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Euthanasia

HELGA KUHSE

i Introduction

'EUTHANASIA' is a compound of two Greek words – *eu* and *thanatos* – meaning, literally, 'a good death'. Today, 'euthanasia' is generally understood to mean the bringing about of a good death – 'mercy killing', where one person, A, ends the life of another person, B, for the sake of B. This understanding of euthanasia emphasizes two important features of acts of euthanasia. First, that euthanasia involves the deliberate taking of a person's life; and, second, that life is taken for the sake of the person whose life it is – typically because she or he is suffering from an incurable or terminal disease. This distinguishes euthanasia from most other forms of taking life.

Every society known to us subscribes to some principle or principles prohibiting the taking of life. But there are great variations between cultural traditions as to when the taking of life is considered wrong. If we turn to the roots of our Western tradition, we find that in Greek and Roman times such practices as infanticide, suicide and euthanasia were widely accepted. Most historians of Western morals agree that Judaism and the rise of Christianity contributed greatly to the general feeling that human life has sanctity and must not deliberately be taken. To take an innocent human life is, in these traditions, to usurp the right of God to give and take life. It has also been seen by influential Christian writers as a violation of natural law. This view of the absolute inviolability of innocent human life remained virtually unchallenged until the sixteenth century when Sir Thomas More published his *Utopia*. In this book, More portrays euthanasia for the desperately ill as one of the important institutions of an imaginary ideal community. In subsequent centuries, British philosophers (notably David Hume, Jeremy Bentham and John Stuart Mill) challenged the religious basis of morality and the absolute prohibition of suicide, euthanasia and infanticide. The great eighteenth-century German philosopher Immanuel Kant, on the other hand, whilst believing that moral truths were founded on reason rather than religion, nonetheless thought that 'man cannot have the power to dispose of his life' (Kant, 1986, p. 148).

Mercy for a hopelessly ill and suffering patient and, in the case of voluntary euthanasia, respect for autonomy, have been the primary reasons given by those who have argued for the moral permissibility of euthanasia. Today, there is widespread popular support for some forms of euthanasia and many contemporary philosophers have argued that euthanasia is morally defensible. Official religious

opposition (for example, from the Roman Catholic Church) does, however, remain unchanged, and active euthanasia remains a crime in every nation other than the Netherlands. There, a series of court cases, beginning in 1971, have established the conditions under which doctors, and only doctors, may practise euthanasia: the decision to die must be the voluntary and considered decision of an informed patient; there must be physical or mental suffering which the sufferer finds unbearable; there is no other reasonable (i.e. acceptable to the patient) solution to improve the situation; the doctor must consult another senior professional.

Before looking more closely at the arguments for and against euthanasia, it will be necessary to draw some distinctions. Euthanasia can take three forms: it can be voluntary, non-voluntary and involuntary.

ii Voluntary, non-voluntary and involuntary euthanasia

The following case is an example of *voluntary* euthanasia:

> Mary F. was dying from a progressively debilitating disease. She had reached the stage where she was almost totally paralysed and, periodically, needed a respirator to keep her alive. She was suffering considerable distress. Knowing that there was no hope and that things would get worse, Mary F. wanted to die. She asked her doctor to give her a lethal injection to end her life. After consultation with her family and members of the health-care team, Dr H. administered the asked-for lethal injection, and Mary F. died.

The case of Mary F. is a clear case of voluntary euthanasia; that is, euthanasia carried out by A *at the request of* B, for the sake of B. There is a close connection between voluntary euthanasia and assisted suicide, where one person will assist another to end her life – for example, when A obtains the drugs that will allow B to suicide.

Euthanasia can be voluntary even if the person is no longer competent to assert her wish to die when her life is ended. You might wish to have your life ended should you ever find yourself in a situation where, whilst suffering from a distressing and incurable condition, illness or accident have robbed you of all your rational faculties, and you are no longer able to decide between life and death. If, whilst still competent, you expressed the considered wish to die when in a situation such as this, then the person who ends your life in the appropriate circumstances acts upon your request and performs an act of voluntary euthanasia.

Euthanasia is *non-voluntary* when the person whose life is ended cannot choose between life and death for herself – for example, because she is a hopelessly ill or handicapped newborn infant, or because illness or accident have rendered a formerly competent person permanently incompetent, without that person having previously indicated whether she would or would not like euthanasia under certain circumstances.

Euthanasia is *involuntary* when it is performed on a person who would have been able to give or withhold consent to her own death, but has not given consent – either because she was not asked, or because she was asked but withheld consent, wanting to go on living. Whilst clear cases of involuntary euthanasia

would be relatively rare (for example, where A shoots B without B's consent to save her from falling into the hands of a sadistic torturer), it has been argued that some widely accepted medical practices (such as the administration of increasingly large doses of pain-killing drugs that will eventually cause the patient's death, or the unconsented-to withholding of life-sustaining treatment) amount to involuntary euthanasia.

iii Active and passive euthanasia

So far, we have defined 'euthanasia' loosely as 'mercy-killing', where A brings about the death of B, for the sake of B. There are, however, two different ways in which A can bring B's death about: A can kill B by, say, administering a lethal injection; or A can allow B to die by withholding or withdrawing life-sustaining treatment. Cases of the first kind are typically referred to as 'active' or 'positive' euthanasia, whereas cases of the second kind are often referred to as 'passive' or 'negative' euthanasia. All three kinds of euthanasia listed previously – voluntary, non-voluntary and involuntary euthanasia – can either be passive or active.

If we change the above case of Mary F. but slightly, it becomes one of passive voluntary euthanasia:

> Mary F. was dying from a progressively debilitating disease. She had reached the stage where she was almost totally paralysed and periodically needed a respirator to keep her alive. She was suffering considerable distress. Knowing that there was no hope and that things would get worse, Mary F. wanted to die. She asked her doctor to ensure that she would not be put on a respirator when her breathing would fail next. The doctor agreed with Mary's wishes, instructed the nursing staff accordingly, and Mary died eight hours later, from respiratory failure.

There is widespread agreement that omissions as well as actions can constitute euthanasia. The Roman Catholic Church, in its *Declaration on Euthanasia*, for example, defines euthanasia as 'an action or omission which of itself or by intention causes death' (1980, p. 6). Philosophical disagreement does, however, arise over *which* actions and omissions amount to euthanasia. Thus it is sometimes denied that a doctor practises (non-voluntary passive) euthanasia when she refrains from resuscitating a severely handicapped newborn infant, or that a doctor engages in euthanasia of any kind when she administers increasingly large doses of a painkilling drug that she knows will eventually result in the patient's death. Other writers hold that *whenever* an agent deliberately and knowingly engages in an action or an omission that results in the patient's foreseen death, she has performed active or passive euthanasia.

In spite of the great diversity of views on this matter, debates on euthanasia have time and again focused on certain themes:

1 Does it make a moral difference whether death is actively (or positively) brought about, rather than occurring because life-sustaining treatment is withheld or withdrawn?
2 Must all available life-sustaining means always be used, or are there certain

'extraordinary' or 'disproportionate' means that need not be employed?
3 Does it make a moral difference whether the patient's death is directly intended, or whether it comes about as a merely foreseen consequence of the agent's action or omission?

The following is a brief sketch of these debates.

iv Actions and omissions/killing and letting die

To shoot someone is an action: to fail to help the victim of a shooting is an omission. If A shoots B and B dies, A has killed B. If C does nothing to save B's life, C lets B die. But not all actions or omissions that result in a person's death are of central interest in the euthanasia debate. The euthanasia debate is concerned with *intentional* actions and omissions – that is, with deaths that are deliberately and knowingly brought about in a situation where the agent could have done otherwise – that is, where A could have refrained from killing B, and where C could have saved B's life.

There are some problems in distinguishing between killing and letting die, or between active and passive euthanasia. If the killing/letting die distinction were to rest simply on the distinction between actions and omissions, then the agent who, say, turns off the machine that sustains B's life, kills B, whereas the agent who refrains from putting C onto a life-sustaining machine in the first place, merely allows C to die. That killing and letting die should be distinguished in this way has struck many writers as implausible, and attempts have been made to draw the distinction in some other way. One plausible suggestion is that we understand killing as initiating a course of events that leads to death; and allowing to die as not intervening in a course of events that leads to death. According to this scheme, the administration of a lethal injection would be a case of killing; whereas not putting a patient on a respirator, or taking her off, would be an instance of letting die. In the first case, the patient dies because of events set in train by the agent. In the second case, the patient dies because the agent does not intervene in a course of events (e.g. a life-threatening disease) already in train that is not of the agent's making.

Is the distinction between killing and letting die, or between active and passive euthanasia, morally significant? Is killing a person always morally worse than letting a person die? Various reasons have been proposed why this should be so. One of the more plausible ones is that an agent who kills causes death, whereas an agent who lets die merely allows nature to take its course. This distinction between 'making happen' and 'letting happen', it has been argued, is a morally important one insofar as it sets limits to an agent's duties and responsibilities to save lives. Whilst it requires little or no effort to refrain from killing anyone, it usually requires effort to save a person. If killing and letting die were morally on a par, so the argument goes, then we would be just as responsible for the deaths of those whom we fail to save as we are for the deaths of those whom we kill – and failing to aid starving Africans would be the moral equivalent of sending

them poisoned food. (See Foot, 1980, p. 161–2.) This, the argument continues, is absurd: we are more, or differently, responsible for the deaths of those whom we kill than we are for the deaths of those whom we fail to save. Thus, to kill a person is, other things being equal, worse than allowing a person to die.

But even if a morally relevant distinction can sometimes be drawn between killing and letting die, this does not, of course, mean that such a distinction always prevails. Sometimes at least we are as responsible for our omissions as we are for our actions. A parent who does not feed her infant, or a doctor who refrains from giving insulin to an otherwise healthy diabetic, will not be absolved of moral responsibility by merely pointing out that the person in her charge died as a consequence of what she omitted to do.

Moreover, when the argument about the moral significance of the killing/letting die distinction is raised in the context of the euthanasia debate, an additional factor needs to be considered. To kill someone, or deliberately to let someone die, is generally a bad thing because it deprives that person of her life. Under normal circumstances persons value their lives, and to continue to live is in their best interest. This is different when questions of euthanasia are at issue. In cases of euthanasia, death – not continued life – is in the person's best interest. This means that an agent who kills, or an agent who lets die, is not harming but benefiting the person whose life it is. This has led writers in the field to suggest: if we are, indeed, more responsible for our actions than for our omissions, then A who kills C in the context of euthanasia will, other things being equal, be acting morally better than B who lets C die – for A positively benefits C, whereas B merely allows benefits to befall C.

v Ordinary and extraordinary means

Powerful medical technologies allow doctors to sustain the lives of many patients who, only a decade or two ago, would have died because the means were not available to avert death. With this an old question is raised with renewed urgency: must doctors always do everything possible to try to save a patient's life? Must they engage in 'heroic' efforts to add another few weeks, days, or hours to the life of a terminally ill and suffering cancer patient? Must active treatment always be instigated with regard to babies born so defective that their short life will be filled with little more than continuous suffering?

Most writers in the field agree that there are times when life-sustaining treatment should be withheld and a patient allowed to die. This view is shared even by those who regard euthanasia or the intentional termination of life as always wrong. It raises the pressing need for criteria to distinguish between permissible and impermissible omissions of life-sustaining means.

Traditionally, this distinction has been drawn in terms of so-called ordinary and extraordinary means of treatment. The distinction has a long history and was employed by the Roman Catholic Church to deal with the problem of surgery

prior to the development of antisepsis and anaesthesia. If a patient refused ordinary means – for example, food – such refusal was regarded as suicide, or the intentional termination of life. Refusal of extraordinary means (painful or risky surgery, for example), on the other hand, was not regarded as the intentional termination of life.

Today, the distinction between life-sustaining means that are regarded as ordinary and obligatory and those that are not is often expressed in terms of 'proportionate' and 'disproportionate' means of treatment. A means is 'proportionate' if it offers a reasonable hope of benefit to the patient; it is 'disproportionate' if it does not. (See Sacred Congregation for the Doctrine of the Faith, 1980, pp. 9–10.)

Understood in this way, the distinction between proportionate and disproportionate means is clearly morally significant. But it is not, of course, a distinction between means of treatment, considered simply as means of treatment. Rather, it is a distinction between the proportionate or disproportionate benefits different patients are likely to derive from a particular treatment. The same treatment can thus be proportionate or disproportionate, depending on the patient's medical condition and on the quality and quantity of life the patient is likely to gain from its employment. A painful and invasive operation, for example, might be an 'ordinary' or 'proportionate' means if performed on an otherwise healthy 20-year-old who is likely to gain a lifetime; it might well be considered 'extraordinary' or 'disproportionate' if performed on an elderly patient, who is also suffering from some other serious debilitating disease. Even a treatment as simple as a course of antibiotics or physiotherapy is sometimes judged to be extraordinary and non-obligatory treatment. (See Linacre Centre Working Party, 1982, pp. 46–8.)

This understanding of ordinary and extraordinary means suggests that an agent who refrains from using extraordinary means of treatment engages in passive euthanasia: A withholds potentially life-sustaining treatment from B, for the sake of B.

Not everyone agrees, however, that the discontinuation of extraordinary or disproportionate treatment is a case of passive euthanasia. 'Euthanasia', it is often argued, involves the deliberate or intentional termination of life. Administering a lethal injection, or withholding ordinary life-sustaining means, are cases of the intentional termination of life; withholding extraordinary means and allowing the patient to die, is not. The question then becomes: what does the doctor 'do' when she withholds disproportionate life-sustaining treatment from B, foreseeing that B will die as a consequence? And how can this mode of bringing the patient's death about (or of allowing the patient's death to occur) be distinguished, in terms of the agent's intention, from the withholding of ordinary care on the one hand, and the administration of a lethal injection on the other?

This brings us to the third major theme on which the debate about euthanasia has focused: the distinction between deaths that are directly intended and deaths that are merely foreseen.

vi Intending death and foreseeing that death will occur

If A administers a lethal injection to B to end B's suffering, A has intentionally terminated B's life. This case is uncontroversial. But has A also intentionally terminated B's life when she seeks to alleviate B's pain by increasingly large doses of drugs ('pyramid pain-killing') that she knows will eventually bring about B's death? And has A terminated B's life intentionally when she turns off the respirator that sustains B's life, knowing that B will die as a consequence? Those who want to hold that the first case is, but the second and third case is not, a case of euthanasia or the intentional termination of life have sought to draw a distinction between these cases in terms of directly intended results, and foreseen but non-intended consequences. Reflecting on the administration of increasingly large and potentially lethal doses of pain-killing drugs, the Vatican's *Declaration on Euthanasia* thus holds that 'pyramid pain-killing' is acceptable because, in this case, 'death is in no way intended or sought, even if the risk of it is reasonably taken' (p. 9). In other words, even if A foresees that B will die as a consequence of what A does, B's death is only foreseen and not directly intended. The direct intention is to kill the pain, not the patient.

This distinction between intended results and foreseen but non-intended further consequences is formalized in the Principle of Double Effect (PDE). The PDE lists a number of conditions under which an agent may 'allow' or 'permit' a consequence (such as a person's death) to occur, although that consequence must not be intended by the agent. Thomas Aquinas, with whom the PDE is said to have its origin, applied the distinction between directly intended and merely foreseen consequences to actions of self-defence. If a person is attacked and kills the attacker, her intention is to defend herself, not to kill the attacker (*Summa Theologiae*, II, ii).

Two main questions have been raised regarding the intention/foresight distinction:

- Can a clear distinction always be drawn between those consequences that an agent directly intends and those that she merely foresees?
- Is the distinction, to the extent that it can be drawn, morally relevant in itself?

Consider the first point in the light of the following frequently cited example:

> A party of explorers is trapped in a cave, in whose narrow opening a rather fat member of the party is lodged, and the waters are rising. If a member of the party explodes a charge of dynamite next to the fat man, should we say that he intended the fat man's death or that he merely foresaw it as a consequence of either freeing the party, removing the fat man's body from the opening, or blowing him to atoms?

If one wants to hold that the fat man's death was clearly intended, in what way, then, is this case different from the one where a doctor can administer increasingly large doses of a pain-killing drug that will forseeably bring about the patient's death, without that doctor being said to have intended the patient's death?

There are serious philosophical problems in any systematic application of the

intention/foresight distinction, and the literature is replete with criticisms and refutations. Nancy Davis discusses some of this literature in the context of deontological ethics (where the distinction is crucial) in Article 17, CONTEMPORARY DEONTOLOGY. Assuming that the difficulties can be overcome, the next question presents itself: is the distinction between directly intended results and merely foreseen consequences morally relevant in itself? Does it matter, morally, whether a doctor when administering what she believes to be a lethal drug merely intends to relieve the patient's pain, or whether she directly intends to end the patient's life?

Here a distinction is sometimes drawn between the goodness and badness of agents: that it is the mark of a good agent that she not directly intend the death of another person. But even if a distinction between the goodness and badness of agents can sometimes be drawn in this way, it is of course not clear that it can be applied to euthanasia cases. In all euthanasia cases, A seeks to benefit B, thus acting as a good agent would. Only if it is assumed that there is a rule which says 'A good agent must never directly intend the death of an innocent', does the attempt to draw the distinction make sense – and that rule then lacks a rationale.

vii Conclusion

The above distinctions represent deeply felt differences. Whether or not these differences are morally relevant, and if so on what grounds, is a debate that is still continuing.

There is, however, one other aspect of the euthanasia debate that has not yet been touched on. People frequently agree that there may be no intrinsic moral difference between active and passive euthanasia, between ordinary and extraordinary means, and between deaths that are directly intended and deaths that are merely foreseen. Nonetheless, the argument is sometimes put that distinctions such as these represent important lines of demarcation as far as public policy is concerned. Public policy requires the drawing of lines, and those drawn to safeguard us against unjustified killings are among the most universal. Whilst it is true that such lines may appear arbitrary and philosophically troubling, they are nonetheless necessary to protect vulnerable members of society against abuse. The question is, of course, whether this kind of reasoning has a sound basis: whether societies that openly allow the intentional termination of life under some circumstances will inevitably move onto a dangerous 'slippery slope' that will lead from justified to unjustified practices.

In its *logical* version, the 'slippery slope' argument is unconvincing. There are no logical grounds why the reasons that justify euthanasia – mercy and respect for autonomy – should logically also justify killings that are neither merciful nor show respect for autonomy. In its *empirical* version, the slippery slope argument asserts that justified killings will, as a matter of fact, lead to unjustified killings. There is little empirical evidence to back up this claim. Whilst the Nazi 'euthanasia' programme is often cited as an example of what can happen when a society acknowledges that some lives are not worthy to be lived, the motivation behind

these killings was neither mercy nor respect for autonomy: it was, rather, racial prejudice and the belief that the racial purity of the *Volk* required the elimination of certain individuals and groups. As already noted, in the Netherlands a 'social experiment' with active voluntary euthanasia is currently in progress. As yet there is no evidence that this has sent Dutch society down a slippery slope.

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