed that the regulations did not allow adequate consideration of infants' suffering.

In a series of British cases, the courts have accepted the view that the quality of a child's life is a relevant consideration in deciding whether life-sustaining treatment should be provided. In a case called *In re B*, concerning a baby like Baby Doe, with Down's syndrome and an intestinal obstruction, the court said that surgery should be carried out, because the infant's life would not be 'demonstrably awful'. In another case, *Re C*, where the baby had a poorly formed brain combined with severe physical handicaps, the court authorised the paediatric team to refrain from giving life-prolonging treatment. This was also the course taken in the case of *Re Baby J*: this infant was born extremely prematurely, and was blind and deaf and would probably never have been able to speak.

Thus, though many would disagree with Baby Doe's parents about allowing a Down's syndrome infant to die (because people with Down's syndrome can live enjoyable lives and be warm and loving individuals), virtually everyone recognises that in more severe conditions, allowing an infant to die is the only humane and ethically acceptable course to take. The question is: if it is right to allow infants to die, why is it wrong to kill them?

This question has not escaped the notice of the doctors involved. Frequently they answer it by a pious reference to the nineteenth-century poet, Arthur Clough, who wrote:

Thou shalt not kill; but need'st not strive officiously to keep alive.

Unfortunately for those who appeal to Clough's immortal lines as an authoritative ethical pronouncement, they come from a biting satire - 'The Latest Decalogue' - the intent of which is to mock the attitudes described. The opening lines, for example, are:

Thou shalt have one god only; who Would be at the expense of two. No graven images may be Worshipped except the currency.

So Clough cannot be numbered on the side of those who think it wrong to kill, but right not to try too hard to keep alive. Is there, nonetheless, something to be said for this idea? The view that there is something to be said for it is often termed 'the acts and omissions doctrine'. It holds that there is an important moral distinction between performing an act that has certain consequences - say, the death of a disabled child - and omitting to do something that has the same consequences. If this doctrine is correct, the doctor who gives the child a lethal injection does wrong; the doctor who omits to give the child antibiotics, knowing full well that without antibiotics the child will die, does not.

What grounds are there for accepting the acts and omissions doctrine? Few champion the doctrine for its own sake, as an important ethical first principle. It is, rather, an implication of one view of ethics, of a view that holds that as long as we do not violate specified moral rules that place determinate moral obligations upon us, we do all that morality demands of us. These rules are of the kind made familiar

by the Ten Commandments and similar moral codes: Do not kill, Do not lie, Do not steal, and so on. Characteristically they are formulated in the negative, so that to obey them it is necessary only to abstain from the actions they prohibit. Hence obedience can be demanded of every member of the community.

An ethic consisting of specific duties, prescribed by moral rules that everyone can be expected to obey, must make a sharp moral distinction between acts and omissions. Take, for example, the rule: 'Do not kill.' If this rule is interpreted, as it has been in the Western tradition, as prohibiting only the taking of innocent human life, it is not too difficult to avoid overt acts in violation of it. Few of us are murderers. It is not so easy to avoid letting innocent humans die. Many people die because of insufficient food, or poor medical facilities. If we could assist some of them, but do not do so, we are letting them die. Taking the rule against killing to apply to omissions would make living in accordance with it a mark of saintliness or moral heroism, rather than a minimum required of every morally decent person.

An ethic that judges acts according to whether they do or do not violate specific moral rules must, therefore, place moral weight on the distinction between acts and omissions. An ethic that judges acts by their consequences will not do so, for the consequences of an act and an omission will often be, in all significant respects, indistinguishable. For instance, emitting to give antibiotics to a child with pneumonia may have consequences no less fatal than giving the child a lethal injection.

Which approach is right? I have argued for a consequentialist approach to ethics. The acts/omissions issue poses the choice between these two basic approaches in an unusually clear and direct way. What we need to do is imagine two parallel situations differing only in that in one a person performs an act resulting in the death of another human being, while in the other she omits to do something, with the same result. Here is a description of a relatively common situation, taken from an essay by Sir Gustav Nossal, an eminent Australian medical researcher:

An old lady of 83 has been admitted [to a nursing home for the aged] because her increasing degree of mental confusion has made it impossible for her to stay in her own home, and there is no one willing and able to look after her. Over three years, her condition deteriorates. She loses the ability to speak, requires to be fed, and becomes incontinent. Finally, she cannot sit in an armchair any longer, and is confined permanently to bed. One day, she contracts pneumonia.

In a patient who was enjoying a reasonable quality of life, pneumonia would be routinely treated with antibiotics. Should this patient be given antibiotics? Nossal continues:

The relatives are contacted, and the matron of the nursing home tells them that she and the doctor she uses most frequently have worked out a loose arrangement for cases of this type. With advanced senile dementia, they treat the first three infections with antibiotics, and after that, mindful of the adage that 'pneumonia is the old person's friend', they let nature take its course. The matron emphasises that if the relatives desire, all infections can be vigorously treated. The relatives agree with the rule of thumb. The patient dies of a urinary tract infection six months later.

This patient died when she did as a result of a deliberate omission. Many people would think that this omission was well-justified. They might question whether it would not have been better to omit treatment even for the initial occurrence of pneumonia. There is, after all, no moral magic about the number three. Would it also have been justifiable, at the time of the omission, to give an injection that would bring about the patient's death in a peaceful way?

Comparing these two possible ways of bringing about a patient's death at a particular time, is it

reasonable to hold that the doctor who gives the injection is a murderer who deserves to go to jail, while the doctor who decides not to administer antibiotics is practising good and compassionate medicine? That may be what courts of law would say, but surely it is an untenable distinction. In both cases, the outcome is the death of the patient. In both cases, the doctor knows that this will be the result, and decides what she will do on the basis of this knowledge, because she judges this result to be better than the alternative. In both cases the doctor must take responsibility for her decision - it would not be correct for the doctor who decided not to provide antibiotics to say that she was not responsible for the patient's death because she did nothing. Doing nothing in this situation is itself a deliberate choice and one cannot escape responsibility for its consequences.

One might say, of course, that the doctor who withholds antibiotics does not kill the patient, she merely allows the patient to die; but one must then answer the further question why killing is wrong, and letting die is not. The answer that most advocates of the distinction give is simply that there is a moral rule against killing innocent human beings and none against allowing them to die. This answer treats a conventionally accepted moral rule as if it were beyond questioning; it does not go on to ask whether we should have a moral rule against killing (but not against allowing to die). But we have already seen that the conventionally accepted principle of the sanctity of human life is untenable. The moral rules that prohibit killing, but accept 'letting die' cannot be taken for granted either.

Reflecting on these cases leads us to the conclusion that there is no intrinsic moral difference between killing and allowing to die. That is, there is no difference which depends solely on the distinction between an act and an omission. (This does not mean that all cases of allowing to die are morally equivalent to killing. Other factors - extrinsic factors - will sometimes be relevant. This will be discussed further in Chapter 8.) Allowing to die - sometimes called 'passive euthanasia' - is already accepted as a humane and proper course of action in certain cases. If there is no intrinsic moral difference between killing and allowing to die, active euthanasia should also be accepted as humane and proper in certain circumstances.

Others have suggested that the difference between withholding treatment necessary to prolong life, and giving a lethal injection, lies in the intention with which the two are done. Those who take this view resort to the 'doctrine of double effect', a doctrine widely held among Roman Catholic moral theologians and moral philosophers, to argue that one action (for example, refraining from life-sustaining treatment) may have two effects (in this case, not causing additional suffering to the patient, and shortening the patient's life). They then argue that as long as the directly intended effect is the beneficial one that does not violate an absolute moral rule, the action is permissible. Though we foresee that our action (or omission) will result in the death of the patient, this is merely an unwanted side-effect. But the distinction between directly intended effect and side-effect is a contrived one. We cannot avoid responsibility simply by directing our intention to one effect rather than another. If we foresee both effects, we must take responsibility for the foreseen effects of what we do. We often want to do something, but cannot do it because of its other, unwanted consequences. For example, a chemical company might want to get rid of toxic waste in the most economical manner, by dumping it in the nearest river. Would we allow the executives of the company to say that all they directly intended was to improve the efficiency of the factory, thus promoting employment and keeping down the cost of living? Would we regard the pollution as excusable because it is merely an unwanted side-effect of furthering these worthy objectives?

Obviously the defenders of the doctrine of double effect would not accept such an excuse. In rejecting it, however, they would have to rely upon a judgment that the cost - the polluted river - is disproportionate to the gains. Here a consequentialist judgment lurks behind the doctrine of double

effect. The same is true when the doctrine is used in medical care. Normally, saving life takes precedence over relieving pain. If in the case of a particular patient it does not, this can only be because we have judged that the patient's prospects for a future life of acceptable quality are so poor that in this case relieving suffering can take precedence. This is, in other words, not a decision based on acceptance of the sanctity of human life, but a decision based on a disguised quality of life judgment.

Equally unsatisfactory is the common appeal to a distinction between 'ordinary' and 'extraordinary' means of treatment, coupled with the belief that it is not obligatory to provide extraordinary means. Together with my colleague, Helga Kuhse, I carried out a survey of paediatricians and obstetricians in Australia and found that they had remarkable ideas about what constituted 'ordinary' and what 'extraordinary' means. Some even thought that the use of antibiotics - the cheapest, simplest, and most common medical procedure - could be extraordinary. The reason for this range of views is easy to find. When one looks at the justifications given by moral theologians and philosophers for the distinction, it turns out that what is 'ordinary' in one situation can become 'extraordinary' in another. For example, in the famous case of Karen Ann Quinlan, the young New Jersey woman who was in a coma for ten years before she died, a Roman Catholic bishop testified that the use of a respirator was 'extraordinary' and hence optional because Quinlan had no hope of recovery from the coma. Obviously, if doctors had thought that Quinlan was likely to recover, the use of the respirator would not have been optional, and would have been declared 'ordinary'. Again, it is the quality of life of the patient (and where resources are limited and could be used more effectively to save lives elsewhere, the cost of the treatment) that is determining whether a given form of treatment is ordinary or extraordinary, and therefore is to be provided or not. Those who appeal to this distinction are cloaking their consequentialist views in the robe of an absolutist ethic; but the robe is worn out, and the disguise is now transparent.

So it is not possible to appeal to either the doctrine of double effect or the distinction between ordinary and extraordinary means in order to show that allowing a patient to die is morally different from actively helping a patient to die. Indeed, because of extrinsic differences - especially differences in the time it takes for death to occur - active euthanasia may be the only humane and morally proper course. Passive euthanasia can be a slow process. In an article in the *British Medical Journal*, John Lorber has charted the fate of twenty-five infants born with spina bifida on whom it had been decided, in view of the poor prospects for a worthwhile life, not to operate. It will be recalled that Lorber freely grants that the object of not operating is that they should die soon and painlessly. Yet of five untreated infants, fourteen were still alive after one and seven after three months. In Lorber's sample, all the infants died within nine months, but this cannot be guaranteed or at least, cannot be guaranteed without stepping over between active and passive euthanasia. (Lorber's opponents have claimed that the untreated infants under his care because they are given sedatives and fed only on der babies do not have healthy appetites.) An Australian clinic following Lorber's approach to spina bifida found that nine untreated infants, five survived for more than two years. For both the infants, and their families, this must be a long, drawn out ordeal. It is also (although in a society with a reasonable level of affluence this should not be the primary consideration) a considerable burden on the hospital staff and the community's medical resources.

Consider, to take another example, infants born with Down's syndrome and a blockage in the digestive system which, if not removed, will make it impossible for the baby to eat. Like Baby Doe', these infants may be allowed to die. Yet the blockage can be removed and has nothing to do with the degree of intellectual disability the child will have. Moreover, the death resulting from the failure to operate in these circumstances is, neither swift nor painless. The infant dies from dehydration or hunger. Baby Doe took about five days to die, in other recorded instances of this practice, it has taken up to two weeks for death to come.

It is interesting, in this context, to think again of our argument that membership of the species *Homo sapiens* not entitle a being to better treatment than a being at a similar mental level who is a member of a different species. We could also have said - except that it seemed too obvious to need saying - that membership of the species *Homo sapiens* is not a reason for giving a being worse treatment than a member of a different species. Yet in respect of euthanasia, this needs to be said. We do not doubt that it is right to shoot badly injured or sick animals if they are in pain and their chances of recovery are negligible. To 'allow nature to take its course', withholding treatment but refusing to kill, would obviously be wrong. It is only our misplaced respect for the doctrine of the sanctity of human life that prevents us from seeing that what it is obviously wrong to do to a horse, it is equally wrong to do to a disabled infant.

To summarise: passive ways of ending life result in a drawn-out death. They introduce irrelevant factors (a blockage in the intestine, or an easily curable infection) into the selection of those who shall die. If we are able to admit that our objective is a swift and painless death we should not leave it up to chance to determine whether this objective is achieved. Having chosen death we should ensure that it comes in the best possible way.

THE SLIPPERY SLOPE: FROM EUTHANASIA TO GENOCIDE?

Before we leave this topic we must consider an objection that looms so large in the anti-euthanasia literature that it merits a section to itself. It is, for instance, the reason why John Lorber rejects active euthanasia. Lorber has written:

I wholly disagree with euthanasia. Though it is fully logical, and in expert and conscientious hands it could be the most humane way of dealing with such a situation, legalizing euthanasia would be a most dangerous weapon in the hands of the State or ignorant or unscrupulous individuals. One does not have to go far back in history to know what crimes can be continued if euthanasia were legalized.

Would euthanasia be the first step down a slippery slope? In the absence of prominent moral footholds to check our descent, would we slide all the way down into the abyss of state terror and mass murder? The experience of Nazism, to which Lorber no doubt is referring, has often been used as an illustration of what could follow acceptance of euthanasia. Here is a more specific example, from an article by another doctor, Leo Alexander:

Whatever proportions [Nazi] crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the 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 the category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially 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.

Alexander singles out the Nazis' so-called euthanasia program as the root of all the horrendous crimes the Nazis later committed, because that program implied 'that there is such a thing as life not worthy to be lived'. Lorber could hardly agree with Alexander on this, since his recommended procedure of not treating selected infants is based on exactly this judgment. Although people sometimes talk as if we

should never judge a human life to be not worth living, there are times when such a judgment is obviously correct. A life of physical suffering, unredeemed by any form of pleasure or by a minimal level of self-consciousness, is not worth living. Surveys undertaken by health care economists in which people are asked how much they value being alive in certain states of health, regularly find that people give some states a negative value - that is, they indicate that they would prefer to be dead than to survive in that condition. Apparently, the life of the elderly woman described by Sir Gustav Nossal was, in the opinion of the matron of the nursing home, the doctor, and the relatives, not worth living. If we can set criteria for deciding who is to be allowed to die and who is to be given treatment, then why should it be wrong to set criteria, perhaps the same criteria, for deciding who should be killed?

So it is not the attitude that some lives are not worth living that marks out the Nazis from normal people who do not commit mass murder. What then is it? Is it that they went beyond passive euthanasia, and practised active euthanasia? Many, like Lorber, worry about the power that a program of active euthanasia could place in the hands of an unscrupulous government. This worry is not negligible, but should not be exaggerated. Unscrupulous governments already have within their power more plausible means of getting rid of their opponents than euthanasia administered by doctors on medical grounds. 'Suicides' can be arranged. 'Accidents' can occur. If necessary, assassins can be hired. Our best defence against such possibilities is to do everything possible to keep our government democratic, open, and in the hands of people who would not seriously wish to kill their opponents. Once the wish is serious enough, governments will find a way, whether euthanasia is legal or not.

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. If it had been, why would the Nazis have kept their operations secret, deceived relatives about the cause of death of those killed, and exempted from the program certain privileged classes, such as veterans of the armed services, or relatives of the euthanasia staff? Nazi 'euthanasia' was never voluntary, and often was involuntary rather than non-voluntary. 'Doing away with useless mouths' - a phrase used by those in charge - gives a better idea of the objectives of the program than 'mercy-killing'. Both racial origin and ability to work were among the factors considered in the selection of patients to be killed. It was the Nazi belief in the importance of maintaining a pure Aryan Volk - a somewhat mystical entity that was thought of as more important than mere individuals lives - that made both the so-called euthanasia program and later the entire holocaust possible. Proposals for the legalisation of euthanasia, in contrast, are based on respect for autonomy and the goal of avoiding pointless suffering.

This essential difference in the aims of Nazi 'euthanasia' and modern proposals may be granted, but the slippery slope argument could still be defended as a way of suggesting that the present strict rule against the direct killing of innocent human beings serves a useful purpose. However arbitrary and unjustifiable the distinctions between human and non-human, fetus and infant, killing and allowing to die may be, the rule against direct killing of innocent humans at least marks a workable line. The distinction between an infant whose life may be worth living, and one whose life definitely is not, is much more difficult to draw. Perhaps people who see that certain kinds of human beings are killed in certain circumstances may go on to conclude that it is not wrong to kill others not very different from the first kind. So will the boundary of acceptable killing be pushed gradually back? in the absence of any logical stopping place, will the outcome be the loss of all respect for human life?

If our laws were altered so that anyone could carry out an act of euthanasia, the absence of a clear line between those who might justifiably be killed and those who might not would pose a real danger; but that is not what advocates of euthanasia propose. If acts of euthanasia could only be carried out by a member of the medical profession, with the concurrence of a second doctor, it is not likely that the

propensity to kill would spread unchecked throughout the community. Doctors already have a good deal of power over life and death, through their ability to withhold treatment. There has been no suggestion that doctors who begin by allowing severely disabled infants to die from pneumonia will move on to withhold antibiotics from racial minorities or political extremists. In fact legalising euthanasia might well act as a check on the power of doctors since it would bring into the open and under the scrutiny of another doctor what some doctors now do on their own initiative and in secret.

There is, anyway, little historical evidence to suggest that a permissive attitude towards the killing of one category of human beings leads to a breakdown of restrictions against killing other humans. Ancient Greeks regularly killed or exposed infants, but appear to have been at least as scrupulous about taking the lives of their fellow-citizens as medieval Christians or modern Americans. In traditional Eskimo societies it was the custom for a man to kill his elderly parents, but the murder of a normal healthy adult was almost unheard of. I mention these practices not to suggest that they should be imitated, but only to indicate that lines can be drawn at places different from where we now draw them. If these societies could separate human beings into different categories without transferring their attitudes from one group to another, we with our more sophisticated legal systems and greater medical knowledge should be able to do the same.

All of this is not to deny that departing from the traditional sanctity-of-life ethic carries with it a very small but nevertheless finite risk of unwanted consequences. Against this risk we must balance the tangible harm to which the traditional ethic gives rise - harm to those whose misery is needlessly prolonged. We must also ask if the widespread acceptance of abortion and passive euthanasia has not already revealed flaws in the traditional ethic that make it a weak defence against those who lack respect for individual lives. A sounder, if less clear-cut, ethic may in the long run provide a firmer ground for resisting unjustifiable killing.

Utilitarian Philosophers :: Peter Singer :: 'Taking Life: Humans'