APPLIED ETHICS

a non-consequentialist approach

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Euthanasia

2.1 Introduction

We saw in *Moral Theory* that the principle of the unconditional protection of innocent human life is at the centre of morality. No moral philosophy that qualifies or demotes this principle, or that removes it from decision-making in ethics, can hope to call itself humane and therefore to command the respect of right-thinking people.

In no matter is the urgency of respecting this principle more apparent than that of so-called 'euthanasia' or 'mercy killing'. Coming from the Greek for 'good death', the term 'euthanasia' has come to be applied specifically in the medical field to the intentional killing of a human being for the purpose of ending his suffering or of removing some burden. Note, however, that it should be construed broadly so as to cover circumstances such as an accident, where an injured person asks a passer-by to end his suffering by killing him, or a wounded soldier asks his comrade to be 'put out of his misery'. The central moral considerations are the same whether or not the setting is professional or institutional (such as in a hospital), though the medical case does raise specific questions of its own, such as what the role of a doctor should be. While the purpose of euthanasia, namely the ending of suffering or removal of a burden, is the one explicitly stated by most organisations that support legalisation of the practice, we will see that other objectives are involved, and that these too need to be evaluated in the light of the philosophical ideas used to justify them.

Euthanasia in various forms is no new practice in civilisation. In ancient Sparta, those regarded as physically unfit for some purpose, or as incurably ill, or as useless to the state, were killed or allowed to die. In ancient Greece and Rome, the evidence suggests that deformed babies

were 'exposed' or left to die. (Sometimes children were killed simply because they were unwanted, such as girls – as happens now in China. So we can see how it is to some extent arbitrary whether certain kinds of killing, especially infanticide, are discussed in the context of abortion or euthanasia.) The practice reached heights hitherto unthinkable in Nazi Germany and various of the Communist countries. It has most probably always been present in one or another part of the world. But the fact that a social practice is common, or even prevalent throughout the world, does not make it morally legitimate. Indeed, the revelation of the atrocities that took place as part of Hitler's 'euthanasia' programme caused many of the nations of the world, particularly in the West, to recoil from the thought that it may be permissible for anyone, especially doctors or other health-care workers, to kill or assist in the killing of an innocent person either because it was thought to be in that person's interests or in the interests of anyone else, including society as a whole.

The resistance by society to the legalisation of euthanasia, however, resting as it does partly on its express prohibition by an unbroken Jewish and Christian moral tradition thought by many people now no longer to have anything to teach us, is slowly breaking down – just as it has in the case of abortion. The practice is now accepted *de facto* in many countries, though the laws say otherwise, and legalisation is but a short step away.

The breaking down of this resistance can be attributed to several factors apart from the general rejection of the West's moral and religious tradition. One that must be mentioned is the staggering advance in medical technology over the last few decades, which has made it increasingly easy for doctors to keep patients alive in circumstances that once would have been dismissed as hopeless. This ability consists among other things of artificial means of feeding, watering and respirating patients in various states of incapacity such as paralysis, coma, or what might be called the 'persistent non-responsive state'. It also includes the availability of an ever-increasing variety of drugs capable of fighting diseases that once would have overwhelmed vulnerable people such as premature babies and the elderly. And it also includes the provision of the highest possible medical services, at least in the affluent West, to more and more people who once would have been excluded from even basic health care.

All of these developments are to be welcomed and encouraged. Nevertheless they have, in the minds of some, led to situations where people are enabled to stay alive in circumstances in which it is thought that their 'quality of life' is too diminished to make that life 'worth living'. This

might, it is said, be due to extreme pain or discomfort, or to a dependence on others thought to be degrading or undignified, or to a person's living a life that is or will become seriously unfulfilling due to his decreased capacity, for example, 'to respond to an environment, to respond to challenges, to give and receive affection in relationships'.[1]

It is for these and other reasons that supporters of euthanasia urge its legalisation. Our main concern here, as we have seen, is not the current or proposed future state of the law; rather, it is with the ethical issues at the centre of practical problems, and so these are what I shall be discussing. The ethical issues are, of course, more important either than the state of the law or of medical practice: this is because medical practice must follow the law, and the law must follow ethics, not the reverse. Once the ethical position is clarified the law must be adapted to it, and medical practice must then conform to the law. Thus the conclusions that should be reached about the morality of euthanasia will in most cases have fairly obvious and direct relevance for proposals concerning both law and practice.

2.2 Varieties of Euthanasia

Various distinctions have to be considered when evaluating euthanasia. The first concerns consent – whether the patient agreed to be killed or requested it. If there is such a request or agreement the euthanasia is called voluntary, and if not, either non-voluntary or involuntary. Some important points should be noted in respect of voluntary euthanasia. One is purely factual, namely that it is the subject of greatest public controversy, being lobbied for heavily by various organisations such as the Voluntary Euthanasia Society in Britain and the Hemlock Society in the United States. The media regularly air programmes supporting voluntary euthanasia, almost always concentrating on the suffering of the person who wants to be killed, and rarely raising the level of argument higher than the mere slogan 'death with dignity'. There is thus a clear and unmistakable push for its legalisation, and the example of the Netherlands is unfailingly presented as a favourable precedent, although in that country euthanasia is (at the time of writing) still officially illegal, doctors hardly ever being prosecuted.[2] I mention this factual point partly because it is philosophically suggestive. Those who support killing by request are variously mute or vague about their attitude to killing that is not by request, or else support it equally strongly (in certain cases, at least) but do not lobby for it as vigorously. The thought then arises that this is because they believe it easier to make out a *prima facie* case for killing when it is asked for than when it is not. The voluntariness component thus assumes a central role in the case for euthanasia. If they are correct about this, and I think they are, it follows that if in the end the case for voluntary killing *cannot* be made out, then it is likely that no case can be made out for euthanasia of *any* sort. It should be added, however, that the voluntariness component is ultimately a philosophical 'red herring': supporters of euthanasia, whether it be voluntary or not, in the end base their reasoning on the same considerations, as we will see.

A further point about voluntary euthanasia is that the consent must be *actual*, that is, there must be an express request for death, though the request need not be made immediately before being carried out. It could be expressed in a so-called 'advance directive' or 'living will', much discussed of late, in which a person stipulates what is to happen to him if he is in a condition in which he is no longer able to request or agree to death; further, the person must not have said or implied anything since the framing of the directive to contradict its terms. There are notorious problems with advance directives, such as the possibility that a given directive does not advert to the precise circumstances in which the person now finds himself, or is no longer applicable because of technological advances not known about when the directive was framed, or is otherwise vague or difficult to construe. It can be assumed for present purposes, however, that a directive *might* not suffer from these or other defects, and so could constitute a clear request for death even if in practice such directives never do so.

The consent involved in voluntary euthanasia must be completely free. It will not be completely free if given under conditions of ignorance, fraud or fear. The requirement of complete freedom reflects the idea that a request for death has the form of an *abandonment* of the right to life, and an abandonment cannot be partial. The analogy with property, which will be discussed at length later, is instructive. A person who throws away a jewel, having been told it is a worthless trinket (or merely erroneously thinking this to be the case), has not freely abandoned his property; nor has he done so if pressured into throwing it away. As will be seen, the analogy with property is flawed when used to support voluntary euthanasia, since the right to life cannot be abandoned, but the point here is that

even if an abandonment is impossible, the *attempt* can be made under conditions of complete freedom. (One can freely intend the impossible, such as an escape from an escape-proof prison, at least if one believes it to be possible.) Again, an analogy with contracts supports this idea. A person who contracts marriage with someone distinct from the person she *believes* she is contracting marriage with is properly said, both in morality and at law, not to have freely consented to the marriage. Now it might be argued, with some propriety, that *no* request for death can be completely free, as there is always some pressure, whether subtle or not so subtle, or some error about one's condition, and so on; but let us assume for the sake of argument that a person might make a completely free request to be killed, even if no one has ever done so.

Euthanasia that is not voluntary can be non-voluntary or involuntary. It is involuntary where the person killed refuses or otherwise actively withholds consent (again, whether this be at the time of the killing or in an advance directive), or where the person *could* have been asked whether he consented, but was not. Less time will be spent discussing this, but not for the reasons usually given by those who write about euthanasia. Typically, involuntary euthanasia is regarded as obviously wrong in a way that its voluntary counterpart is not. This is because ethical weight is given to *autonomy*: just as a person's consent to be killed is said to legitimise the killing, so his withholding of consent (or the ignoring of his wishes when he could have been consulted) illegitimises the killing. As will be shown, however, the concept of autonomy as construed by supporters of euthanasia is ethically irrelevant to the debate, and moreover this is implicitly *agreed* by both sides. The *real* reasons for supporting euthanasia have nothing whatsoever to do with autonomy and are common to euthanasia in all its forms. Less time will be spent on the involuntary kind, then, because the invalidation of those reasons in respect of the other two kinds will suffice to show this kind to be impermissible as well. A further reason involuntary killing is seldom discussed at length is that it is assumed to be rare and so of less pressing ethical concern. That this is false, however, is shown by the report of the Remmelink Committee, which carried out a thorough and detailed survey of euthanasia in the Netherlands. The report showed that in 1990 well over one thousand people (perhaps even five thousand or more, judging by the less than transparent wording of the report) were killed by doctors without explicit request (though they could have been consulted). (A similar figure was reported again in 1995. In both 1990 and 1995 well over 50 per cent of doctors interviewed said they either had or would be prepared to end the life of a patient without their explicit request, the clear implication being that this included cases where the patient was or would be capable of being consulted.) Sometimes it is said that involuntary euthanasia must be rare, since there could be no conceivable reason why a person who could have been consulted was not (Peter Singer suggests this). But the assertion is specious since there could well be one of a number of reasons: for instance, a doctor might worry that, were he explicitly to ask the patient whether he wanted to be killed, the latter, even if he agreed, would tell his relatives, who would cause a furore; such a scenario is hardly inconceivable. It should also be noted that not all writers regard involuntary euthanasia as obviously wrong, and in the honesty of their reasoning show why voluntariness is an irrelevance, whatever its *apparent* importance. Jonathan Glover, for instance, suggests that it is not obviously wrong that someone going to a Nazi concentration camp, ignorant of their terrible fate, should be killed without their request before they arrive at the camp, in order to spare them the ordeal.[3] And although Peter Singer does not officially wish to justify involuntary euthanasia, he also says that 'if we are preference utilitarians, we must allow that a desire to go on living can be outweighed by other desires'.[4] By its very nature, then, preference utilitarianism, as with all forms of consequentialism, must allow involuntary euthanasia as more than a mere logical possibility.

Non-voluntary euthanasia is the killing of someone who is not capable of being consulted as to his wishes. There are various reasons why this might be the case. The most commonly discussed ones involve babies and infants, and adults who are in a coma, or in what is usually called a 'persistent vegetative state' but which is more properly called a 'persistent non-responsive state'. A coma can be exhibited in a variety of ways, ranging from the case of a person all of whose vital functions, such as eating, drinking, excretion and breathing, need to be maintained artificially, to that of someone needing very little attention except perhaps food and drink. There might be, according to current testing procedures, almost total cessation of brain function, or there might only be damage to some of the neo-cortex, which is thought to support 'higher' mental functions such as thought and speech. In general there is little if any response to stimuli, and no locomotion. Here voluntariness (in the absence of an advance directive) is not an issue, and supporters of euthanasia will advert explicitly to 'quality of life' criteria in assessing whether a given patient should (or could) be killed. Such criteria also extend logically to patients

who are terminally ill, and in such pain that they need medication so strong that it renders them unconscious and so 'incompetent' to make a decision about whether to be killed; or even to elderly people suffering senile dementia. Again, 'quality of life' criteria are applied to newborn babies suffering some handicap; it is not a rarity for babies with a disability as mild as Down's Syndrome to be left to die (most are aborted), and the more serious the handicap, spina bifida being the one usually cited, the more likely it is that, in a typical Western hospital, the child will be treated 'conservatively', that is, not at all, with or without the parents' consent. Indeed, in a much-publicised case in New Zealand in 1998, a severely handicapped baby was allowed to die (deprived of life support) even though the parents explicitly wanted their child to be kept alive, even putting pictures of the baby on the Internet in the hope of gaining public support. The court in New Zealand permitted the doctors to withdraw treatment.[5]

2.3 Voluntary Euthanasia and Autonomy

Having laid some of the groundwork for assessing the ethics of euthanasia, we can move on to the assessment itself, bearing in mind the principles already laid down in chapter 4 of *Moral Theory* concerning the right to life.

Consider some of the following remarks: 'I'm not giving up . . . but everyone has the right to say they don't want to continue'; 'I've always had control over my life . . . I just want to have control over my own death'; 'I want you to do something for me so that if I decide I want to die, I can do it on my own terms and exactly when I choose.'[6] These are all expressions of the right to *autonomy* in one's actions, or to self-determination in respect of what a person does with his life, including ending it. The voluntary euthanasia campaigner Derek Humphry puts it thus: 'The quintessence of voluntary euthanasia is personal choice and self-control, with sometimes a little help from one's friends.'[7] The point is put more formally by Singer, who states: '[T]he 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.'[8]

The idea here is that the right to life is *alienable*, or capable of waiver. This is the principal argument for voluntary euthanasia: *All rights are alienable; there is a right to life; therefore, the right to life is alienable.* If a person of sound mind, thinking rationally, assessing his own situation as carefully as he can, with all relevant information made available to him, makes a deliberate decision to die, which decision is unencumbered by duress or undue influence, and expressed clearly and persistently, then we should, it is argued, take this to be an alienation by him of his right to life. From which it is claimed to follow that other agents are duty-bound to respect that person's autonomous choice and provide him with whatever assistance is necessary to carry out his decision. If he is capable of taking his own life, we should provide him with the equipment necessary to do so. If he is too frightened to do it himself, or is physically incapable, we are permitted, if not bound in conscience, to do for him what he would otherwise have done for himself.

The problem with the argument set out above is that, though valid, the first premise is not true. The principle of respect for autonomy is entrenched in current moral thinking and derives essentially from Kantian ethics. Its current expression, however, is not something Kant himself would have recognised. For Kant, the autonomy of a rational being was subject to the precepts of morality. Thus he famously claimed that suicide was immoral, arguing that there was an incoherence in the idea that a rational being could somehow will his non-existence. Equally famously, however, the paucity of his conception of the Moral Law left him with few substantive arguments as to *why* there was an incoherence here. Current thinking, however, influenced as it has been by existentialist, libertarian and relativist theories, sees autonomy as equivalent to self-determination, or the decision by a free being to decide for himself, on whatever grounds are meaningful *to him*, to live and to die as he wishes.

Further consideration, however, shows that there can be no truth to the idea that all rights are alienable.[9] The principal analogy drawn by the euthanasia supporter is with property rights. Surely, it is argued, property rights are alienable, so why isn't the right to life? A premise usually found in this argument is that the right to life just *is* a species of property right, since we own our bodies. (Some readers may recall the 1980s play supporting suicide and euthanasia, *Whose Life is it Anyway?*) One response is that the right to life is not a property right vested in us; theists sometimes argue that it is God who owns our lives or our bodies, not us – we have them on trust, as it were, to use correctly. (Let us, for simplicity,

assume that if we own our bodies we own our lives, and vice versa.) Some writers, theistic or not, argue that our bodies are not the sorts of thing we can own anyway. Whatever the merits of such claims, let us put them to one side for the purpose of the argument. The problem for the friend of the life – property analogy, nevertheless, is that there are *still* relevant dissimilarities between the rights to life and property, and any similarities *support* the inalienability of the right to life.

The hallmark of property is that it is alienable. So if I happily stand by watching while you take apples from my orchard, or say 'Sure, take as many as you like', you do me no wrong. And of course property can be sold, given away or bequeathed. The disanalogy with life, however, is that while you can certainly alienate your right to this or that property, for example, your apples, you cannot alienate your right to property *in general*, considered apart from any particular piece of property. You cannot validly say, 'I renounce my right as a human being to own property.' Alienating your right to this or that property does not entail alienating your right to property in general, and is thus compatible with retaining that right. On the other hand, a purported alienation of your right to your particular life entails a purported alienation of your right to life in general, it being impossible to have more than one life. So, whereas the alienation of the right to this or that property says nothing about the right to property in general, the purported alienation of your particular life does say something about what you are trying to do with your right to life in general. There is thus an important disanalogy showing why particular property can be alienated in a way that a particular life cannot. Any *similarity* between the two cases only supports the inalienability of the right to life, since the right to property in general does seem inalienable.

It might be said that even the right to property in general is alienable. What about someone who renounces her right to property in general when, say, she enters a commune where there is no private property? Here it seems there would be nothing unjust about the leader of the commune's depriving the new member of her secretly acquired clock-radio. But there are at least two possible interpretations of such a case which point to its dissimilarity with the right to life. They are mutually exclusive, but either one will block the analogy, and anyway they might have separate applications to different cases – so we can leave open which interpretation is correct. One is that there is no alienation of the right to property in general, only a consent to abide by the laws of the commune, which may forbid private property. Once the new member ceases to be a member by

leaving, and hence ceases to be subject to the laws of the commune, she is free to exercise her right to own property again, a right that never left her. Another interpretation is that there is an alienation but it is only temporary, and the right is reassumed once the member ceases to be a member. In neither case is there a permanent renunciation of the right to property, which is evidenced by the fact that the leader of the commune would be acting manifestly unjustly if he chased after the former member, acknowledging that she had left but still trying to stop her owning any property! In the case of a request for death, however, the intention is permanently to renounce the right to life – once killed, the right could hardly be reassumed. Supporters of the 'right to die' cannot buttress their position by appeal to a case such as this.

Reflection on other cases shows that there is nothing absurd in the concept of an inalienable right, and, moreover, that there are a variety of such rights. Nevertheless, examples that would once have commanded universal assent may not do so now, even if they are plausible. This is because the conception of autonomy which Kant understood, and which itself is embedded in traditional morality, has mutated, under the influences mentioned earlier, into what might be called a doctrine of the *paramountcy of the will* – the idea that the will must be allowed to range freely over whatever ends a person deliberately chooses as integral to his 'personal fulfilment', perhaps in one of the variety of utility-maximizing ways proposed by consequentialists, the utility being, however, solely personal. Perhaps this can be seen in the current attitude to bodily integrity. People once thought there was an inalienable right to bodily integrity: you simply could not cede your right not to have your bodily integrity assaulted. Of course you could consent to an infringement in some cases, such as a surgical operation, but this was not a *cession*, merely an agreement to a limited, well-defined infringement for the explicit purpose of *promoting* bodily integrity. Indeed, apart from therapeutic or socially necessary cases, for example, bumping into people in a crowded room, it was thought you could not consent to any old assault on your bodily integrity, since this was a good you were morally bound to promote. So any purported abandonment of the right to bodily integrity was considered null and void. If a person were to say, 'Here's my body; do what you will with it', and moreover to say that this permission had effect *in perpetuity*, that is, was a genuine renunciation, he would have been considered irrational or subject to unwholesome influences. Now, however, it seems that many people do not find anything irrational in a similar statement by someone who

was such an inveterate masochist that he allowed any and every assault on his bodily integrity. But reflection on less arcane cases shows that the contemporary attitude is not so firm. Perhaps you would think more carefully if someone came up to you holding a syringe and assorted paraphernalia, and asked you to inject him with heroin because he had not tried it before and was keen to get addicted. (Perhaps he asks you because he is too nervous to do it himself, or is physically incapable.) Now, even viewing this as a purported permission to infringe, surely you would think twice, if not refuse the request outright. But if you would baulk at it as a purported permission to infringe, how much more would you think twice if you were told by the person that he had abandoned any right he had to be healthy, and one of the first things he wanted to do after such an abandonment was to get addicted to heroin? Wouldn't your reluctance properly be said to stem from the belief that the right to bodily integrity is not the sort of thing a person can simply renounce?

Consider another example, say someone desperate to stay hooked for the rest of his life on smoking or drinking. He knows that every so often he will have second thoughts and want to reform his ways, but it is precisely at those times, he tells you, that you must make sure he has a plentiful supply of alcohol or tobacco at hand so as to ensure he stays addicted. Would you agree to such a request? Suppose, when you question him on his motive for wanting to stay addicted, he claims that he has, quite simply, given up his right to be healthy, for whatever reason. Again, it is fair to say that most of us would find the doctrine of the paramountcy of the will coming under extreme pressure here. There are some things, we would say, that you just cannot give up on. If this is so, then perhaps those who agree with the proposed way of dealing with these cases ought to go back and re-examine their intuitions about cases where they *disagree* about alienability; and the right to life ought to be one of those cases.

I have said that the moral importance of autonomy is not equivalent to the paramountcy of the will, though this is how it is currently understood. A proper understanding, however, sees autonomy as always and everywhere subject to human good. Autonomy is not the moral capacity to do whatever you like (even if what you seek to do is primarily 'self-regarding', in John Stuart Mill's terminology); this is accepted on all sides of the euthanasia debate, except by the most extreme libertarians or relativists with flawed moral theories of their own. Nor, however, is it the moral capacity to do whatever you *believe* to contribute to your 'fulfilment' or even to be *good* for you. Since morality is objective – there exist *truths* about what is good for a person – someone might, quite simply, have false beliefs about what is good for him. Of course a person might be incapable of making a mistake about what he *wants* to do, or about what he thinks will make him *feel* good or otherwise contribute to his well-being as understood by him. But to claim that such facts – about what a person *believes* is good for him – exhaust the moral questions to which they are relevant is unambiguously to work with a subjectivist conception of morality, which was rejected in chapter 1 of *Moral Theory*. The possibility of false beliefs about what is good for a person entails that autonomy must be limited – limited, that is, by the very human goods that it is proper, *qua* human being, to pursue. The will can have various degrees of freedom in, say, the means chosen to pursue some good, but it still must be directed at the pursuit of the good. And since human life is indeed a good, and the fundamental good, since it is the source of all human dignity and well-being (see chapter 4 of *Moral Theory*), autonomy cannot be exercised with a view to abandoning it. The same goes for human dignity itself. A person can live in an undignified way, but he cannot abandon his basic right to live in a dignified way, a right that he is indeed bound to exercise within the limits of circumstance.

When autonomy is construed in this way, there can be seen to be no conflict between it and the good of life. Autonomy does not include the right to kill, or the right to be killed, any more than it includes supposed rights to act against any other good, such as that of human dignity. Rather, autonomy is constrained by and ranges over all *morally legitimate* options, and in the pursuit of such options the moral agent has, and must be accorded, the right to exercise free will. Such a constraint is *truly* liberating, in that it provides a structure within which the agent can recognise his worth as a human being, and outside of which he becomes the prisoner of a way of thinking that is in its way seductive but ultimately destructive.

It should be noted too that what has been said about voluntary euthanasia applies equally to 'physician-assisted suicide', which has also been the subject of much recent lobbying and media discussion (virtually all of it supportive of the practice). What it would be wrong for someone to do to another at his request, it would be wrong for the person making the request to do to himself. This is because the mere availability or lack of means to carry out an illegitimate choice makes no difference to its wrongness. There will, in the case of assisted suicide, be a slightly different account of the distribution of moral responsibility, but the wrongness of the

end pursued means that those who procure or co-operate in the act are still liable to the extent of their participation. The person who commits suicide will have committed a wrong act as well as having wrongly asked for the participation of another in that act; and the latter, while not guilty of having killed anyone, will have blameworthily co-operated in a killing in the same way that anyone is to be blamed for co-operating in an immoral act.

In the light of these considerations, we can see that there is no right to voluntary euthanasia *qua* voluntary. I also suggested, however, that the voluntariness requirement, given so much support by those who ultimately wish to see the legalisation of euthanasia in all its forms, is quite simply an ethical 'red herring'. Just as you would, it is hoped, baulk at injecting someone with heroin on request, so you would, it is hoped, baulk at any old request to be killed. If a person in no pain, in no distress, perhaps with no more than a bout of influenza, were to ask for death, no doctor (perhaps not even the infamous Dr Kevorkian) would accede to the request. Why? If the request is genuine, that is, a sincere attempt at alienating the right to life, why *shouldn't* the doctor accede to the request? Why does an evaluation of the patient's reasons *matter*? The fact that the reasons *do* matter itself indicates that it is not the voluntariness component that is morally relevant, but the reason for infringement. Thus it seems that most, if not all, parties to the debate will agree that there simply is no right to do with one's life whatever one wishes. The real disagreement, protestations by some supporters of voluntary euthanasia to the contrary, is over whether there can be good reasons to act on a request to infringe someone's right to life other than the mere fact of the request itself. It is here that so-called 'quality of life' judgements enter powerfully into the debate, and it is to this matter that we must now turn.

2.4 Non-Voluntary Euthanasia and 'Quality of Life'

There are various sorts of case appealed to by supporters of non-voluntary euthanasia. Recall that non-voluntariness amounts to the lack of an explicit request either to be killed or not to be killed, by someone who is not capable of making such a request. Recall that any request need not be contemporaneous with the decision to kill or not to kill: an 'advance directive' against killing, by a person currently incapable of making a request, would render the killing of that person an act of involuntary euthanasia. Also, if he were capable of making a request, but not consulted, then the killing would be involuntary. Cases of non-voluntariness, then, centre on the lack of capacity to make a request by someone who has either always lacked the capacity, or once had it but now does not, and never expressed a desire regarding death relevant to the circumstances he is currently in. The former situation is usually illustrated by the case of a handicapped baby, say with spina bifida, or anencephaly (where most of the brain is missing, though enough is present for the baby to maintain its vital functions for some period of time), or some severe physical or mental disability, or even a mild disability such as Down's Syndrome or cerebral palsy. The latter situation is usually illustrated by cases of coma, such as a patient wholly unconscious, that is, in a constant deep sleep, or by a patient in a persistent non-responsive state, where there might be periods of waking and sleeping, though no response to stimuli according to current medical tests. Or sometimes it is exemplified by the case of a patient with a 'locked-in' syndrome, say after a severe stroke, where he is alert and conscious, but virtually unable to respond or communicate except perhaps by eye movement – he might be almost completely paralysed. Other discussed cases include elderly people with severe dementia or otherwise almost totally incapacitated and dependent on others for food and daily care: they are conscious, but perhaps 'incompetent', that is, unable to make express requests about how they are to be treated. In all of these and similar cases, the patient, whether child or adult, may to some degree require artificial life support, such as respiration, or tube feeding, or intravenous drugs to support vital organ function. Or he may require no more basic care than feeding by hand, as well as warmth and hygiene, with his vital functions being otherwise self-supporting. All types of combination may arise, and consideration of the particular facts of a situation is always essential in deciding how to treat a person in a given condition. But there are certain broad themes applying to the cases mentioned that enable us to outline a wholly general approach. It is impossible, however, to elaborate appropriate principles and guidelines without discussing flaws in the arguments *for* euthanasia in any or all of these cases.

Supporters of euthanasia who espouse a consequentialist ethical theory are inclined to try to forge a distinction between babies and adult human beings. Although consequentialists do not believe in *rights*, they sometimes give a passing nod to the concept by claiming that babies do not

have the characteristics that make them subjects of rights, which in consequentialist terms means that they do not meet some threshold requirement for being subjects it would *of itself* be wrong to kill, all things being equal. So, it might be said they lack, in the words of Peter Singer, 'characteristics like rationality, autonomy and self-consciousness', in which case '[k]illing them, therefore, cannot be equated with killing normal human beings', the implication being that babies are not normal human beings. The absurdity of such a claim is apparent from the very stating of it, and recalls the consequentialist stipulation that killing people is not wrong *per se*, only *persons* understood in the technical philosophical sense (always italicised here and in *Moral Theory*) of beings 'capable of seeing themselves as distinct entities, existing over time', which is possible for '[n]o infant – disabled or not', who thus lack 'as strong a claim to life' as *persons*.[10] The thought, then, is that babies, simply by *being* babies – disabled or not – do not even reach the first rung of the consequentialist ladder of moral importance: perhaps the capacity to feel pain gets them some of the way, but the 'all things being equal' clause renders sentience of minor significance. The concept of *personhood* has already been discussed and criticised at length (in the previous chapter and in chapter 4 of the companion volume), but it is worth making some further brief remarks relevant to the present context. We must always bear in mind the *personist* emphasis on *occurrent* mental states as crucial to moral status. As was shown in the last chapter, the *personist* in fact relies on potentiality (indicated by such terms as 'capacity' – Tooley – and 'capability' – Singer) as much as his opponent, but the official position is that a being is not a *person* unless it is actually in a state of awareness of itself, of its past and/or future, actually desires to live, and so on. It has to have a *present* sense of itself, to be engaged in ongoing 'personal projects', to behave in a way indicative of its awareness.

For the *personist*, then, the proposition that man is a rational animal (to quote Aristotle) is not strictly true; what *is* true is that *persons* are rational. On the traditional view, babies are as rational as any human, whether or not they can currently (or ever will) engage in certain types of behaviour, display certain kinds of awareness, or be in any state of actual know-ledge of themselves as beings with a past and/or a future in which they have an interest. On the *personist* view, only certain kinds of human being, in certain circumstances, can be called rational: indeed they may be rational at one time in their lives and not rational at another: rationality can come and go like health or hunger. But it has been my contention that

rationality as a component of humanity never leaves an individual any more than his humanity itself leaves him. Further, the sense of oneself *as* doing such-and-such, say existing over time, covers a multitude of distinct characteristics. Is it bare awareness of mortality that matters? Or the actual making of choices that evidence a sense of oneself as having an ongoing 'project' for one's life? Or is it the having of sensations that matters? Or feelings? Or emotions? Or desires? Or preferences? Or 'interests'? Are the relevant interests simply the ones *stipulated* by the *personist* theory? If so, the theory begs the question. Or is there another sense of 'interest' that captures what the consequentialist wants to say? (Recall the 'shopping list' of indicators of *personhood* offered by Tooley and mentioned in the previous chapter.)

The point of raising these questions in this context is to show that there is no *one* property or set of properties that *personists* agree upon as providing the threshold that a baby, or indeed an adult suffering one or other medical condition such as those mentioned above, must meet in order to have moral importance. But it is still the common *personist* conviction that even a normal, healthy baby, let alone a disabled one, has very little claim on life, since its does not fit into a technical category of importance about whose contents *personists* are hazy. In a notorious example, Singer goes so far as to place newborn babies in the same moral category as *snails* as far as killing is concerned: 'Killing a snail or a day-old infant does not thwart any desires of this kind [for the future], because snails and newborn infants are incapable of having such desires.'[11] Indeed, the *personist* uncertainty over just what makes a *person* is usually 'compensated' for by the 'all things being equal' clause favoured by consequentialists, or what are sometimes called 'extrinsic considerations'. Thus, it is the 'effect the killing will have on its parents'[12] that makes the killing of a baby undesirable, it is sometimes said. On the other hand, if parents 'regret that a disabled child was ever born',[13] this might be a reason *for* killing it. Further, acceptance by many consequentialists of the notorious 'replaceability thesis' means that, if parents had a child with a comparatively mild disability such as haemophilia (Singer's example), and wanted to have another child who (almost certainly?) would *not* have this condition, they would be well advised to kill the first child and replace it with another. Indeed, the importance of whether they *want* to do so is unclear in consequentialist writings: they may simply be *obliged* to, on a common view, though 'adverse effect[s] on others' need to be considered. If the consequentialist calculation shows that the killing and replacement would

have a greater net 'benefit' than any other action, it is hard to see why it would be anything other than a *duty*.[14]

The theory I have been defending, however, differs greatly from any version of *personism* (whether or not supplemented by consequentialism – which it usually is) in its attitude to babies, handicapped or not. The right to life attaches to *all* innocent human beings, at every stage of development. Theorists such as Singer and Tooley correctly point out the logical implications of the *personist* approach: not only does it make abortion permissible, but consistency requires its extension to *infanticide*. It is proper to think, however, that any theory that leads to the permissibility of infanticide has gone wrong very early. For morality requires, above all, the *protection* of the most vulnerable members of society, of which babies are a prime example. If morality is not about this, then it is about nothing. And there can be no argument here that parents have a right to decide whether their baby lives or dies, for they *have* no such right: the power to choose the life or death of their child does not sit alongside the power to decide their child's education, or how it is to be brought up. And before we move from *personism* to the question of a 'life worth living', it is worth delving a little further into the issues just raised.

The fundamental idea on which the traditional moral attitude to killing the innocent is based is well put by a recent critic of consequentialism in applied ethics, Jacqueline Laing: 'It is a part of the very concept of innocence that it is not susceptible to variation by the desires or consent of others. On the contrary, desires of third parties, to be morally relevant, must conform to the standard of reasonableness.'[15] And yet, as was mentioned in chapter 4 of *Moral Theory*, it is not clear whether, for the consequentialist, preferences must always be taken at face value (as long as they are not incoherent) or can sometimes be omitted from calculation on the ground of unreasonableness. Singer, for one, equivocates on the point, as Laing notes. He says, for instance, that '[p]arents may, *with good reason*, regret that a disabled child was ever born. In that event the death of the child will have on its parents can be a reason for, rather than against killing it' (my emphasis).[16] Is Singer saying that the disabled child's life is objectively regrettable? If so, the preference of the parents is taken into account because it is allegedly a reasonable response to the child's disability. If so, one might wonder whether the preferences of a Chinese couple are reasonable if they regret having produced a girl when what they and their culture most value is a boy. Would it be reasonable for them to kill her and replace her with a boy? You might have thought not, but for the consequentialist it is not just the health or disability of the child that matters, but the overall effect of its existence on the family and society generally. If, as Singer believes, 'adverse effects on others' must be taken into account, he can hardly dismiss as unreasonable the Chinese parents for whom there is a great social stigma (say, in their village) and financial burden in having a girl. If Singer does in fact want to distinguish here between the disabled child and the burdensome female, he needs to give an account of the rationality of preferences which is *consistent with the consequentialist way of deciding moral questions*, something neither he nor any other prominent consequentialist appears to have done. On the other hand, if the preference utilitarian is true to the pluralism and preference-neutrality of consequentialism (emphasised by Bernard Williams), he will not concern himself too much with the reasonableness or otherwise of the parents' preferences: if the parents of the disabled child want it to die, then they may kill it. And the same for the Chinese parents of the female child, even if their regret is merely personal and not based on anything more than a sense of shame which may not be objectively justified, given the actual attitudes of others. (Needless to say, if there is an objectively adverse social effect this will merely cement the overall calculation in favour of the death of the girl. If the society at large wants the girl to live, the calculation will lead to her life being spared, whatever the parents may think; in any case, the child's living or dying will be a decidedly precarious affair.)

The contrast with traditional morality could not be clearer. For the traditionalist, the very innocence of a person, child or adult, *requires* that other people respond reasonably to its existence and condition. Innocence demands protection, and disability, however severe, demands care. Singer himself believes that there is such a thing as 'the basic attitude of care and protection of infants [that] we must not imperil'.[17] He invokes it when tackling the question of whether it is legitimate to grow human beings with deliberately damaged brains for use as spare parts in transplant surgery. So again he seems to be suggesting that there are certain attitudes which it is reasonable to have towards our children. And yet invoking the 'attitude of care and protection' is surely curious, given that the consequentialist already approves of killing, when maximisation requires it, the unborn, the immature, the comatose, the severely disabled, the senile and the terminally ill. (Usually, though not always, they will not be *persons*; sometimes they will have asked to be killed, for example, the terminally ill.) Why does killing people in such categories *not* imperil our

'basic attitude of care and protection' to human beings in such situations? If it does, it seems Singer at least ought to have second thoughts about what he recommends. If not, it is hard to see why 'baby-farming' would be any more of a problem. In any case, just think of all the needy patients whose lives could be saved by the extra supply of organs: wouldn't the potential diminishing of our 'basic attitude of care and protection' towards infants be more than compensated for by the enhancement of our attitude of care and protection towards needy patients?

For the consequentialist, then, there appears to be a trilemma: (1) take third-party preferences at face value, and make the innocent person's living or dying depend contingently upon the attitudes of others; (2) insist as well that preferences abide by a reasonableness constraint that is also consistent with consequentialist procedure, which (a) requires the spelling out of the constraint, something not done yet and unlikely to prove easy, and (b) must still lead to judgements, in *some* cases, that make an innocent person's living or dying contingent upon the attitudes of others; (3) insist on a reasonableness constraint that entails giving up consequentialism. Needless to say, the consequentialist is unlikely to be impressed by this trilemma, given his generally divergent intuitions about what is or is not morally repugnant.

Returning now from the question of preferences, we have seen that one of the central arguments against non-voluntary euthanasia is based on the falsehood of *personism* (criticised at length in chapter 4 of *Moral Theory*). We saw in the previous chapter that the *personist* can only fix his definition so as to include the drugged, the sleeping, and so on, at the cost of bringing in every other human being, which entails *personism*'s collapse into humanism. Another argument, directed not just against non-voluntary euthanasia but against any kind of euthanasia – when the voluntariness element is seen as the irrelevance it ultimately is for all parties – concerns the concept of a 'life worth living'. It is simply impossible to give a non-arbitrary account of the category into which a human being must fall for him to have a life that is *not* 'worth living'. Supporters of euthanasia can and do appeal to a multitude of 'morally relevant characteristics' as ingredients in the recipe for a being who is or is not 'worthy of life'. It is no accident that they do so, since various combinations give results that are not obviously nonsensical, no matter how immoral they may be, but that differ greatly as to who is admitted to the special category of beings deserving of some moral consideration. In every case, however, the category will be one that excludes certain people, whether they be young, old, incapacitated or otherwise presently, or inherently, unable to exhibit the full range of behaviour typical of a healthy adult human being. Such categories, therefore, fly in the face of the fundamental idea that all human beings, at whatever stage of development, whether 'normal' or not, have equal dignity and deserve whatever protection they need from the aggression of those more powerful than they are.

One reason why supporters of euthanasia rely on 'quality of life' judgements is that they confuse intrinsic and instrumental value. Suppose you believe that the sole point of being alive is that it gives you the means to do other things that are fulfilling, or enjoyable, or valued by your society, or whatever. Faced with a person in a deep coma, unable to do anything for himself except perhaps breathe (though even this may need artificial support), you may tend to think that the quality of this person's life is virtually zero, since it is not being put to any of the uses that give life its sole point. It will then be a short step to conclude that a variety of extrinsic considerations, such as the financial cost to the state, or the distress of the patient's family, tip the balance in favour of killing him. A view of the importance of life, however, which sees it as having intrinsic as well as instrumental value, countenances a different approach. Now it would be perverse for anyone to say that the comatose patient was *flourishing*, or exercising his humanity to the fullest – clearly he is not. But then neither do *any* of us flourish in an undiminished way, and it is impossible to see how the person in a comatose state is qualitatively different from any of us in that respect; it is only the *degree* of diminished flourishing that is different. But the question of whether and to what extent the person is flourishing is irrelevant to a consideration of whether the *last remaining* good he pursues, namely bare life itself, should be eliminated as well. His life may no longer have instrumental value, but its intrinsic value remains untouched by illness or incapacity, no matter how severe. Recall that in chapter 4 of *Moral Theory* I said it was the pursuability of goods *in general* that made life intrinsically valuable. In other words, it is not that a particular person's life has a point if *he* is capable of pursuing other things of value. *His* life has a point even if this is not the case, because human life *in general* has the characteristic of involving the pursuit of goods, which makes human beings the sorts of beings who are subject to moral evaluation. Since this pursuit is conceptually inseparable from life itself, life must be seen as the fundamental element among a number of elements that constitute a moral existence, which is an existence of intrinsic dignity. Further, I distinguished be-

tween the claim that life has value if goods are pursuable, and the claim that life has value *only* if goods are pursuable. Supporters of euthanasia usually conflate these two claims, but it is only the second that enables them to argue (leaving aside the general/particular point just made) that if goods are not pursuable by some individual, that individual's life loses value. Yet it is this second claim that is unjustifiable, because it ignores the status of life as a basic good in its own right. An analogy here with the value of art is helpful, though imperfect.[18] Charles may possess a beautiful work of art and yet it may for one reason or another (say, the cost of insuring it, or having to look at it day after day) cease to give him the pleasure it once did. The work of art will thus cease to have instrumental value for him; but it would be wrong to conclude that he was free to destroy it. This is not because someone *else* might derive pleasure from it – suppose the work of art, though beautiful, pleases no one because its style has gone out of fashion. Still, Charles would not be free to set it on fire, and again not because one day, *perhaps*, someone might derive pleasure from it. Since it is a beautiful work of art, it retains its beauty even if it pleases no one and serves no useful purpose. (Recall the discussion at the beginning of chapter 4 of *Moral Theory*.) As with many works of art currently in existence, its fate might lie in a dusty attic. Destroying it, however, would be a different matter – an act of cultural vandalism, we might say. But if this is the right attitude to art, how much more should it be the right attitude to life?

One argument often proposed in support of euthanasia is that 'we would not treat a dog like that', so why should human beings be left in a state of total incapacitation, which may involve severe pain? If we are prepared to 'put out of its misery' a suffering animal, why not a human being? There are two possible responses to this line of thought: they may be mutually exclusive, but since our concern here is with euthanasia, all that needs to be shown is that despite its intuitive appeal, the argument carries little weight and can be handled in a variety of ways. (In fact, as the next chapter will suggest, it is the second response we should prefer.) The first will appeal to believers in animal rights, namely that perhaps we ought to re-examine the idea that it is acceptable to kill an animal merely because we presume to judge that its suffering makes its life 'not worth living'. It is a familiar idea among believers in animal rights that we ought critically to examine our intuitions about what is acceptable treatment of animals. We cannot, then, simply take it as given that the euthanasia of animals is permissible. A more plausible account of such an action, it might be said,

is that it is not the suffering of the animal that we cannot bear, but our own discomfiture at having to deal with the animal, knowing that we are limited in what we can do to ease its distress.

Another response to the argument is to question the blithe drawing of analogies between our treatment of animals and our treatment of each other. We regard it as acceptable, for instance, to keep animals as pets, to curtail their freedom of movement for our own pleasure, to train them to respond to our every command, to breed them when and how we see fit; not to mention the obvious facts of our eating animals and wearing their skin, and various other forms of exploitation. We rightly regard it as unacceptable to treat each other in a similar fashion: if the fight against slavery was against anything, it was against such forms of treatment. We have an attitude to animals, then, that is quite different to our attitude to each other as human beings. A believer in animal rights will say that such attitudes are inconsistent, and that 'putting an animal out of its misery' is just one example of treating animals as less than full objects of moral respect. On the other hand, a person who believes that the difference in attitude is justifiable will require far more in support of the euthanasia of people than a mere gesture at a familiar slogan.

A further problem with the case for euthanasia lies in a subtle confusion of ideas found in the writings of its supporters. Surely, it is argued, we *do* recognise that some lives are not 'worth living', as can be seen in our attitude to drugs which cause birth defects. When the link is discovered, the drug is withdrawn and compensation is paid to the victims. We do not simply regard the lives of children disabled by a drug taken during pregnancy as 'different' from those of healthy children; we regard the disability as tragic, and 'the life of a disabled person as likely to be . . . worse than that of a normal person'.[19] The problem here, however, is the confusion between the idea of a life that is worse than another, and one that is not 'worth living' pure and simple. The life of a child disabled by a drug may indeed be scarred by a great evil, the effect of the drug undesirable, the drug itself dangerous and compensation payable. Indeed, the life of a disabled person may, if the disability is severe, be *worse* than that of a normal, healthy person. But 'worse' does not mean 'worthless'. It is one thing to acknowledge that one life may be worse than another because the condition or circumstances of the first are worse than those of the second, and quite another to say that the life of the second is not 'worth living'. There is a vast argumentative gap between claiming that we can *compare* lives according to how well they are going and claiming that there is a

threshold below which a life possesses 'negative value'. The appeal to the facts just mentioned, then, has no force.

Supporters of euthanasia often remark that the plausibility of their case is seen when more attention is paid to the 'mercy' in 'mercy killing'. Euthanasia, it is said, is driven by a motive of benevolence towards the suffering, and this exculpates the person who carries it out. Once this motive is given its due importance, it can be seen that euthanasia is far from murder, as its opponents portray it. There are several problems with this line of argument. First, to say that the motive of the 'mercy killer' is praiseworthy is to beg the question of whether the motive even *makes sense*. A person may protest that he acts out of benevolence without *in fact* doing so, if his motive is incoherent. And it is incoherent to suppose that the death of a human being can be good *for him*. On the contrary, if an action is good for a person, it improves his condition, or makes his life go better than it would have had the action not been performed. Setting someone's broken leg is good for him, as is curing someone's disease. But you can never cure a person by killing him – death is not, as it were, the ultimate medicine. Which is why R. M. Hare, the most influential consequentialist thinker of recent times (and regarded by many as one of the century's most important moral philosophers), was dangerously confused when he wrote, in support of Singer, to a German bioethicist: 'Singer's position no more involves discrimination against cripples than does the setting of broken legs. One sets fractures because one thinks that it is better to have whole legs than broken ones; but this does not imply any contempt for cripples who for some reason did not get their legs restored to normal.'[20] (Recall the discussion in chapter 4 of *Moral Theory* of whether a person can benefit materially after his death.)

Second, there is far more to the motives of the 'mercy' killer than the admittedly incoherent desire to do good for a person by killing him. At least on a consequentialist view 'extrinsic considerations' come into play, and if there is any value to be found in the life of a disabled baby, or of a senile adult, that value can be outweighed by the burden on the parents of that baby (who might want to have another, healthy child) or on the family of the adult, or on the state, of caring for the person concerned. The 'family as a whole', it has been claimed by Singer, can decide if it is in *their* own best interests to kill their child.[21] Jonathan Glover says: 'Some senile old people and some children born with gross abnormalities may be such an emotional burden on their families that, thinking purely of side-effects, it would arguably be better if they were dead.'[22] Once motives connected with such considerations come into play, it becomes clear that 'mercy killing', if it is about mercy at all, is often about being merciful to everyone but the patient. If someone kills another out of the motive to prevent him from being a burden to the killer or to other people, that motive is better described as 'sinister' than as 'benevolent'. Third, even if it were possible to have saintly motives when killing another, that would not justify the act. Suppose a person murdered his grandmother with the motive of benefiting under her will and thereby being able to feed his poor, starving family. This would hardly relieve the killer of guilt. And finally, on a consequentialist view of action, *all* motives are irrelevant: only consequences count morally.

So no consequentialist can appeal to the motive of mercy in the justification of euthanasia. All he is allowed to appeal to is the magic ingredient X that the consequentialist seeks to maximise. Whether someone's life is 'worth living' will depend on the extent to which X is maximised in his case. For a preference utilitarian such as Singer, what matters in the first instance is whether the individual wants to live; and whatever the answer to that question (the question is of course irrelevant if the potential victim is not competent), the decision whether he ultimately lives or dies depends on what *other* people want: the individual's family and friends, the medical personnel caring for him (for whom a large and probably the principal consideration will be the bearing of the financial and logistical burden of having the individual 'on their books'), the state as a whole, and anyone with some sort of interest in the individual's life or death. Now if, as was argued in *Moral Theory*, the whole idea of 'maximisation' by a consequentialist calculus is mistaken, there can be no calculation of whether someone's life is 'worth living'. The supporter of euthanasia, if not relying on some such chimerical, pseudo-mathematical concept of a life 'worth living', will tend to use the term as a catch-all category loaded with subjectivity and personal preference. In neither case does the concept rest on plausible objective principles.

2.5 Active and Passive Euthanasia

Two broad types of killing have traditionally been recognised by both morality and law: killing by commission and killing by omission. The former involves a positive act that brings about death and the latter in-

volves a failure to act that brings about death. Just as not every act causes a death, so not every omission causes a death. As you sit reading this book, there are many things you are omitting to do, such as going for a walk, that do not cause a death. Also, as you read this book people are dying from disease in the Gobi desert: but your not flying there to help, even if you *knew* they were dying, and even if you *could* fly there (you had the time and the money, and so on), does not bring about the deaths of those people.

Some omissions, however, do bring about deaths. An omission that does so, all things being equal, is as morally culpable as a positive act that brings about death. A mother who starved her child to death would be as guilty of murder as if she had beaten it to death, assuming no peculiarity of circumstance to differentiate the cases (suppose the starving and the beating are deliberate and wanton). The primary feature of an omission that is as morally culpable as a commission in similar circumstances is that there is a *prior duty to act*. A duty to act can arise in various ways: it can arise from a promise; or from a legally binding contract (which creates a moral as well as a legal duty to honour it); or from a condition of responsibility for another's behaviour (an employer, for instance, has a duty to prevent crime by his employees in the course of their work, and a teacher has a duty to ensure, within the limits of his capability, that his students do well at school); or from a condition of responsibility for public welfare (the state is duty-bound to keep law and order); or in numerous other situations. In particular, there is a duty to take care of those for whose care we are responsible. The responsibility arises from a relationship of proximity, not merely geographic but based on the structure of a society, its laws, customs and institutions. Typical relationships of proximity involving a duty of care are parent – child (the duty of care being reciprocal, since the child has the duty to care for its parents when necessary), guardian – ward, teacher – pupil (the teacher being duty-bound to provide a safe environment at school), employer – employee, and doctor – patient.

It is common practice now, however, for doctors to 'treat selectively' certain patients. This means that patients who would otherwise have been cared for are left to die, such as babies born with certain disabilities, or terminally ill patients who contract minor ailments, such as infections, that could shorten their lives if left untreated. Thus some doctors, for whose patients they have a duty of care, now practise killing by omission in certain situations. Since killing by omission, where there is a prior duty to protect life, is morally as culpable as a positive act to bring about or

hasten death, such failures to act come within the ambit of principles governing euthanasia. Usually, they are called cases of passive euthanasia, and a positive intervention to end life is called active euthanasia. Morality, however, recognises no difference between a failure to cure an infection in a terminally ill patient, even if his death were imminent, where the failure involves the intention that the patient should die, and a lethal injection to hasten the death of such a patient.

Supporters of euthanasia often appeal to the widespread practice of 'selective non-treatment' as an argument for active intervention to bring about death. First, they say that the acceptance of death by omission amongst the medical profession shows that it is part of normal medical procedure based on expert judgement, and is thus morally justified. Second, they ask: 'if it is right to allow infants to die, why is it wrong to kill them?'[23] After all, allowing a baby (or other patient) to die can lead to a protracted and painful death, especially if the doctor simply refrains from attending to the patient's vital needs, such as food and drink. Would a quick, painless injection not be more humane?

As to the first point, there is a difference between what is accepted at a given time as standard medical practice and what is a morally *acceptable* practice. Morality in medicine is not defined by what doctors typically do. Rather, as was said earlier, practice follows morality and is therefore dictated by what is morally acceptable. In various societies and at various times in history (and even now) the medical profession has actively co-operated in unacceptable behaviour, such as forced sterilisation and abortion (even pro-abortionists baulk at the thought of *coercion*), eugenics, torture, and medical experiments on 'undesirables', be they physically disabled or politically dangerous. Of course, morality needs to take account of expert medical judgement, since it is impossible to frame ethical directives for specific cases in the absence of detailed knowledge of current medical techniques, methods of diagnosis, assessment of the risk of certain procedures, and so on. But ethical directives are about the *ethical* treatment of patients, not just about what is technically possible, or expedient, or cost-effective. Principles of ethical treatment must therefore follow ethical guidelines, and the actual practice of the medical profession must abide by those principles.

As to the second point about 'selective non-treatment', the conditional assertion on which it is based presupposes an answer we have already seen to be unacceptable. The assertion is that if allowing a patient to die is right, so is active killing; indeed, active killing might be *preferable*, if it

involves less pain and trauma for all concerned. But whereas the supporter of euthanasia asserts the antecedent of the conditional, that it is right to allow death, the opponent denies the consequent, that active killing is ever right. Since active killing is never right, neither is allowing a patient to die. Killing by omission, then, is morally as culpable as killing by commission. The crucial qualification, however, is that the kind of killing by omission that is as culpable as a killing by commission is where the intention of the omission is to *end life*. That the intention is relevant is precisely the point of the comparison for both supporters and opponents of euthanasia. What the supporter countenances is *intentional* active killing in some cases, just because it would be 'better for all concerned' than the widespread intentional *passive* killing ('selective non-treatment') that occurs at present. But in order to become clear about what is and is not an intentional killing by omission we need to make some distinctions between different kinds of case.

Various confusions have undermined the proper understanding of the active/passive distinction. Sometimes, supporters of euthanasia talk as if *any withdrawal* of treatment is *ipso facto* a justifiable omission. This, they claim, is because when treatment is withdrawn, say for an infection, 'nature is allowed to take its course', and the patient dies not from this but from the underlying disease. There are at least two problems with such reasoning. The first is that to the extent that the appeal to nature's taking its course is used as an implicit justification for at least the permissibility of an omission that has this result, it is spurious. Suppose a child is prescribed antibiotics for a serious infection, and the parent begins giving them but stops the treatment after a week, and the child dies. Can she evade responsibility as the *agent* of death by pleading that nature took its course and the child ultimately died of the infection? The parent is not responsible for the initial illness, but her *specific duty* to take care of the child in her charge makes her responsible for the death of that child if she withdraws treatment. The responsibility is both moral and causal: the active withdrawal of treatment *prevents* recovery and *hastens* death. Thus her omission to continue with the antibiotics is murder, as is the failure of a doctor to continue giving antibiotics to a terminally ill patient who develops an infection. It is hard to see how the fact that the patient is going to die anyway (aren't we all?) makes a moral difference.

The second problem is the confusion of factual situations that are importantly different. The withdrawal of treatment may have the complexion of an omission or a commission, depending on circumstances. The

failure by doctors to give treatment to newborn disabled babies is a clear *withholding* of treatment, and so an omission. The failure to continue antibiotic treatment already begun looks like an omission by *withdrawal*, since treatment has commenced, that is, the doctor is intervening positively, but then stops intervening, or ceases to act. On the other hand, the disconnecting of the air supply of a comatose patient connected to a ventilator looks much more like a *commission* by withdrawal, as does the turning off of an intravenous drip. Here what gives the behaviour the complexion of a commission is that it is a positive intervention in a continuous life-sustaining process, no different to the doctor's placing a pillow over a patient's mouth to stop his breathing; whereas the decision not to continue with antibiotics involves no intervention, just a failure to do what the doctor had previously been doing. Perhaps a conflicting intuition is generated by the thought that if a total stranger walked into the hospital and switched off the ventilator, it would self-evidently be a killing by commission, whereas if done by the doctor who began the ventilation in the first place, we would be less inclined to call it a commission. On the other hand, it is hard to see how the facts about who started the treatment make a difference. Fortunately, however, this attempt at classification, interesting though it is, is also relatively unimportant ethically since, as has been said, a killing by omission is morally as bad as a killing by commission, where the intention is to end life. Two practical consequences of a correct classification, however, are that first, those who are more impressed by the wrongness of commissions than omissions, even if the impression is unjustified, should recognise that some types of behaviour they regard as instances of the former are really instances of the latter; and second, since culpable omissions arise in the context of duties to act, there might be a temptation to treat all types of behaviour leading to death by those with duties to act in given situations (such as doctors) as omissions, which is wrong. Those capable of culpable omission are equally capable of active killing.

Another confusion involves the bringing in of a different distinction to the active/passive one: that between intention and foresight. Sometimes it is said that there is an ethical inconsistency in claiming that a doctor does no wrong if he omits to give a disabled child antibiotics, 'knowing full well that without antibiotics the child will die',[24] but does do wrong if he gives the child a lethal injection. Here the question of knowledge is brought in and it muddies the waters, so it is important to recapitulate some of the points made in chapter 3 of *Moral Theory* about the importance of the

intention/foresight distinction. The distinction, as we saw, is encapsulated in the famous Principle of Double Effect (PDE), which has come under enormous attack in recent years, mainly from consequentialists. The principle has been criticised in a wholly *ad hominem* way as essentially religious, and also as mysterious or obscure. In fact, PDE is none of these things. It is a simple and easily grasped codification of the intention/foresight distinction, a distinction essential to any moral theory worthy of the name. This does not mean that its *application* in a given factual situation might not be difficult and complex.

You will recall that PDE follows our common-sense understanding of morality by giving a central place to *intentional* action in moral evaluation. Intention is central because morality is about ends and objectives, what an agent *tries to achieve* with his actions. This may also be, and usually is, what he *wants* to achieve, and what he *believes* or *knows* he can achieve, but intention is not mere desire, belief or knowledge. Intention concerns *purpose*. Thus, a doctor who gives a patient a lethal injection, say an overdose of painkiller, because he *intends* to kill the patient, commits a straightforward intentional killing. If he injects the patient with a saline solution, thinking it is a lethal dose of painkiller and intending to kill, then again, although the patient does not die, the doctor's *intent* is to kill. If, on the other hand, he gives a non-lethal dose of painkiller with the objective of eliminating the pain and not the patient, he does not intend to kill, even if the patient suffers a severe reaction and dies. Further, if he gives a dose he believes is likely to be lethal, but does so with the intention to dull the pain, which may be so severe it requires a high dose, and the patient dies, he does not intentionally kill. And if his intention is the same but this time he is virtually *certain* the patient will die, he still does not intentionally kill, since this simply was not his purpose.

The distinction between what an agent intends, and what he believes or knows, is always portrayed by consequentialist writers as at best a mere semantic distinction of no moral relevance. After all, if the consequences or effect of actions are what matter, how can a mere difference in state of mind be relevant? The reply to this criticism is that, on the contrary, there is a *world* of difference between intention and foresight (where by the latter we include cognitive states such as belief and knowledge). Far from being a mere semantic difference, it is a profound difference rooted in the nature of things that completely alters the complexion of an action. Indeed, it alters the very *identity* of the action, because the very characterisation of what the agent *does* depends on what he *intends*. Is the doctor

trying to kill the patient's pain? Or is he trying to kill the patient? What does he *intend*? There cannot be a more fundamental difference relevant to the problem of evaluating the doctor's behaviour.

It would be wrong, however, to infer from the central importance of intention to moral evaluation that where an agent performs an action and merely foresees a certain result rather than intending it, he avoids responsibility altogether. Consider a doctor who, in order to treat a patient with a minor illness, say a common infection, prescribes a highly dangerous drug that he foresees may well cure the infection but is also likely to provoke a cardiac arrest. Can he avoid responsibility for the bad effect by saying that he did not *intend* to cause a cardiac arrest, merely to cure the infection? Of course we would say he cannot. He may not be guilty of an intentional killing if the patient dies, but he will at least have been grossly negligent, and at most subjectively reckless in his disregard for the serious side effect, which brings with it a high degree of culpability. The reason for this is that the condition he tries to cure simply is not grave enough to warrant a treatment that risks serious side effects. More abstractly, he does not have a *sufficiently weighty reason* for allowing the risk of a bad effect flowing from his action. Hence we must recognise extra elements in the intention/foresight distinction that give the distinction its proper ethical role. We can say that it is permissible to perform an action of which an evil effect is foreseen only when certain conditions obtain. (They were stated more precisely, and discussed in depth, in chapter 3 of *Moral Theory*.) First, the action must not be intrinsically wrong (prescribing a drug to cure an illness is not intrinsically wrong). Second, something good must flow from the act (such as the curing of the infection, or a strong chance of its being cured), and it must not be caused by the evil effect, since an axiom of morality is that the ends do not justify the means (the risk of cardiac arrest is not a *means* the doctor employs to cure the infection, rather it is an independent side effect). Third, the agent must intend only the good effect (the curing of the cold), since it is wrong to intend an evil effect (the risk of cardiac arrest, which in this case is foreseen). Finally, the agent must have, in the good which he intends, a sufficiently weighty reason for permitting the evil effect that also flows from his act, since it is wrong even to *permit* an evil without such a reason. In this case, the doctor does not have a sufficiently weighty reason to allow the risk of cardiac arrest, and he would certainly be acting wrongly if he prescribed a drug carrying that risk for no ulterior purpose whatsoever, except perhaps curiosity as to its effects.

So, to return to the earlier case of a doctor who omits to give a disabled child antibiotics, knowing full well it will die without them, further matters need to be settled before responsibility can be assessed. Suppose that the antibiotics carried a high risk of causing brain damage. The doctor might then omit to give them with the express intention of avoiding this effect, while foreseeing but not intending probable death. Is this a sufficiently weighty reason for the omission? It would be foolish to think that such questions are always easily answered, but two important points need to be kept in mind. First, death is rarely if ever a physically certain effect of a given therapy. Rather, certain therapies hasten death, or increase its likelihood, or make the likelihood very high, and the question is then whether the *risk* of death is permissible, given the therapeutic objective. Indeed, death is rarely if ever a physically certain effect of *anything* that we do in the pursuit of some good objective. A parent who rushes her desperately ill child to hospital, in the process going through every red light in heavy traffic, creates a substantial risk of death in pursuit of a good objective. Normally such behaviour is permissible if there is no alternative, if the aim is sufficiently praiseworthy and directed at the good of an individual or the common good. On the other hand, if getting the child to hospital means running over a pedestrian as a virtually certain but intended effect of driving, our judgement would be different. Similarly, if a certain fatal poison was discovered to have marvellous pain-killing properties, it would be unacceptable to use it. This is primarily because the unintended effect *defeats the therapeutic purpose* for which it is used, which is to keep the living patient in as good a condition as possible. Thus one needs to balance the degree of likelihood of the effect, its severity, the importance of the therapeutic objective, its achievability, and the availability of alternatives. Perhaps no objective can outweigh the physical certainty of death, but a high risk might be worth running for relief of unbearable pain, just as it is worth running in a dangerous operation aimed at relieving someone of a grave condition. It is these risks that must be assessed in clinical situations.

Second, consequentialists who see no point in the intention/foresight distinction invariably portray such an assessment as a 'covert quality of life judgement'. If, say, relieving severe pain is permitted at the cost of a high risk of death, this, they say, will be because we have made a prior judgement that the patient's quality of life will be so poor without treatment that we allow it to take precedence over saving life. This is a gross misrepresentation of the reasoning involved. A patient in severe, persistent pain is of course suffering from an evil which the doctor should, if possible, try to eliminate or minimise. Such a judgement is *nothing like* the judgement that the patient's 'quality of life' will be so poor as not to be 'worth living' without treatment, or that he is 'better off dead' than in pain, thus legitimising any and every attempt to relieve pain no matter what the attendant risks. Nor indeed is the judgement that the doctor is *permitted* to take drastic measures the same as the judgement that he is *obliged* to. The consequentialist will always say that since the patient is better off dead than in such pain, death is *preferable* to such pain. On a utility calculation, he will say, the doctor is *morally obliged* to give the high-risk treatment since it involves the good consequences of a chance of pain relief and a high risk of death, which together outweigh a life in such pain. *No such calculation* is made on a non-consequentialist view such as that being defended here. The death of an innocent person is always a grave evil, it never factors into a moral equation as something desirable by comparison to the alternative of a life of diminished flourishing, and so a doctor would, I contend, be within his rights to refuse to administer the high-risk treatment even if he had a sufficiently weighty reason for giving it. In other words, the reason makes the treatment morally lawful, but never obligatory. Indeed, this is a current medical practice which should be maintained: doctors frequently refuse to administer dangerous therapies even if there are serious benefits to be obtained, though they may be obliged to refer the patient to a doctor who would be inclined to act. Further, the moral judgement does *not* involve anything like a consequentialist sliding scale of pains, pleasures, desires or preferences, the wishes of people other than the patient are not given the equal importance they are on that scale, and there is no threshold below which a patient's life ceases to be 'worth living' according to a specious quality of life judgement. The intention/foresight distinction and its various qualifications involve quite a different way of thinking, and the consequentialist misrepresents it by claiming otherwise.

Further, the consequentialist claims that for a supporter of the distinction, it follows that we can 'avoid responsibility simply by directing our intention to one effect rather than another'.[25] We have already seen that an agent cannot simply plead 'I foresaw the effect but did not intend it' in order to avoid responsibility: all of the conditions attached to the distinction need to be considered, such as whether there was a sufficiently weighty objective involved in taking the action he did. But it must also be emphasised that talk of 'simply directing our intention to one effect rather than

another' is a caricature of human action. (See further chapter 3 of *Moral Theory*.) The doctor who omits to give the disabled child antibiotics and pleads that he merely foresaw death but did not intend it, needs, like any person whose actions are under scrutiny, to be asked certain questions. Was he trying to achieve something else? If he says he was trying to avoid causing brain damage, and there is evidence that this is an effect of the drug, and his behaviour at the relevant time supports this interpretation, we can take his plea to be a faithful reflection of his state of mind. But if he does not have any other objective to produce – he simply withheld the drug – or he admits to proposing euthanasia to the parents just prior to the decision not to act, or he says his objective was 'to spare the child a miserable life', or various other pieces of evidence are produced to show that his aim or purpose – what he was trying to *achieve* by not acting – was the child's death, then any plea to the effect that he 'merely foresaw' death must fall on deaf ears. Courts of law are, and have for centuries been, adequately equipped to deal with such cases and to evaluate evidence of a person's state of mind. Far from an agent's being able 'at the drop of a hat' to direct his intentions one way rather than another, the distinction between what he intends and what he foresees, what his purpose was and what it was not, reflects *a fundamental difference of psychological attitude*, which can be judged by innumerable pieces of evidence concerning behaviour, words spoken, known or previously expressed opinions, and so on. Far from being a superficial semantic distinction, the difference between intention and foresight lies at the heart of our interpretation of the behaviour of others, doctors included.

2.6 Ordinary and Extraordinary Means

In 1989, a terrible disaster at Hillsborough football stadium in England claimed the lives of 96 people. One of the injured was Tony Bland, whose brain was starved of oxygen in the accident. He lapsed into a persistent non-responsive state (called a 'persistent vegetative state' by the medical profession), in which it seems most (but by no means all) brain function ceased. For four years he lay in hospital. Throughout that time he breathed spontaneously, his eyes were open most of the time, but he did not communicate with anyone, as far as could be determined. Nor could he swallow, so he needed to be fed through a tube. In 1993, after a lengthy court

battle, his family and doctors won the right, via a declaration of the House of Lords, to withdraw the tube feeding him and giving him fluids. He died soon afterwards.[26]

A major issue in the case was whether artificial feeding constituted 'medical treatment', since the court considered that in some circumstances treatment, as opposed to basic, non-medical care, could be withdrawn. The circumstances in this case, it held, were that Mr Bland's continued life was a source of 'humiliation' and 'indignity' to him, and a violation of 'how he would want to be remembered'. We have already looked at the issue of quality of life judgements and pointed out their arbitrariness and their failure to respect the dignity of every human being. Whereas the court saw Tony Bland's life as undignified, its proper response should have been to recognise that there is nothing whatsoever undignified in living with disability or even total incapacity, but that true indignity lies in the thinly disguised contempt with which some human beings regard others.

Our main concern here, however, is with the issue of medical treatment. The court was gesturing at a traditional ethical distinction between types of means used to care for and prolong the life of the sick. According to the distinction, there is no obligation to maintain the last vestiges of life at all costs, no matter what the burden. This might appear to conflict with the unconditional value of human life: after all, if life has ultimate value, is any act too burdensome to perform in promotion or protection of life? The conflict is illusory, however. For there is a tight connection between what we are obliged to do and what we *can* do: our duties cannot extend beyond our physical and mental capacities. Heroic action is rightly praised, but it is never imposed. Rather, morality requires action in conformity with the normal abilities of a person given his situation in life, his pre-existing duties, his expertise, and so on.

The distinction, then, is between what are usually called *ordinary* and *extraordinary* actions. In the case of actions related to the prolongation of life, ordinariness consists in the maintenance, by oneself or by others for oneself, of normal, everyday means of sustenance. These include things such as food, drink, shelter and warmth. To refuse any of these when to do so would hasten or bring about death is tantamount to suicide, or culpable homicide if denied to one person by another where there is a responsibility of the latter for the former. On the other hand, extraordinary actions are ones that are overly burdensome, futile, or involve serious dangers to the person treated or others. An individual has the right to

refuse extraordinary treatment for one or all of these reasons, the common thread being that such treatment would test his capacities beyond what he can reasonably be expected to bear. Similarly, a doctor is permitted to refuse to administer extraordinary treatment because of such an effect on his patient, or because it tests the doctor's own capacities beyond what he, *as a doctor*, can reasonably be expected to do. A typical case would be a patient brought into emergency, haemorrhaging severely, all of whose vital functions barely register on the monitors, and who goes into persistent cardiac arrest. Such a person would be on a headlong rush towards death, and there are, given the laws of nature and the limits of medicine, bounds to what a doctor in such a situation can and should do. Of course, resuscitation should be attempted, along with the usual emergency-room procedures for restoring cardiac and other bodily functions. But the patient may recover, only to go into arrest again, and this may happen several times. After a while, the doctor will simply give up, having done all he can, within his physical and technological limits, to keep the patient alive. After that, the underlying condition will prevail and the patient may well die. This is a typical case in which a doctor is permitted to cease treatment, where to carry on would be futile.

In current writing on euthanasia, however, and as reflected in the judgement on Tony Bland, 'extraordinary' is interpreted to cover virtually any intervention, simply because it is artificial, or assisted by technology, or provided by professionals. Food and drink are the most basic and ordinary means of sustaining life, yet the court decided that because they were being provided through a tube they constituted 'treatment', and since they were treatment they were also by implication extraordinary, involving artificial intervention in natural processes. Thus they held that Tony Bland could be starved to death. Although an inquest after his death found he died from the injuries suffered in the original accident, this flew in the face of reality, since he had been alive for four years after the accident, breathed on his own, and simply needed help to eat and drink, along with other basic maintenance. Far from dying from the original injuries, he uncoincidentally died soon after the court ruled that his feeding tube could be withdrawn.

It is wrong, however, to regard the provision of basic care as medical treatment. Doctors have duties both as members of their profession and as ordinary human beings, and they can be responsible for the care of a person in both capacities, especially where basic care is involved. The mere fact that food is provided using artificial equipment by someone

wearing a badge or carrying a stethoscope does not mean that the feeding, which is the common duty of *any* person who has the maintenance of another in his hands, comes within the province of special or professional care, even if professional skills assist in providing that care. This is no different to the case of a doctor who bandages the gash of someone he sees lying bleeding in the road: if he is carrying his black bag he might be able to do a better job than a non-professional using a torn shirtsleeve, but he is exercising a duty of common humanity by which any of us would be bound in similar circumstances.

Second, basic care aside, medical treatment is not extraordinary simply by virtue of involving machinery or electronics, or requiring round-the-clock attention, nor simply by virtue of being expensive. The issue of classification becomes more difficult as new, specialist technologies come into question, and there is no room for a detailed discussion. Several points can be made, however. One is that the ordinary/extraordinary distinction is not fixed. Several centuries ago, the amputation of a leg to save a life would have been extraordinary because it was intensely painful and distressing, but now the operation, while still a drastic measure, is easily and painlessly performed. There is nothing mysterious or incomprehensible about the fluidity of the distinction: procedures that were once beyond the capacity of a patient to bear or a doctor to perform competently are now routine; as expertise develops, so human capacities improve. Again, the distinction varies at a given time across circumstances. The use of cardiac resuscitation is extraordinary where arrest is continuous and persistent, and ordinary where the heart responds well and regains its normal function (of course, this is not known by the doctor in advance, so assessment of probabilities is involved). Antibiotics are ordinary treatment for an elderly patient with Alzheimer's disease who contracts pneumonia (pneumonia might be the 'old person's friend', but this does not mean doctors can help it along by not treating it where there is hope of recovery); but extraordinary for a person likely to suffer a severe allergic reaction to them.

A further point is that, contrary to its misrepresentation by consequentialist writers, there is no 'covert quality of life judgement' involved in deeming some means extraordinary relative to the circumstances. The use of a respirator on someone in a coma from which there is little hope of recovery is not extraordinary by virtue of that fact. It would be if it still failed to provide proper oxygenation due to some chronic bodily breakdown, but not simply because the patient may not recover. The confusion

centres on the meaning of 'futile'. It does *not* mean 'incapable of restoring an adequate quality of life', but 'incapable of fulfilling its designated function'. A respirator on its own will not repair severe brain damage, nor cure paralysis. But it is not meant to. Its function is to enable someone to breathe, and if it does that it is anything but futile. The same applies to food, drink and warmth.

The problem of high-risk treatment is already covered by the intention/foresight distinction. If a given treatment runs such a high risk of serious harm that it would defeat the purpose of the treatment, which is to restore health, then it could be deemed extraordinary and may be withheld by a doctor, or indeed withdrawn once commenced (say, if the risk increases substantially during administration), as long as the intention of the doctor is not to bring about death. (A doctor might protest: 'How do I know what I intend in these sorts of complicated and dangerous situations? I just *act* as the situation demands.' The response is (a) that this begs the question of what the situation *does* demand, including morally; and (b) that if a doctor does not know what he intends when he carries out a procedure, perhaps he should cease practising as a doctor and spend more time getting to know himself.) As for burdensomeness, this is a difficult matter requiring careful consideration of cases in the light of principle. Again, it does not involve a simple consequentialist calculation. The mere fact that a treatment is expensive does not make it extraordinary. Nor does the fact that it could be used with greater success on another patient. As long as it is not *futile* to use it on one patient, that patient should not be abandoned in favour of another simply because the probability of success is higher. Nor does the fact that the cost of the treatment is better put towards other medical resources to achieve a greater overall 'good'. One cannot simply trade off a respirator for a comatose patient against five X-ray machines. Nor can one balance a comatose bank clerk against a Nobel Prize-winning economist who might recover from brain damage if resources were diverted from the former person. Once such calculations are made based on 'quality of life' judgements and opinions about who deserves treatment, who will make a 'greater contribution' to society, who is more 'productive', and so on, the whole point of medicine is defeated and patients cease to be human beings with equal dignity, but rather units in a production line. Burdensomeness *does* involve questions of cost and distribution of resources, and certainly prior decision-making about how to allocate funds must be informed by questions such as: How can as many people as possible have access to as much overall care as possible? How

great is the *need* for respirators compared to the need for, say, CAT scanners? What alternative means of treatment are available? What preventive measures against certain conditions are in place? But such decision-making must not be informed by a judgement to the effect that comatose patients, for instance, simply do not deserve treatment because they are 'less than human', or have no further 'contribution' to make to society.

In a given case, a patient must not be treated in such a way as to give the impression: that his treatment is a gift; that it will be used on him unless and until the doctor judges his life not to be 'worth living'; that when this judgement is made, he will be left to die and the equipment will be moved on to someone else. Rather, the burdensomeness of a treatment is related to whether it is doing what it is supposed to do, whether it carries unacceptable risks, and whether and to what degree it taxes the capacities of doctor or patient. In particular, doctors have duties to more than one person. If a treatment requires such ongoing involvement that a doctor is at serious risk of neglecting his duties to other patients, the treatment can be deemed extraordinary, but again a careful consideration of cases is required.

There is much more that could be said about the ordinary/extraordinary distinction. But I hope that it has at least been shown what the distinction is *not*; that the true distinction is a necessary element of bioethical thinking; and what are some of the principles and applications for which the distinction is appropriate.

2.7 Euthanasia, Death and 'Brain Death'

It is an analytic truth that euthanasia cannot be performed on someone who is already dead. The question is, when is a person dead? It is easily asked, but more difficult to answer. Although it would take us too far into metaphysics to defend it, there is at least a case for saying that death itself is not something that can be observed. This might seem a startling claim: after all, don't doctors observe death all the time? I would say that what they or anyone else observes is *the moment of death* – they observe a person's dying, but they do not observe *what actually happens* which *constitutes* the death of that person. To take an analogy, we cannot directly observe each other's thoughts, in the sense of seeing what actually goes on inside a person's mind when he thinks something – no amount of

looking inside the brain will locate a thought. But we can observe each other in the *act* of thinking. (Let us leave aside whether it is possible directly to read someone's mind. Even if a human being could perform such an unlikely feat, his having direct *knowledge* of the thoughts of another would not mean he actually saw what was going on in the other's mind.)

For practical purposes, not being able to observe the actual event or events that constitute death makes the *determination* of when a person has died more difficult than it otherwise would have been, because we have to rely on *evidence* of death, *signs* or *indicators* of death. This is all we have to go on. But what are the indicators of death? This too is a difficult matter, as witnessed by the way criteria have changed over the years. Something like the irreversible cessation of circulation and respiration has been the traditional definition of death (in the sense of *certain indicator* of death). But how do we know when these processes are irreversible? When the person is dead? But that would be circular. The fact is, throughout the whole of human history up to the last few decades, and in virtually every civilisation that has left us records of the way they treated the dead, the *irreversibility* of breathing and circulation have themselves been determined by something like *the onset of putrefaction* (or the *withering* of the whole body, especially in warmer and drier climates, where putrefaction takes a long time if it happens at all.) If you want to be really sure someone is dead, you need to wait for his whole body to begin to decay. (Since the *onset* of putrefaction can be confused with a disease such as gangrene, even this indicator is liable to lead to misdiagnosis in rare cases; waiting for the signs of decay in the *whole* body cancels out this possibility.) In most cultures bodies have traditionally been left exposed ('in state') for several days, both to allow a proper process of grieving and to make it quite clear to all and sundry that the person is indeed dead and in at least the initial stages of decay.

The onset of putrefaction as an indicator of death is now seen by virtually everyone in the medical profession, and in medical ethics, as preposterous – not because it is not certain enough, but because it is *too* certain! After all, there is not much you can do with a putrefying body other than bury it. You cannot 'harvest' its organs – its heart, lungs, corneas, kidneys, liver, pancreas, and so on. Now the 1950s and 1960s brought great advances in medical technology, allowing patients to be kept alive for longer than ever imagined, even indefinitely, through artificial respiration, tube feeding, and various instruments for keeping the blood circulating, the body warm and the other life processes intact. Although this should

have been seen as cause for rejoicing that life could be maintained beyond the bounds of what was thought possible, doctors soon began to see 'ethical problems' on the horizon. Uncoincidentally, within months of the famous (and unsuccessful, since the patient died 18 days later) heart transplant by Dr Barnard in 1967 in South Africa, Harvard Medical School, seeing the possibilities opening up for organ transplantation, set up a committee to 'redefine' the concept of death. As the committee's chairman Henry Beecher told the Dean of the medical school, 'the time has come for a further consideration of the definition of death. Every major hospital has patients stacked up waiting for donors.'[27]

As subsequent events revealed, the entire procedure of the Harvard Brain Death Committee, as it came to be known, was governed by political motives. Organ transplant operations were increasing in number and success; doctors wanted fresh, healthy organs; patients needed them; so the committee redefined death to open up the market. The committee did not even pretend to enter into metaphysical and impartial scientific discussion of what death *is*. When it published its findings in 1968, its motives were clear: (1) organs were needed; (2) people were being kept alive by technology even though they had 'permanent loss of intellect' and were a 'burden . . . on their families, on the hospitals, and on those in need of hospital beds already occupied by these comatose patients'.[28]

The Harvard committee's new definition – 'whole brain death' – won the day, was confirmed by a presidential commission in 1981, and is still the definition that commands an overwhelming consensus among doctors, other health-care workers, scientists working in the field, and medical ethicists. 'Whole brain death' was defined to mean various things: 'permanent loss of intellect'; 'no discernible central nervous system activity'; 'irreversible loss of all brain function'; and even 'irreversible coma as a result of permanent brain damage'. The last definition, however, covers even those patients in a 'persistent vegetative state', who sometimes breathe spontaneously (without help), blink their eyes and have other reflex actions. But the Harvard committee did not want to go so far as to count such people as dead. (As Singer comments: 'To call for the undertakers to bury a "dead" patient who is still breathing would be a bit too much for anyone to swallow.'[29]) Nor have most 'experts', until the last decade or so. In 1993, as I mentioned earlier, the House of Lords allowed Tony Bland to be starved to death, even though he was in a persistent non-responsive state and so definitely was not suffering from 'whole brain death'. The Law Lords were somewhat vague as to whether Mr Bland

was dead. Lord Hoffmann stated that 'his body is alive, but he has no life', a curious contradiction he immediately qualified by saying that he had no life 'in the sense that even the most pitifully handicapped but conscious human being has a life'.[30] The general view was that Mr Bland was in a state 'with no prospect of recovery', and 'of no benefit'[31] to him – as though being alive were not beneficial.

We are now in a position where people such as Tony Bland – whose brains are still partially functioning, who are breathing, vomiting, dribbling, sleeping and waking, twitching their muscles or even moving their eyes – are, throughout the world, having their food withdrawn, being denied continuing medical treatment, in short, being 'allowed to die'. Often their organs are 'harvested', and the relatives of such patients regularly report having pressure exerted on them to agree to their loved one's becoming an 'organ donor'.

Why the shift from 'whole brain death' to something less? The need for organs has been mentioned. So has the belief that a person who is diagnosed as whole brain dead might be a 'burden' on others, from which it follows that someone who is *less* than whole brain dead is also conceivably a burden, since there is little difference between the cases as far as the strain on the family and the health-care system is concerned. But at the bottom of the further 'redefinition' of death to cover breathing people such as Tony Bland is, once again, *personism*: unless the person is conscious he is not a *person*. If he is not conscious he can 'have no life', as Lord Hoffmann said in the Bland case. In the end, the extent to which the brain is damaged – part or whole, brainstem (supporting breathing, circulation and other basic body functions) or cortex (supporting higher mental functions) – is not *of itself* the proper focus of attention. This notion is reinforced by the fact, as Singer points out, that recent experience has shown that the brains of people suffering from apparent whole brain death – as diagnosed by standardly accepted procedures such as testing for spontaneous eye movement and reactions to various stimuli – still carry out certain functions, such as supplying hormones to the rest of the body. Neurophysiologists now realise that there is far more to the brain than electrical activity, hormonal activity being equally important, if not more so.[32] 'Whole brain dead' patients who are cut open for their organs sometimes show an immediate rise in blood pressure and the quickening of their heartbeat, both of which are brain-regulated. There are two things to note about these startling facts. First, they have not stopped doctors from continuing to take organs from patients diagnosed as 'whole brain dead', which shows that they do not take the criterion seriously themselves. Second, they are consistent with the fact that the person having his organs taken out *is feeling pain*.

That he is not feeling a thing, however, is asserted by doctors time and again. These are only reflex responses, they claim. How do they know? Well, they cannot answer 'Because the brain is dead', since we have just seen that when a person is diagnosed as 'whole brain dead' his brain may still be functioning – indeed, given the poor state of our knowledge of the brain, it is fair to conjecture that virtually every single person who has ever been diagnosed as having 'permanent and total loss of brain function' has had a brain that was, in some respects, still functioning. And yet they insist that these bodily responses are merely reflex, like the twitching of a frog's leg after it has been cut off.

Do they, then, insist that the patient whose heart jumps when he is cut open for his kidneys is really dead after all? Some do, but as Singer shows, most do not. Nor do many relatives who are asked whether they would agree to the removal of their loved one's organs for transplant. Indeed, as Singer shows, the diagnosis of death involves not a small amount of hypocrisy in the medical profession. Some doctors *say* the patient is dead but do not believe it. Some say he is 'technically alive' but 'clinically dead', 'as good as dead', 'dead enough', or 'about as dead as you can get'. (These phrases are not all taken from Singer, but are readily heard in conversations with doctors and in reports that reach the media.) In fact, as Singer accepts, all such patients are, quite simply, *alive*. But *that* should not stop their becoming organ 'donors', he continues, because what mattered all along, even to the authors of the Harvard report on brain death, and what matters to just about everyone now, is whether the person is (a) conscious, and (b) capable of ever regaining consciousness. In other words, is the person concerned a *person*?

Once we turn back from the blind alley we are taken down by debates about brain death, says Singer, and we focus on *personhood*, we will then see that Tony Bland, every bit as much as a patient whose brainstem itself is severely damaged so that he needs almost total artificial life support, can from the ethical point of view be regarded as a potential source of organs for transplantation. The same goes for a baby born with hardly any brain, or one born with a severely damaged brain. They are all unequivocally alive, but then who said being alive as such counted for anything? Remember that I claimed earlier that the only sure sign of death is putrefaction, long after a person's organs have ceased to be of any use to

anyone. Singer agrees. He says: 'If we choose to mark death at any moment before the body goes stiff and cold (or to be really on the safe side, before it begins to rot) *we are making an ethical judgement*' (my emphasis).[33] In other words, when we disconnect the life-support system of a person whose heart is still beating, or we take the food away from a person who is still breathing, we are indeed killing him, but we are more importantly making an ethical – in other words, for Singer, utilitarian – judgement about, for instance, the benefit that patient's death can confer on others by the supply of his organs. We are, as traditional morality puts it, sacrificing the life of an innocent person to save others, as surely as the judge who condemns an innocent man to death to quell the rioting mob.

Perhaps you are not yet convinced that the thousands of people around the world today with various levels of severe brain damage, who are used as organ 'donors', are really alive. If so, consider the following. Charles is on a respirator; he is fed through a tube, but does not appear to move, and his eyes are always closed. He responds to no stimulus whatsoever, not even the most painful. Nothing can be done to rouse him. The doctor declares him dead, and asks for permission to disconnect life support and take out his organs, to which Charles's family agrees. When he is cut open, the doctor sees his heart is beating. The body is disconnected from every artificial device, and the heart still beats. The blood pressure fluctuates, maybe the heart quickens. It takes an hour to remove the required organs, and during the entire period the heart continues to beat. Is Charles dead? The doctor believes Charles is a 'beating-heart cadaver', as the technical term goes. Does such a term make sense?

It is a fact that these sorts of operation occur throughout the world on a regular basis. The surgeon prefers the heart to beat while he removes the organs, so that he has a constant supply of blood for as long as possible, keeping them fresh and more likely to work in the subsequent transplants. Sometimes, however, the disconnection is made and the doctors and family wait for the heart to stop beating. It can, in fact, beat for an hour after disconnection. Is the body a 'beating-heart cadaver' during that time? Would you be happy for it to be buried while its heart is still beating? Or cremated? If not, why would you be happy for its organs to be removed?

As Martyn Evans points out, not only ought we to be decidedly uneasy about burying someone whose heart is still beating, but the fact that heartbeat does not influence advocates of 'whole brain death' as the criterion of genuine death means that logically they should not be swayed either from diagnosing as dead someone who is still breathing, as Tony Bland

was: 'there is no convincing reason', Evans asserts, 'why those who accept the idea of "brainstem death" [that is, usually death of the whole brain, including brainstem] can distinguish – as they do – between the moral significance of persistent heartbeat and the moral significance of persistent breathing'.[34] If it is permissible to 'harvest' the organs of someone whose heart is still beating, it should be permissible to do so even while he is still breathing. What is the difference? To say that breathing requires the brain in a way that heartbeat does not, and moreover in a way that somehow makes a *moral* difference, is beside the point. Even if we *knew* – which we do not – exactly whether and how either heartbeat or circulation depend on brain activity, the question is why the brain *as such* matters at all to someone who believes the organs can legitimately be taken from a person with a persistent heartbeat. To reply 'Because breathing shows the brainstem is still functioning' does not help, because why does the brainstem matter? To say 'Because it regulates breathing' is circular. To say 'Because breathing is important' is again not to say *why*. After all, not only has heartbeat already been dismissed, but a patient might fail most if not all of the other selected criteria for brainstem function and still breathe spontaneously – 'brainstem' death has never been taken to mean 'total loss of brainstem function', as Evans points out, not least because no one knows how to *measure* total loss of brainstem function. And even if breathing were made the *only* criterion of brainstem function, or the most important, we still need to know why. No appeal to the social, cultural or emotional centrality of breathing to our understanding of life can be a good reason, since the same applies equally, if not more, to a persistent heartbeat.

As we saw earlier, to the vast majority of doctors and medical ethicists the only reason why brain activity is more important than heart or lung activity is that the brain supports consciousness. Heartbeat is increasingly being disregarded, as is breathing, which as a matter of logic is only proper. As has been argued, it is hard to see how the regulatory role of the brain in either heart or lung function can be non-trivially shown as crucial to the determination of death or to the moral assessment of how a person should be treated. Furthermore, lung function can be maintained by a respirator, and even cardiac function by an artificial heart (the technology of which is improving in leaps and bounds). Why does the existence of such maintenance mean that the patient either is dead or can be treated as if dead? No doctor would say this of a fully conscious paralysed child who needed spoon-feeding, so the fact that a person's bodily functions

need assistance cannot be the answer. The answer is that for most doctors and medical ethicists it is consciousness, not life, that matters. The same applies to advocates of euthanasia for the purpose of removing organs (as well as removing a 'burden' on the family and the state). And yet we would baulk at burying someone who had a beating heart, or who was still breathing. Perhaps, as *personists* become more and more explicit about the consequences of their theory, they will advocate the sweeping away of that taboo as well?

It follows from what has been argued that virtually every case in which a person's organs are removed for transplantation is a case of homicide, whether intentional or negligent. So little is known about the nature of death and its relation to physiology that even in, say, the case of a car accident where the victim is pronounced dead on arrival at casualty, and has his organs immediately removed, he is probably still alive. And I briefly mentioned the common phenomenon of rising blood pressure and quickening heartbeat when a 'brain-dead' person is opened up for his organs. This looks for all the world like a reaction to pain. Is it? It would take us too far afield to explore the area, but there are good reasons for the claim that *even on the personist criterion of consciousness* some, perhaps most, organ donors are being wronged, in the sense that they can feel pain and are fully aware of their bodies' being cut open without anaesthetic, an experience whose horror it is difficult to imagine. It is also quite possible, if not probable, that Tony Bland felt the agony of starving to death. In evidence I offer first a story and then a piece of research.

In 1996 it was reported that a Mr Gary Dockery, aged 39, awoke from being in a coma for 7½ years. A policeman, he had been wounded in 1988 by a shot in the head, and had been in a coma ever since. His family never gave up hope, and when he developed pneumonia they maintained a bedside vigil. (Many such patients, as well as senile elderly people with pneumonia, are not treated and allowed to 'slip away'.) Mr Dockery suddenly awoke and began talking. Soon he was telling jokes and talking to relatives on the telephone. His sister Lisa, according to a family friend, said 'it was like flipping on a light switch'. The friend added, 'All of a sudden, Gary started mumbling. She [Lisa] started talking to him and he started saying words.' He asked for his sons, whom he had not seen since they were aged 5 and 12. When they came into the room, now aged 12 and 20, their father still recognised them. According to the report, 'While amazed and encouraged by Mr. Dockery's consciousness, doctors cautioned the family it could be temporary. The brain works to repair itself from injury, but how long it can keep Mr. Dockery alert is unknown.' It turned out that Mr Dockery 'talked, joked and reminisced for eighteen hours'. According to his police partner Kenneth Cox, 'he was afraid to go to sleep. He wanted to just keep talking and listening.' Soon, however, he had to have an emergency operation on his lungs and 'spoke rarely after the surgery'. His doctors said he could still 'read, recognize numbers and say hello or good morning', but he was 'partially paralyzed and could not feed himself or walk'. Mr Dockery died from a pulmonary embolism in April 1997.[35]

The empirical research concerns two studies. The first was conducted in 1996, and involved an examination of the records of 40 patients admitted to a brain damage rehabilitation unit between 1992 and 1995 and who had been diagnosed as being in a 'persistent vegetative state' (the same state as Tony Bland, whom the House of Lords declared could be deprived of food). It was found that 17 of the patients (43 per cent) had been *misdiagnosed*, and were able to communicate effectively using eye-pointing or a touch-sensitive buzzer. What the authors mean by 'misdiagnosis', of course, is that the patients were every bit as conscious as you or I, though diagnosed as 'vegetables'. Indeed, the study suggests that the very idea of a 'persistent vegetative state' is to say the least dubious, and that the best one can say is that some people enter a persistent *non-responsive* state. Most of them do not receive nearly enough of the therapy they need, as was revealed in a recent television documentary on the brilliant results obtained at a special institute in Hungary. Patients whom their families had just about 'given up for dead', who looked as though they could not move a muscle or respond to a single stimulus, when given appropriate therapy and the right sort of equipment (such as buzzers and other instruments sensitive to the slightest muscle or eye movement), were able to communicate as normally as anyone else.[36]

The second study appeared in a different journal but in the same week as the first. It concerned a survey of over one thousand British neurophysiologists, neurosurgeons, rehabilitation therapists and other doctors, asking them about their attitude to the management of patients in a 'persistent vegetative state'. Of the doctors, 90 per cent said that it could be appropriate not to treat acute infections (such as pneumonia) and other life-threatening conditions, and 65 per cent said that the withdrawal of 'artificial nutrition and hydration' – that is, food and water – could be appropriate.[37]

2.8 Euthanasia and Nazism

In 1949, Dr Leo Alexander, an American-Jewish psychiatrist who was a consultant to the US Secretary of War at the Nuremberg war crimes trials, wrote:

> 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 handicapped and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But, it is important to realise that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the non-rehabilitable sick.[38]

In recent years there have been protests all around the world at speeches and lectures given by supporters of euthanasia. In Germany, Switzerland and Austria conferences have been disturbed or forced to be abandoned. The protests have come from the disabled, from religious groups, and from people with a painful memory of what happened under Nazism, in which tens of thousands of people deemed to have 'lives unworthy of life' were systematically exterminated. The 1941 film *Ich klage an*, about a doctor who kills his wife when she is diagnosed as having multiple sclerosis, was seen by 15.3 million Germans. By then euthanasia propaganda had convinced many if not most people that it was acceptable if formally 'legal' and discreetly carried out. Indeed, relatively few of the officials in the Nazi euthanasia programme were seriously punished by the Allies, itself a disturbing fact. As far back as the 1920s, a poll in Saxony found that 73 per cent of parents responded positively to the following question: 'Would you agree to the painless curtailment of the life of your child if experts had established that it was suffering from incurable idiocy?' Some parents even petitioned Hitler to allow their disabled children to be killed, to which he readily agreed.

It is no coincidence that people in countries that suffered under Nazism

have been at the forefront of demonstrations against public advocates of 'mercy' killing. After all, many of them have direct or indirect knowledge of the very programmes now being advocated. Is it surprising that many of them, convinced of the evil inherent in such policies, demand that their advocates not be allowed to spread such propaganda?

Professor R. M. Hare, one of the 'fathers' of modern consequentialist bioethics, has written: 'It [current writing in support of euthanasia] does not support anything like Nazi practices, which involved the killing of children on questionable scientific grounds without the consent of their parents.'[39] Further, he adds, modern writers appeal to the 'balance of advantage' for everyone in allowing such killing.

As anyone with even a superficial knowledge of the Nazi programme is aware,[40] it is precisely the 'balance of advantage' that the Nazis invoked in their support: advantage for the parents, for the doctors, for the rest of the family, and of course for the state, for whom only the 'socially productive' had moral value. Further, while the killing was often without parental consent, it often *was*. In any case, as we have seen, parents have no right to decide whether their child lives or dies and, moreover, even if they have *some* say in the matter, according to contemporary writers, it is not decisive, and the consequentialist calculation might *require* that their child be sacrificed to the advantage of the health-care bureaucracy or of the state in general, not least because they might be able later to produce a healthy child who would be less of a drain on public resources. Current advocates of euthanasia do not base their opinions on racial grounds, but nor, as we have seen, did the Nazis. They *extended* their policies to include racial and ideological undesirables, but the policy of destroying 'lives unworthy of life' (*lebensunwerten Lebens*), based on criteria of social and financial burden to others, never wavered. As for 'questionable scientific grounds', nothing is more questionable than the pseudo-scientific concept of a Quality Assisted Life Year, or QALY, so much in use by medical professionals and others as a slide rule in the calculation of whether a human being has the prospect of a life above a certain arbitrary threshold, in which he will be a 'productive' member of society.

It is, therefore, a mistake to claim that we are at the edge of a slippery slope to mass murder. We are *on* that slope, one that has already been traversed by other societies.[41] This time, however, we have technology and expertise far in advance of anything available to the Nazis. We are able to maintain the lives of people for longer and longer periods and to harvest their organs when we deem fit, to be used for other units on the

medical production line. Doctors, equipped with ever-improving technology and burdened by increasing demands for economic productivity, are becoming servants of the state hired to maximise utility.[42] And, in many ways, the state and the judicial system, which give implicit and progressively explicit support to euthanasia, have far greater powers, both to persuade and to execute policy, than those possessed by the Nazi state. Given these considerations, it is hard to see why advocates of euthanasia are horrified at the suggestion that there is any significant parallel between what they support – which is increasingly less a matter of abstract proposals than of everyday concrete reality – and what the Nazis themselves carried out.

3

Animals

3.1 The Problem

Just as the conflict over abortion has raged since the 1960s, so too the problem of our treatment of animals has taken a prominent place in moral debate. In fact the 'animals issue' has its roots in the nineteenth century, when in Britain, the USA and elsewhere, parliaments passed various kinds of anti-cruelty legislation and charitable bodies were formed to protect animals from harsh or neglectful treatment, rescue strays, promote public understanding of animal welfare, and so on.

In the past few decades, however, what used to be a generally accepted movement for the humane treatment of animals has turned into, or been enlarged by, other currents of thinking that have led to the animals issue becoming perhaps second to abortion in the passions and divisions it arouses. Just as pro-abortion and pro-life supporters have engaged in stormy protests and even outright violence, so there have been clashes between different sections of society over the question of animals: 'animal liberationists' attack scientific establishments and farms, releasing captive animals into the wild; 'animal rights' supporters block the transport of sheep and cattle for slaughter in other countries; farmers and scientists in turn accuse their critics of ignorance and stupidity; in Britain in 1998 several hundred thousand farmers and their supporters marched through the streets of London to protest the erosion of their way of life partly because of the animal rights movement – the march included supporters of fox hunting who defended their pastime against strident criticism in the media and its proposed prohibition by law. Animal experimentation, hunting, the eating of meat, the existence of zoos and circuses, the destruction of habitats, even the keeping of pets: all of these and other prac-