

A portrait of Peter Singer, an older man with glasses, wearing a dark suit jacket over a light blue shirt. He is positioned in front of a bookshelf filled with books. The text is overlaid on the lower half of the image.

PETER
SINGER

PRACTICAL ETHICS

THIRD EDITION

(or me, anyway) as superior to that of the early and mediaeval Christian writers, also thought infanticide the natural and humane solution to the problem posed by sick and deformed babies. The change in Western attitudes to infanticide since Roman times is, like the doctrine of the sanctity of human life of which it is a part, a product of Christianity. Perhaps it is now possible to think about these issues without assuming the Christian moral framework that has, for so long, prevented any fundamental reassessment.

None of this is meant to suggest that someone who goes around randomly killing babies is morally on a par with a woman who has an abortion. We should put very strict conditions on permissible infanticide; but these restrictions should owe more to the effects of infanticide on others than to the intrinsic wrongness of killing an infant. Obviously, in most cases, to kill an infant is to inflict a terrible loss on those who love and cherish the child. My comparison of abortion and infanticide was prompted by the objection that the position I have taken on abortion also justifies infanticide. I have admitted this charge to the extent that the *intrinsic* wrongness of killing the late fetus and the *intrinsic* wrongness of killing the newborn infant are not markedly different. In cases of abortion, however, we assume that the people most affected – the parents-to-be or at least the mother-to-be – want to have the abortion. Thus, infanticide can only be equated with abortion when those closest to the child do not want it to live. As an infant can be adopted by others in a way that a pre-viable fetus cannot be, such cases will be rare. (Some of them are discussed in the following chapter.) Killing an infant whose parents do not want it dead is, of course, an utterly different matter, just as forcing a woman to have an abortion she does not want to have is utterly different from allowing a woman to choose to have an abortion.

7

Taking Life

Humans

At the end of the last chapter, we looked beyond abortion to the issue of infanticide, thus confirming the suspicions of supporters of the sanctity of human life that once abortion is accepted, euthanasia lurks around the corner. For them, that is an added reason for opposing abortion. Euthanasia has, they point out, been rejected by doctors since the fifth century BC, when physicians first took the Oath of Hippocrates and swore 'to give no deadly medicine to anyone if asked, nor suggest any such counsel'. Moreover, they argue, the Nazi extermination programme is a terrible modern example of what can happen once we give the state the power to kill innocent human beings.

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

When the first edition of this book appeared in 1979, no country had legalized euthanasia, although in Switzerland a physician could prescribe lethal drugs to patients seeking aid in dying. Thirty years on, voluntary euthanasia and/or physician-assisted suicide is legal in the Netherlands, Switzerland, Belgium, Luxembourg, and the American states of Oregon, Washington and Montana. Before we consider the justifiability of these practices, some terminological clarification will be helpful.

FORMS OF AID IN DYING

Like abortion, providing aid in dying is highly controversial, and the politics of the issue has affected the terms used. In the United States, the discussion has focused on whether, if a patient asks a doctor for help in dying, the doctor ought to be allowed to prescribe something that will, if the patient takes it, end the patient's life swiftly and humanely. This has been legalized in the states of Oregon and Washington following citizen-initiated referenda that were passed by a majority of voters, and the Montana Supreme Court declared in 2009 that it is not contrary to law. It is usually called 'physician-assisted suicide' but in the United States, at least, 'suicide' has such negative associations that organizations seeking to legalize it prefer to call it 'death with dignity' or 'aid in dying.' These terms are too vague for philosophical discussions. 'Death with dignity' can mean almost anything, depending on what one considers a dignified way to die. 'Aid in dying' is barely more specific. It could refer to acts that make a dying person more comfortable, without shortening life, like giving modest amounts of pain relief, or it could refer to giving a patient, on request, a lethal injection. In addition, neither of these expressions says anything about *who* assists the patient to die. The term 'physician-assisted dying' gets closer to what happens, but it still does not emphasize that it is the patient who takes the step of ending her own life. Although it is certainly true that patients who are terminally ill and choose to end their own life to avoid further suffering are making a very different decision from people who kill themselves because they are emotionally disturbed, that does not change the basic fact that all these people are ending their own lives rather than continuing to live for as long as they can. Hence, we should not shy away from the term 'physician-assisted suicide,' because that offers the most precise description of what happens when a physician, acting on a request from the patient, provides a prescription for a drug which the patient then takes to end her life. In using this term, we should try to dismiss any negative associations that the term 'suicide' may have. Many cultures have considered suicide, in certain circumstances, to be a rational, honourable, and even sometimes a noble act. The Stoic philosopher Seneca wrote that a wise person 'lives as long as he ought, not as long as he can'. Cato the Younger, a Roman politician renowned for his integrity and refusal to take bribes, committed suicide when he was unable to stop Julius Caesar's overthrow of the Roman republic. According to Plutarch's account, Caesar said 'Cato, I grudge your death' – acknowledging that in ending his life,

Cato had done something truly noble. So let's use that term, without prejudicing our discussion of whether, in the circumstances we shall be discussing, physician-assisted suicide is justifiable or should be legal.

Physician-assisted suicide can be considered as one form of euthanasia, but the latter term has a wider meaning. According to the dictionary, 'euthanasia' refers to 'a gentle and easy death', but it is now used to refer to the killing of those who are incurably ill and in great pain or distress, in order to spare them further suffering or distress. Hence, it differs from physician-assisted suicide in that the physician or other person providing euthanasia may do the killing, for example, by giving the patient a lethal injection. Within the usual definition of euthanasia there are three different types, each of which raises distinctive ethical issues. It will help our discussion if we begin by setting out the three forms of euthanasia and place them within the broader framework. We can then assess the justifiability of each form.

Voluntary Euthanasia

Voluntary euthanasia is euthanasia carried out at the voluntary request of the person killed, who must be, when making the request, mentally competent and adequately informed. Euthanasia can be voluntary even if a person is not mentally competent right up to the moment of death because a person may, while in good health, make a written request for euthanasia specifying the conditions under which, if she should cease to be mentally competent, she would wish to die. In killing a person who has made such a request, has re-affirmed it from time to time, and is now in one of the states described, one could truly claim to be acting with her consent; and this would therefore be voluntary euthanasia.

In the Netherlands, a series of court cases during the 1980s upheld a doctor's right to assist a patient to die. The courts did not distinguish between providing a patient with a prescription for a lethal dose of a drug and giving the patient a lethal injection – in fact, in the Netherlands most doctors think it better that the physician be present when the patient dies to make sure that nothing goes wrong. Moreover, some patients are unable to swallow, or keep down, a large dose of a drug, and so injections are generally preferred.

In 2002, the Dutch parliament legalized voluntary euthanasia, as long as doctors comply with certain guidelines (which will be described later in this chapter). Belgium did the same later in the year. In 2008, Luxembourg became the third country to legalize voluntary euthanasia.

Involuntary Euthanasia

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

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

Nonvoluntary Euthanasia

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

In 1988 Samuel Linares, an infant, swallowed a small object that stuck in his windpipe, causing a loss of oxygen to the brain. Had such a case occurred fifty years earlier, Samuel would undoubtedly have died soon afterwards, and no decision would have had to be made. Instead, given the availability of modern medical technology, he was admitted to a Chicago hospital in a coma and placed on a respirator. Eight months later he was still comatose, still on the respirator, and the hospital was planning to move Samuel to a long-term care unit. Shortly before the move, Samuel's parents visited him in the hospital. His mother left the room, while his father produced a pistol and told the nurse to keep away.

He then disconnected Samuel from the respirator and cradled the baby in his arms until he died. When he was sure Samuel was dead, he gave up his pistol and surrendered to police. He was charged with murder, but the grand jury refused to issue a homicide indictment, and he subsequently received a suspended sentence on a minor charge arising from the use of the pistol.

In Canada in 1993, Robert Latimer killed his twelve-year-old disabled daughter Tracey by placing her in the cabin of the family truck and piping exhaust fumes into it. Evidence suggested that Tracey, who had a severe form of cerebral palsy, could not walk, talk, or feed herself and had suffered considerable pain. Latimer said that his priority was 'to put her out of her pain'. He was convicted of murder and sentenced to life imprisonment with a minimum of ten years before parole. Many Canadians felt the sentence was unreasonably harsh, but several appeals failed to free Latimer. He was granted parole in 2008.

Obviously, such cases raise different issues from those raised by voluntary euthanasia. There is no desire to die on the part of the person killed. The question can be raised whether, in such cases, the death is carried out for the sake of the infant or for the sake of the family as a whole. Caring for Samuel Linares would have been a great and no doubt futile burden for the family and a drain on the state's limited medical resources; but if he was comatose, he could not have been suffering, and death could not be said to be in (or contrary to) his interests. It is therefore not euthanasia, strictly speaking, as I have defined the term. It might nevertheless be a justifiable ending of a human life.

Because cases of infanticide and nonvoluntary euthanasia are the kind of cases most nearly akin to our previous discussions of the status of animals and the human fetus, we shall consider them first.

JUSTIFYING INFANTICIDE AND NONVOLUNTARY EUTHANASIA

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

The case of someone who has never been capable of choosing to live or die is a little more straightforward than that of a person who had, but

has now lost, the capacity to make such a decision. We shall, once again, separate the two cases and take the more straightforward one first. For simplicity, I shall concentrate on infants, although everything I say about them would apply to older children or adults whose mental age is and has always been that of an infant.

Life and Death Decisions for Disabled Infants

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

In Chapter 4, we saw that the fact that a being is a human being, in the sense of a member of the species *Homo sapiens*, is not relevant to the wrongness of killing it; instead, characteristics like rationality, autonomy and self-awareness make a difference. Infants lack these characteristics. Killing them, therefore, cannot be equated with killing normal human beings or any other self-aware beings. The principles that govern the wrongness of killing nonhuman animals that are sentient but not rational or self-aware must apply here too. As we saw, the most plausible arguments for attributing a right to life to a being apply only if there is some awareness of oneself as a being existing over time or as a continuing mental self. Nor can respect for autonomy apply where there is no capacity for autonomy. The remaining principles identified in Chapter 4 are utilitarian. Hence, the quality of life that the infant can be expected to have is important.

This conclusion is not limited to infants who, because of irreversible intellectual disabilities, will never be rational, self-aware beings. We saw in our discussion of abortion that the potential of a fetus to become a rational, self-aware being cannot count against killing it at a stage when it lacks these characteristics – not, that is, unless we are also prepared to count the value of rational self-aware life as a reason against contraception and celibacy. No infant – disabled or not – has as strong an intrinsic claim

to life as beings capable of seeing themselves as distinct entities existing over time.

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

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

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

Consider, for instance, Tay-Sachs disease, a genetic condition that within the first year of life causes the child's muscles to atrophy. The child becomes blind, deaf, unable to swallow and eventually paralysed. The child also suffers mental deterioration and has seizures. Even with

the best medical care, children with Tay-Sachs disease usually die before their fifth birthday. This seems to be a life that can reasonably be judged not to be worth living. When the life of an infant will be so miserable as not to be worth living, from the internal perspective of the being who will lead that life, both the 'prior existence' and the 'total' version of utilitarianism entail that if there are no 'extrinsic' reasons for keeping the infant alive – like the feelings of the parents – it is better that the child should be helped to die without further suffering.

A more difficult problem arises – and the convergence between the two views ends – when we consider disabilities that make the child's life prospects significantly less promising than those of a normal child, but not so bleak as to make the life one not worth living. Haemophilia may serve as an example. The haemophiliac lacks the element in normal blood that makes it clot and thus risks prolonged bleeding, especially internal bleeding, from the slightest injury. If allowed to continue, this bleeding leads to permanent crippling and eventually death. The bleeding is painful, and although improved treatments have eliminated the need for constant blood transfusions, haemophiliacs still have to spend a lot of time in hospital. They are unable to play most sports and live constantly on the edge of crisis. Nevertheless, haemophiliacs do not appear to spend their time wondering whether to end it all; most find life definitely worth living, despite the difficulties they face.

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

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

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

If we favour the total view rather than the prior existence view, then we have to take account of the probability that when the death of a disabled infant will lead to the birth of another infant with better prospects of a happy life, the total amount of happiness will be greater if the disabled infant is killed. The loss of happy life for the first infant is outweighed by the gain of a happier life for the second. Therefore, if killing the haemophiliac infant has no adverse effect on others, it would, according to the total view, be right to kill him.

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

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

finding out the sex of the fetus and aborting all males fetuses. Statistically, only half of these male children of women who carried the defective gene would have suffered from haemophilia, and so half of the fetuses being killed were normal. This practice was widespread in many countries and yet did not cause any great outcry. Now that we have techniques for identifying haemophilia before birth, we can be more selective, but the principle is the same: women are offered, and usually accept, abortions in order to avoid giving birth to children with haemophilia.

The same can be said about several other conditions that can be detected before birth. Down syndrome is one of these. Children with this condition have intellectual disabilities, and most will never be able to live independently, but their lives, like those of children, can be joyful. The risk of having a Down syndrome child increases sharply with the age of the mother, and for this reason in many countries prenatal diagnosis is offered to all pregnant women over thirty-five. The overwhelming majority of pregnant women who are told that their child will have Down syndrome end their pregnancy, and many start another pregnancy, which in most cases leads to the birth of a child without this condition.

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

When death occurs before birth, replaceability does not conflict with generally accepted moral convictions. That a fetus is known to be disabled is widely accepted as grounds for abortion. Yet, in discussing abortion, we saw that birth does not mark a morally significant dividing line. It is not easy to defend the view that fetuses may be 'replaced' before birth but newborn infants may not be. Nor is there any other point, such as viability, that does a better job of dividing the fetus from the infant. Self-awareness, which could provide a basis for holding that it is wrong to kill one being and replace it with another, is not to be found in either the

fetus or the newborn infant. Neither the fetus nor the newborn infant is an individual capable of regarding itself as a distinct entity with a life of its own to lead, and it is only for newborn infants, or for still earlier stages of human life, that replaceability should be considered to be an ethically acceptable option.

Some disability advocates object strongly to this conclusion. They say that to replace either a fetus or a newborn infant because of a disability is wrong, for it suggests to disabled people living today that their lives are less worth living than the lives of people who are not disabled. Yet that belief is the only way to make sense of actions that we all take for granted. Recall thalidomide: this drug, when taken by pregnant women, caused many children to be born without arms or legs. Once the cause of the abnormal births was discovered, the drug was taken off the market, and the company responsible had to pay compensation. If we *really* believed that there is no reason to think the life of a disabled person is likely to be any worse than that of a normal person, we would not have regarded the use of thalidomide by pregnant women as a tragedy. No compensation would have been sought by parents or awarded by the courts. The children would merely have been 'different'. We could even have left the drug on the market, so that women who found it a useful sleeping pill during pregnancy could continue to take it. If this sounds grotesque, that is only because we are all in no doubt at all that it is better to be born with limbs than without them. To believe this involves no disrespect at all for those who are lacking limbs; it simply recognizes the reality of the difficulties they face.

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

Even those who reject abortion and the idea that the fetus is replaceable are likely to regard *possible* people as replaceable. Recall the second woman in Parfit's case of the two women, described in Chapter 5. She was told by her doctor that if she went ahead with her plan to become pregnant immediately, her child would have a disability (it could have been haemophilia); but if she waited three months, her child would not have the disability. If we think she would do wrong not to wait, it can only

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be because we are comparing the two possible lives and judging one to have better prospects than the other. Of course, at this stage no life has begun; but the question is, when does a life, in the morally significant sense, really begin? In Chapters 4 and 5, we saw several reasons for saying that life only gains its full moral significance when there is awareness of one's existence over time.

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

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

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

The issue of ending life for disabled newborn infants is not without complications, both factual and philosophical. Philosophically, the most

difficult issue is whether to accept the prior existence or the total version of utilitarianism (or some other view altogether), because in the case of infants with disabilities whose lives are nevertheless worth living, the justifiability of a decision to end the infant's life will depend on which view we choose. Nevertheless, the main point remains clear, even after the various objections and complications have been considered: killing a disabled infant is not morally equivalent to killing a person. Very often it is not wrong at all.

Other Nonvoluntary Life and Death Decisions

In the preceding section, we discussed justifiable killing of beings who have never been capable of choosing to live or die. Ending a life without consent may also be considered in the case of those who were once persons capable of choosing to live or die but now, through accident or old age, have permanently lost this capacity and did not, prior to losing it, express any views about whether they wished to go on living in such circumstances. These cases are not rare. Many hospitals care for motor accident victims whose brains have been damaged beyond all possible recovery. They may survive, in a coma or perhaps barely conscious, for many years. Rita Greene, a nurse, was twenty-four when she became ill and went into a persistent vegetative state. She died at the age of sixty-three without ever having recovered consciousness. Estimates of the number of people in a persistent vegetative state in the United States at any given time range from 10,000 to 40,000. In other developed countries, where life-prolonging technology is not used so aggressively, there are far fewer long-term patients in this condition.

Decisions about the treatment of people in a persistent vegetative state sometimes come before the courts and receive extensive publicity. None has received more attention than the case of Terri Schiavo, who died in a Florida hospice in 2005 after spending fifteen years in what her doctors said was a persistent vegetative state. Michael Schiavo, Terri's husband, wanted her feeding tube removed so that she would die. He claimed that this was in accordance with her wishes, as previously expressed to him. Robert and Mary Schindler, her parents, denied this and also claimed that she showed signs of awareness and so was not in a persistent vegetative state. Court decisions favoured Michael Schiavo, and the feeding tube that was keeping Terri Schiavo alive was withdrawn. The case was soon taken up as a cause by those opposed to abortion and euthanasia. They succeeded in persuading the Florida legislature to pass a new law to keep

Terri's case before the Florida courts, and when the courts again failed to order that Terri be kept alive, Congress was recalled from a break to pass a special law allowing the Schindlers to take their case to a federal court. President George W. Bush flew from his Texas ranch to Washington to sign the law, but the federal court also held that Michael Schiavo had the right to make the decision to withdraw his wife's feeding tube. The U.S. Supreme Court refused to hear an appeal from that decision, and Terri died. An autopsy showed that Terri Schiavo's brain was severely atrophied, and that no treatment could have reversed the loss of brain matter.

It is possible that a small percentage of patients diagnosed as being in a persistent vegetative state do have some awareness. Improved imaging techniques enable us to see, however, that for many patients in a persistent vegetative state, there is no blood flow to the parts of the brain responsible for consciousness. Without blood flow, the brain rapidly decays; and so in those patients, the existence of consciousness, or the recovery of it, can definitely be excluded. Once it is clear that a patient in a persistent vegetative state has no awareness, and never again can have any awareness, her life has no intrinsic value. These patients are alive biologically but not biographically. If this verdict seems harsh, ask yourself whether there is anything to choose between the following options: (a) instant death; or (b) instant coma, followed by death without recovery in ten years. I can see no advantage in survival in a comatose state if death without recovery is certain.

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

be subjected to nonvoluntary euthanasia under any circumstances to register their refusal. If this became routine, it would have the additional benefit of preventing lengthy and costly legal cases like that of Terri Schiavo.

JUSTIFYING VOLUNTARY EUTHANASIA

Where euthanasia and physician-assisted suicide are illegal, doctors who help their terminally ill patients to die are risking serious criminal charges. Although juries are extremely reluctant to convict in cases of this kind, the law is clear that neither a request to be killed, nor the degree of suffering, nor the incurable condition of the person killed are defences to a charge of murder. Advocates of voluntary euthanasia propose that this law be changed so that a doctor may lawfully respond to a patient's desire to die without further suffering. The case for voluntary euthanasia has some common ground with the case for nonvoluntary euthanasia, in that death is a benefit for the one killed – or at least, in the case of people who are irreversibly unconscious, not a harm. The two kinds of euthanasia differ, however, in that voluntary euthanasia involves the killing of a person, a rational and self-aware being. (People who are rational and self-aware at the time they make a request may no longer be rational and self-aware at the time when the request is acted on, but for simplicity I shall disregard this complication.)

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

Let us return to the general principles about killing proposed in Chapter 4. I argued there that killing a being with a sense of his or her own future is a more serious matter than killing a merely conscious being. I gave four distinct grounds on which this could be argued:

1. The classical utilitarian claim that because self-aware beings are capable of fearing their own death, killing them has worse effects on others.
2. The preference utilitarian calculation that counts the thwarting of the victim's desire to go on living as an important reason against killing.
3. A theory of rights according to which to have a right one must have the ability to desire that to which one has a right, so that to

have a right to life one must be able to desire one's own continued existence.

4. Respect for the autonomous decisions of rational agents.

Now suppose we have a situation in which a person suffering from a painful and incurable disease wishes to die. Do any of the four grounds for holding that it is normally worse to kill a person provide reasons against killing when the individual is a person who wants to die?

The classical utilitarian objection does not apply to killing that takes place only with the genuine consent of the person killed. That people are killed under these conditions would have no tendency to spread fear or insecurity, because if we do not wish to be killed, we simply do not consent. In fact, the argument from fear points in favour of voluntary euthanasia, for if voluntary euthanasia is not permitted we may, with good cause, be fearful that our deaths will be unnecessarily drawn out and distressing. In the Netherlands, a nationwide government-commissioned study found that 'many patients want an assurance that their doctor will assist them to die should suffering become unbearable'. Often, having received this assurance, no request for euthanasia eventuated. The availability of euthanasia brought comfort without euthanasia having to be provided.

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

Next, according to the theory of rights we have considered, it is an essential feature of a right that one can waive one's rights if one so chooses. I may have a right to privacy; but I can, if I wish, install webcams in every room of my house and leave them on 24/7. No one who looks at the resulting images on my Web site violates my right to privacy, because I have waived the right. Similarly, to say that I have a right to life is not to say that it would be wrong for my doctor to end my life, if I choose to waive my right to life.

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

So, although there are reasons for thinking that killing a self-aware being is normally worse than killing any other kind of being, in the special

case of voluntary euthanasia most of these reasons count for euthanasia rather than against it. Surprising as this result might at first seem, it really does no more than reflect the fact that what is special about self-aware beings is that they can know that they exist over time and will, unless they die, continue to exist. Normally this continued existence is fervently desired, but when the foreseeable continued existence is dreaded rather than desired, the wish to die may take the place of the normal wish to live, reversing the reasons against killing. Thus, the case for voluntary euthanasia is arguably much stronger than the case for nonvoluntary euthanasia.

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

We now have a growing body of experience with the legalization of voluntary euthanasia and physician-assisted suicide, and that provides a basis for responding to these concerns. Although the Dutch parliament did not legalize euthanasia until 2002, this followed almost two decades during which Dutch physicians could be sure that they would not be prosecuted for carrying out euthanasia, as long as they followed guidelines developed by the courts in a series of cases in which physicians had been charged with euthanasia and acquitted. When euthanasia was legalized, similar conditions became part of the law. In the Netherlands, euthanasia is lawful only if:

- it is carried out by a physician;
- the patient has explicitly requested euthanasia in a manner that leaves no doubt that the patient's desire to die is voluntary, well-informed and well-considered;
- the patient has a condition causing protracted physical or mental suffering which the patient finds unbearable;
- there is no reasonable alternative (reasonable from the patient's point of view) to alleviate the patient's suffering; and

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

These guidelines make murder in the guise of euthanasia very difficult to carry out, and there has been no suggestion that this is occurring in the Netherlands. Since the law was passed, governments of different political complexions have held power, with the Christian Democrats taking the leading role in successive coalition governments. Nevertheless, there has been no move to repeal the legalization of euthanasia. It is not a coincidence that the next nations to legalize euthanasia, Belgium and Luxembourg, are neighbours of the Netherlands and that their laws are similar to the Dutch law. The majority of Belgians, in particular, are well-placed to observe the practice of euthanasia in the Netherlands, because they speak Dutch. It is implausible that these countries would have legalized euthanasia if there were clear evidence of serious abuses in the Netherlands.

Similarly, Oregon legalized physician-assisted suicide in 1997, so there is now considerable experience of that practice in one part of the United States. There has been no evidence of any abuse of the law. Once again, a neighbour has observed and then followed. At the elections held in 2008, the voters of Washington passed a law very similar to Oregon's.

Another common objection to euthanasia is that doctors can be mistaken. In rare instances, patients diagnosed by two competent doctors as suffering from an incurable condition have survived and enjoyed years of good health. Possibly the legalization of voluntary euthanasia would, over the years, mean the deaths of one or two people who would otherwise have recovered from their immediate illness and lived for some extra years. This is not, however, the knockdown argument against euthanasia that some imagine it to be. Against a very small number of unnecessary deaths that might occur if euthanasia is legalized we must place the very large amount of pain and distress that will be suffered quite pointlessly, by patients who really are terminally ill, if euthanasia is not legalized. Longer life is not such a supreme good that it outweighs all other considerations. (If it were, there would be many more effective ways of saving life – such as a ban on smoking or a reduction of speed limits to ten kilometres per hour, not to mention the issue of foreign aid that is the topic of the next chapter.) The possibility that two doctors may make a mistake means that the person who opts for euthanasia is deciding on the balance of probabilities and giving up an extremely small chance of survival in order to avoid suffering that is overwhelmingly likely to end

in death. This may be a perfectly rational choice. Probability is the guide of life, and of death too.

Against this, some will reply that improved care for the terminally ill has eliminated pain and made voluntary euthanasia unnecessary. But it is not only physical pain that makes people wish to die: they may suffer from bones so fragile they fracture at sudden movements, uncontrollable nausea and vomiting, slow starvation due to a cancerous growth, inability to control one's bowels or bladder, difficulty in breathing and so on. These symptoms often cannot be eliminated, at least not without keeping the patient unconscious all the time.

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

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

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

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

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

Dr. Jack Kevorkian, a Michigan pathologist, sought to help people who want to die but cannot get assistance from their own doctor. Initially, he helped people to die with a 'suicide machine' consisting of a metal pole with three different bottles attached to a tube of the kind used to provide an intravenous drip. He would insert the tube in the patient's vein, but with the switch set so that only a harmless saline solution can pass through it. The patient could then flip a switch allowing a coma-inducing drug to come through the tube; this was automatically followed by a lethal drug contained in the third bottle. Dr. Kevorkian announced that he was prepared to make the machine available to any terminally ill patient who wished to use it. In June 1990, Janet Adkins, who was suffering from Alzheimer's disease but still competent to make the decision to end her life, contacted Dr. Kevorkian and told him of her wish to die rather than go through the slow and progressive deterioration that the disease involves. Dr. Kevorkian was in attendance while she made use of his machine. He then reported Janet Adkins' death to the police. He was subsequently charged with murder, but the judge refused to allow the charge to proceed to trial, on the grounds that Janet Adkins had caused her own death. During the next eight years, Dr. Kevorkian assisted many other people to die. He was repeatedly charged with assisting suicide, but no jury convicted him of that offence. When his licence to practise medicine was withdrawn, and he was no longer able to obtain the lethal drug he had been using, he altered the 'suicide machine' so that it released carbon monoxide, through a gas mask, to the patient. Finally in 1998, Kevorkian decided to help Thomas Youk, who was dying from ALS, also known as Lou Gehrig's disease, and had asked Kevorkian to end his life. Those suffering from ALS lose control of their muscles, and so as the inevitable end approaches, they are unable to flip switches or take drugs. Kevorkian crossed the line from assisted suicide to voluntary euthanasia by giving Youk a lethal injection. Moreover, in a clear challenge to the legal authorities, he released a video taken while he was giving the injection. This time, a jury convicted him of second-degree homicide, and he served eight years in prison before being released on parole.

Philip Nitschke prefers to work at the edge of the law rather than to challenge it directly. Nitschke was practicing medicine in Australia's Northern Territory when that region legalized voluntary euthanasia. Nitschke helped four terminally ill people end their lives before the law was overturned by the Federal government in 1997. Convinced that people have a right to end their own lives if they choose to do so, he founded Exit International, an organization that runs workshops in Australia, New Zealand, the United Kingdom and the United States advising people on how to end their lives reliably and safely. He has co-authored *The Peaceful Pill Handbook* to provide the same knowledge to those who cannot attend the workshops. The hard copy version of the book has been banned in Australia, but is available in the United States, and Nitschke has made an electronic version available online (although it is an offense to download it in Australia). Whatever one thinks about the ethics of voluntary euthanasia and physician-assisted suicide, whether such information should be publicly available is itself an ethical question, given the possibility of misuse by those who are not terminally or incurably ill. Many advocates of the legalization of voluntary euthanasia and physician-assisted suicide are themselves against publishing 'do it yourself' guides to dying, arguing that laws restricting aid in dying to doctors provide important safeguards. Nitschke might agree that this would be desirable, but consider that because there are still few countries in which either voluntary euthanasia or physician-assisted suicide is legal, the importance of helping those who have good reason to end their lives outweighs the small risk of misuse.

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

The question is a reasonable one, because respect for individual freedom can be carried too far. John Stuart Mill thought that the state should never interfere with the individual except to prevent harm to others. The individual's own good, Mill thought, is not a proper reason for state intervention. But Mill may have had too high an opinion of the rationality of most human beings. It may occasionally be right to prevent people making choices that are obviously not rationally based and which we can be sure they will later regret. The prohibition of voluntary euthanasia cannot

be justified on paternalistic grounds, however, for voluntary euthanasia is an act for which good reasons exist. Voluntary euthanasia occurs only when, to the best of medical knowledge, a person is suffering from an incurable and painful or extremely distressing condition. In these circumstances one cannot say that to choose to die quickly is obviously irrational. The strength of the case for voluntary euthanasia lies in this combination of respect for the preferences, or autonomy, of those who decide for euthanasia; and the clear rational basis of the decision itself. When information about ending one's life is made easily available, people may decide to end their lives without such a clear rational basis. Legal, regulated voluntary euthanasia and physician-assisted suicide have far less potential for abuse, and when they are available, there is no need to make it easy for people to find out how to kill themselves.

NOT JUSTIFYING INVOLUNTARY EUTHANASIA

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

Something very like involuntary euthanasia appears to have taken place in a hospital in New Orleans during the floods caused by Hurricane Katrina in 2005. Memorial Medical Center, a community hospital that was holding more than 200 patients at the time, was cut off by the rising water. Three days after the hurricane hit, the hospital had no electricity, the water supply had failed, and toilets could no longer be flushed. Some patients who were dependent on ventilators died. In stifling heat, doctors and nurses were hard-pressed to care for surviving patients lying on soiled beds. Adding to the anxiety were fears that law and order had broken down in the city, and the hospital itself might be a target for armed bandits.

Helicopters were called in to evacuate patients. Priority was given to those who were in better health, and could walk. State police arrived and told staff that because of the civil unrest, everybody had to be out of the hospital by 5 P.M.

On the eighth floor, Jannie Burgess, a 79-year-old woman with advanced cancer, was on a morphine drip and close to death. To evacuate her, she would have to be carried down six flights of stairs and would require the attention of nurses who were needed elsewhere. If she were

left unattended, however, she might come out of her sedation and be in pain. One of the physicians present instructed the nurse to increase the morphine 'giving her enough until she goes'. Another physician told nursing staff that several patients on the seventh floor were also too ill to survive. She injected them with morphine and another drug that slowed their breathing until they died.

At least one of the patients injected with this lethal combination of drugs appears to have otherwise been in little danger of imminent death. Emmett Everett was a 61-year-old man who had been paralysed in an accident several years earlier and was in the hospital for surgery to relieve a bowel obstruction. When others from his ward were evacuated, he asked not to be left behind; but he weighed 380 lbs (172 kg), and it would have been extremely difficult to carry him down the stairs and then up again to where the helicopters were landing. He was told the injection he was being given would help with the dizziness from which he suffered.

Whether any of these killings can be justified in these circumstances is debatable, but the killing of Emmett Everett, in my view, cannot be. Significantly, the physicians' actions were not the result of a slippery slope from the acceptance of voluntary euthanasia or physician-assisted suicide, for those practices have always been illegal in Louisiana. Rather, from what the physicians told Sheri Fink, on whose *The New York Times* report the previous account is based, the physicians saw what they were doing as an application of the doctrine of double effect, on which physicians commonly draw when giving morphine to relieve pain in a terminally ill patient, though they know it will shorten life. We shall discuss that doctrine shortly.

Would it ever be possible to justify involuntary euthanasia on paternalistic grounds, to save someone extreme agony? We can imagine a case in which the agony is so great, and so certain, that it overrides all four reasons against killing self-aware beings. Yet to make this decision one would have to be confident that one can judge when a person's life is so bad as to be not worth living – and that one is in a better position to make that judgment than the person herself. But the fact that the other person wishes to go on living is good evidence that her life is worth living. What better evidence could there be?

The only kind of case in which the paternalistic argument is at all plausible is one in which the person to be killed does not realize what agony she will suffer in the future, and if she is not killed now she will have to live through to the very end. On these grounds, one might kill a person who has – though she does not yet realize it – fallen into the

hands of homicidal sadists who will torture her to death. These cases are, fortunately, more commonly encountered in fiction than reality.

Here, the distinction between critical and intuitive levels of moral reasoning (see pp. 78–80, Chapter 4) is again relevant. If in real life we are unlikely ever to encounter a case of justifiable involuntary euthanasia, then it may be best to dismiss from our minds the fanciful cases in which one might imagine defending it and treat the rule against involuntary euthanasia as, for all practical purposes, absolute. At the intuitive level, the level of moral reasoning we apply in our daily lives, we can simply say that euthanasia is only justifiable if those killed either:

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

ACTIVE AND PASSIVE EUTHANASIA

The conclusions we have reached in this chapter violate one of the most fundamental tenets of Western ethics – that killing an innocent human being is always wrong. I have already shown that my conclusions are, at least in the area of disabled infants, a less radical departure from existing practice than one might suppose because of the widespread support for prenatal diagnosis and abortion of a pregnancy that will lead to a disabled child. In this section, I shall argue that there is another area of accepted medical practice that is not intrinsically different from the practices that I advocate. Against this background, the conclusions we have reached may seem less shocking than they otherwise would.

'Baby Doe' – a legal pseudonym – was born in Bloomington, Indiana, in 1982, with Down syndrome and some additional problems, including an improperly formed oesophagus – the passage from the mouth to the stomach. This meant that Baby Doe could not receive nourishment by mouth. Surgery to fix the problem was offered, but the parents, after discussing the situation with their obstetrician, refused. Without surgery, Baby Doe would soon die. Baby Doe's father later said that as a school-teacher he had worked closely with Down syndrome children, and that he and his wife had decided that it was in the best interests of Baby Doe, and of their family as a whole (they had two other children), to refuse

consent for the operation. The hospital authorities, uncertain of their legal position, took the matter to court. Both the local county court and the Indiana State Supreme Court upheld the parents' right to refuse consent to surgery. The case attracted national media attention, and an attempt was made to take it to the United States Supreme Court; but before this could happen, Baby Doe died.

One result of the Baby Doe case was that the United States government, headed at the time by President Ronald Reagan, issued regulations directing that all infants are to be given necessary life-saving treatment, irrespective of disability. But the new regulations were strongly resisted by the American Medical Association and the American Academy of Pediatrics. In court hearings on the regulations, even Dr. C. Everett Koop, Reagan's surgeon general and the driving force behind the attempt to ensure that all infants should be treated, had to admit that there were some cases in which he would not provide life-sustaining treatment. Dr. Koop mentioned three conditions in which, he said, life-sustaining treatment was not appropriate: anencephalic infants (infants born without a brain); infants who had, usually as a result of extreme prematurity, suffered such severe bleeding in the brain that they would never be able to breathe without a respirator and would never be able even to recognize another person; and infants lacking a major part of their digestive tract, who could only be kept alive by means of a drip providing nourishment directly into the bloodstream.

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

In a series of British cases, the courts have accepted the view that the quality of a child's life is a relevant consideration in deciding whether life-sustaining treatment should be provided. In a case called *In re B*, concerning a baby like Baby Doe, with Down syndrome and an intestinal obstruction, the court said that surgery should be carried out, because the infant's life would not be 'demonstrably awful'. In another case, *Re C*, where the baby had a poorly formed brain combined with severe physical handicaps, the court authorised the paediatric team to refrain from giving life-prolonging treatment. This was also the course taken in

the case of *Re Baby J*; this infant was born extremely prematurely and was blind, deaf and would probably never have been able to speak.

A survey of European physicians working in neonatal intensive care units in France, Germany, Italy, Luxembourg, the Netherlands, Spain, Sweden and the United Kingdom showed that in all these countries, a majority had set limits to the intensive care given to an infant because it had an incurable condition. They had, for example, withheld resuscitation after a baby's heart had stopped or not put the baby on a respirator. Thus, though many would disagree with Baby Doe's parents' decision (because people with Down syndrome can live enjoyable lives and are often warm and loving individuals), virtually everyone recognizes that in more severe conditions, allowing an infant to die is the only humane and ethically acceptable course to take. The question is: if it is right to allow infants to die, why is it wrong to kill them?

This question has not escaped the notice of the doctors involved. Frequently, they answer it by invoking a verse by the nineteenth-century poet, Arthur Clough:

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

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

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

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

What grounds are there for accepting the acts and omissions doctrine? Few champion the doctrine for its own sake as an important ethical first principle. It is, rather, an implication of one view of ethics, of a view that holds that so long as we do not violate specified moral rules that place determinate moral obligations on us, we do all that morality demands of us. These rules are of the kind made familiar by the Ten Commandments and similar moral codes: 'Do not kill', 'Do not lie', 'Do not steal' and so on. Characteristically they are formulated in the negative, so that to obey them it is necessary only to abstain from the actions they prohibit. Hence, obedience can be demanded of every member of the community.

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

An ethic that judges acts according to whether they do or do not violate specific moral rules must, therefore, place moral weight on the distinction between acts and omissions. An ethic that judges acts by their consequences will not do so, for the consequences of an act and an omission will often be, in all significant respects, indistinguishable. For instance, deciding not to put a premature infant who cannot breathe unaided on a respirator has consequences just as fatal as giving the child a lethal injection.

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

An old lady of 83 has been admitted [to a nursing home for the aged] because her increasing degree of mental confusion has made it impossible for her to stay

in her own home, and there is no one willing and able to look after her. Over three years, her condition deteriorates. She loses the ability to speak, requires to be fed, and becomes incontinent. Finally, she cannot sit in an armchair any longer, and is confined permanently to bed. One day, she contracts pneumonia.

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

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

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

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

One might say, of course, that the doctor who withholds antibiotics does not kill the patient, she merely allows the patient to die; but one must then answer the further question why killing is always wrong and

letting die is sometimes right. The answer that most advocates of the distinction give is simply that there is a moral rule against killing innocent human beings and none against allowing them to die. This answer treats a conventionally accepted moral rule as if it were beyond questioning; it does not go on to ask whether we should have a moral rule against killing (but not against allowing to die). We have already seen that the conventionally accepted principle of the sanctity of human life is untenable. The moral rules that prohibit killing but accept 'letting die' cannot be taken for granted either.

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

Others have suggested that the difference between withholding treatment necessary to prolong life and giving a lethal injection lies in the intention with which the two are done. Those who take this view resort to the 'doctrine of double effect', a doctrine widely held among Roman Catholic moral theologians and moral philosophers, to argue that one action (for example, refraining from life-sustaining treatment) may have two effects (in this case, not causing additional suffering to the patient and shortening the patient's life). They then argue that as long as the *directly intended* effect is the beneficial one that does not violate an absolute moral rule, the action is permissible. Though we foresee that our action (or omission) will result in the death of the patient, this is merely an unwanted side effect. But the distinction between directly intended effect and side effect is a contrived one, and the doctrine can easily be misused, as we have seen in the case of Memorial Medical Center in New Orleans after Hurricane Katrina. We cannot avoid responsibility simply by directing our intention to one effect rather than another. If we foresee both effects, we must take responsibility for the foreseen effects of what we do. We often want to do something but cannot do it because of its other, unwanted consequences. For example, a chemical company might want to get rid of toxic waste in the most economical manner, by

dumping it in the nearest river. Would we allow the executives of the company to say that all they directly intended was to improve the efficiency of the factory, thus promoting employment and keeping down the cost of living? Would we regard the pollution as excusable because it is merely an unwanted side effect of furthering these worthy objectives? Obviously, the defenders of the doctrine of double effect would not accept such an excuse. In rejecting it, however, they would have to rely on a judgment that the cost – the polluted river – is disproportionate to the gains. Here, a consequentialist judgment lurks behind the doctrine of double effect. The same is true when the doctrine is used in medical care. Normally, saving life takes precedence over relieving pain. If in the case of a particular patient it does not, this can only be because we have judged that the patient's prospects for a future life of acceptable quality are so poor that in this case relieving suffering can take precedence. This is, in other words, not a decision based on acceptance of the sanctity of human life, but a decision based on a disguised quality of life judgment.

Equally unsatisfactory is the common appeal to a distinction between 'ordinary' and 'extraordinary' means of treatment, coupled with the belief that it is not obligatory to provide extraordinary means. Together with my colleague, Helga Kuhse, I carried out a survey of paediatricians and obstetricians in Australia and found that they had remarkable ideas about what constituted 'ordinary' and 'extraordinary' means. Some even thought that the use of antibiotics – the cheapest, simplest and most common medical procedure – could be extraordinary. The reason for this range of views is easy to find. When one looks at the justifications given by moral theologians and philosophers for the distinction, it turns out that what is 'ordinary' in one situation can become 'extraordinary' in another. For example, in the landmark case of Karen Ann Quinlan, a young New Jersey woman who was in a coma, breathing with the aid of a respirator and considered to have no prospect of recovery, a Roman Catholic bishop testified that the use of a respirator was 'extraordinary' and hence optional because Quinlan had no hope of recovery from the coma. Obviously, if doctors had thought that Quinlan was likely to recover, the use of the respirator would not have been optional and would have been declared 'ordinary'. On the other hand, when the respirator was removed and Quinlan, to most people's surprise, continued to breathe on her own, her parents, who were Roman Catholics, did not seek the removal of her feeding tube. Quinlan survived for another nine years but never recovered from her coma.

In 2004, during the controversy over Terri Schiavo, Pope John Paul II stated firmly that a feeding tube must not be withdrawn from people in a vegetative state, saying that 'the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act'. It is hard to see how the use of a feeding tube is not a medical act – inserting one is not something that people without health care training can do. Is there really a significant moral difference between withdrawing a respirator and withdrawing a feeding tube? The patient's prospects of at least a minimal quality of life (and, where resources are limited and could be used more effectively to save lives elsewhere, the cost of the treatment) should determine whether a given form of treatment is to be provided or not.

Indeed, because of extrinsic differences – especially differences in the time it takes for death to occur – active euthanasia may be the more humane course. In the 1970s, Dr. John Lorber, a British physician, recommended that infants born with the most severe form of spina bifida – then a relatively common birth defect in which the baby has a wound on the back exposing the nerves – should be allowed to die, because he considered that their prospects of a worthwhile life were poor. Lorber openly acknowledged that the object of not treating these infants is that they should die soon and painlessly. Yet when he charted the fate of twenty-five infants born with spina bifida on whom it had been decided not to operate, he found that fourteen were still alive after one month and seven after three months. An Australian clinic following Lorber's approach to spina bifida found that of seventy-nine untreated infants, five survived for more than two years. For both the infants, and their families, this must have been a long, drawn-out ordeal. It is also (although in a society with a reasonable level of affluence this should not be the primary consideration) a considerable burden on the hospital staff and the community's medical resources. (Today, far fewer babies are born with spina bifida, partly because of the discovery that taking folic acid early in pregnancy reduces the incidence of the condition and partly because spina bifida can now be detected during pregnancy and most fetuses with the condition are aborted.)

Consider, to take another example, infants born with Down syndrome and a blockage in the digestive system which, if not removed, will make it impossible for the baby to eat. Like 'Baby Doe', these infants may be allowed to die. Yet the blockage can be removed and has nothing to do with the degree of intellectual disability the child will have. Moreover, the death resulting from the failure to operate in these circumstances is,

though sure, neither swift nor painless. The infant dies from dehydration or hunger. Baby Doe took about five days to die, and in other recorded instances of this practice, it has taken up to two weeks for death to come.

It is interesting, in this context, to think again of our earlier argument that membership of the species *Homo sapiens* does not entitle a being to better treatment than a being at a similar mental level who is a member of a different species. We could also have said – except that it seemed too obvious to need saying – that membership of the species *Homo sapiens* is not a reason for giving a being *worse* treatment than a member of a different species. Yet in respect of euthanasia, this needs to be said. If your dog is ill and in pain with no chance of recovery, the humane thing to do is take her to the vet, who will end her suffering swiftly with a lethal injection. To ‘allow nature to take its course’, withholding treatment while your dog dies slowly and in distress over days, weeks or months, would obviously be wrong. It is only our misplaced respect for the doctrine of the sanctity of human life that prevents us from seeing that what it is obviously wrong to do to a dog, it is equally wrong to do to a human being who has never been able to express a view about such matters.

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

THE SLIPPERY SLOPE: FROM EUTHANASIA TO GENOCIDE?

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

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

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

Whatever proportions [Nazi] crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in the category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick.

Alexander singles out the Nazis' so-called euthanasia program as the root of all the horrendous crimes the Nazis later committed, because that program implied ‘that there is such a thing as life not worthy to be lived’. Lorber could hardly agree with Alexander on this, because his recommended procedure of not treating infants with the worst form of spina bifida is based on exactly this judgment. Although people sometimes talk as if we should never judge a human life to be not worth living, there are times when such a judgment is obviously correct. A life of physical suffering, unredeemed by any form of pleasure or by a minimal level of self-awareness, is not worth living. As we have already noted, life with Tay-Sachs disease is a plausible example of a life not worth living. Surveys undertaken by health care economists in which people are asked how much they value being alive in certain states of health, regularly find that people give some states a negative value – that is, they indicate that they would prefer to be dead than to survive in that condition. Apparently, the life of the elderly woman described by Sir Gustav Nossal was, in the opinion of the matron of the nursing home, the doctor, and the relatives, not worth living. If we can set criteria for deciding who is to be allowed to die and who is to be given treatment, then why should it be wrong to set criteria, perhaps the same criteria, for deciding who should be killed?

So it is not the attitude that some lives are not worth living that marks out the Nazis from normal people who do not commit mass murder. What

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

In fact, the Nazis did not have a euthanasia program, in the proper sense of the word. Their so-called euthanasia program was not motivated by concern for the suffering of those killed. If it had been, they would not have kept their operations secret, deceived relatives about the cause of death of those killed, or exempted from the program certain privileged classes, such as veterans of the armed services or relatives of the euthanasia staff. Nazi 'euthanasia' was never voluntary and often was involuntary rather than nonvoluntary. 'Doing away with useless mouths' – a phrase used by those in charge – gives a better idea of the objectives of the program than 'mercy-killing'. Both racial origin and ability to work were among the factors considered in the selection of patients to be killed. It was the Nazi belief in the importance of maintaining a pure Aryan *Volk* – a quasi-mystical racist concept that was thought of as more important than mere individuals' lives – that made both the so-called euthanasia program and later the entire holocaust possible. Proposals for the legalization of euthanasia, on the other hand, are based on respect for autonomy and the goal of avoiding pointless suffering.

Hence, there is little prospect that legalizing euthanasia will lead us to slide into the abyss of Nazi-style atrocities. It could still be argued that no matter how arbitrary the distinctions between human and nonhuman, fetus and infant, and killing and allowing to die, may be, the rule that it is always wrong to kill an innocent human being at least marks a workable line. The distinction between an infant whose life may be worth living and one whose life definitely is not is much more difficult to draw. Perhaps people who see that some kinds of human beings may be killed

in certain circumstances are more likely to conclude that it is not wrong to kill others not very different from the first kind. So will the boundary of acceptable killing be pushed gradually back? In the absence of any logical stopping place, will the outcome be the loss of all respect for human life?

If our laws were altered so that anyone could carry out an act of euthanasia, the absence of a clear line between those who might justifiably be killed and those who might not would pose a real danger; but that is not what advocates of euthanasia propose. If acts of euthanasia can only be carried out by a member of the medical profession, with the concurrence of a second doctor, it is not likely that the propensity to kill would spread unchecked throughout the community. Doctors already have a good deal of power over life and death through their ability to withhold treatment. There has been no suggestion that doctors who begin by allowing severely disabled infants to die from pneumonia will move on to withhold antibiotics from political extremists or patients who belong to a racial minority. In fact, legalizing euthanasia might well act as a check on the power of doctors because it would bring what some doctors do now, on their own initiative and in secret, into the open and under the scrutiny of another doctor.

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

All of this is not to deny that departing from the traditional sanctity of life ethic carries with it a small but nevertheless finite risk of unwanted consequences. Against this risk we must balance the tangible harm to which the traditional ethic gives rise – harm to those whose misery is needlessly prolonged. We must also ask if the widespread

acceptance of abortion and passive euthanasia has not already revealed flaws in the traditional ethic that make it a weak defence against those who lack respect for individual lives. A sounder, if less clear-cut, ethic may in the long run provide a firmer ground for resisting unjustifiable killing.

8

Rich and Poor

SOME FACTS ABOUT POVERTY

At the end of the twentieth century, the World Bank sent out a team of researchers to record the views of 60,000 women and men living in extreme poverty. Visiting seventy-three countries, the research team heard, over and over, that poverty meant these things:

- You are short of food for all or part of the year, often eating only one meal per day, sometimes having to choose between stilling your child's hunger or your own, and sometimes being able to do neither.
- You can't save money. If a family member falls ill and you need money to see a doctor, or if the crop fails and you have nothing to eat, you have to borrow from a local moneylender; he will charge you so much interest that the debt continues to mount, and you may never be free of it.
- You can't afford to send your children to school; or if they do start school, you have to take them out again if the harvest is poor.
- You live in an unstable house, made with mud or thatch that you need to rebuild every two or three years, or after severe weather.
- You have no close source of safe drinking water. You have to carry it a long way, and even then, it can make you ill unless you boil it.

Along with these material deprivations goes, very often, a humiliating state of powerlessness, vulnerability and a deep sense of shame or failure.

Extreme poverty, as defined by the World Bank, means not having enough income to meet the most basic human needs for adequate food, water, shelter, clothing, sanitation, health care or education. In 2008, the