ACTIVE AND PASSIVE EUTHANASIA:

A CASE FOR MORAL SYMMETRY

by

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Active and Passive Euthanasia:
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Abstract

My thesis is that there is no morally significant difference between active euthanasia and passive euthanasia. Traditionally, the distinction between active and passive euthanasia has been based on the alleged moral difference between killing and letting die. Killing is generally considered to be morally wrong in itself while letting die is considered to be morally acceptable in some circumstances. Those who condemn active euthanasia while accepting passive euthanasia usually do so because they view active euthanasia as a form of killing and passive euthanasia as a form of letting die.

I argue that there is no morally significant distinction between killing in itself and letting die in itself: when all else is equal, killing and letting die have the same moral status. This conclusion is based on Jonathan Bennett's work on positive and negative instrumentality, which categorizes one's causal responsibility for an event in terms of one's behaviour as selected from all possible behaviour options at a particular moment. Bennett concludes that since letting die is a type of negative instrumentality and killing is a type of positive instrumentality, and there is no moral significant distinction between positive and negative instrumentality, then there is no morally significant distinction between killing and letting die.

With killing and letting die out of the running as candidates for a moral difference between active and passive euthanasia, I consider other factors which might make active euthanasia morally worse than passive euthanasia. These factors are means, outcomes, motives, intentions, and long-term consequences. I

conclude that none of these factors provides a moral difference between active and passive euthanasia. Hence, if passive euthanasia is morally acceptable, then so is active euthanasia.

Dedication

To Sue Rodriguez, for her courage.

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Chapter 1 - The Alleged Problem

Imagine a fifty-year-old woman suffering from terminal throat cancer. She is in pain. She knows that she will likely live for another three months and that her situation will not improve before she dies. She does not want to go on living and asks her doctor for a lethal injection. After consulting with the rest of the medical team and the dying woman the doctor agrees to his patient's wishes and gives her a lethal injection. The woman is dead in a couple of minutes.

Now imagine another fifty-year-old woman suffering from terminal throat cancer in the same hospital with the same doctor. Again, she is in pain. She knows she has about three months to live and that her situation will not improve before she dies. She does not want to go on living and asks her doctor to cease active treatment so that she will die. Again, following consultation with the medical team and the patient the doctor agrees to his patient's wishes and ceases treatment. The woman dies in a couple of days.

Many people would think that the doctor was acting in a morally acceptable manner in letting the second woman die. But some of these people who find the second woman's death acceptable, would condemn the behaviour of the doctor in the first woman's death. They would say that the doctor was wrong to administer the lethal injection. These are the people for whom I am writing. I hope to convince them that since they find passive euthanasia morally acceptable, they also should find active euthanasia morally acceptable. The only differences here are that the

first woman asked for and received a lethal injection while the second woman asked for and had active treatment discontinued, and the first woman died in a couple of minutes while the second died in a couple of days. In both cases the doctor complied with patient's wish to end her life. In both cases the doctor acted from compassion for his patient and in recognition of her autonomy.

It seems that people condemn active euthanasia while accepting the morality of passive euthanasia because they believe that killing is always wrong while letting die is at least sometimes acceptable. In this chapter I argue that these beliefs about killing and letting die have traditionally provided the basis for the alleged moral distinction between active and passive euthanasia. In the next chapter I argue that all things being equal, killing in itself is no morally worse or better than letting die in itself. Therefore, if killing is always wrong, then so is letting die, or if letting die is sometimes right, then so is killing. Once the moral symmetry of killing and letting die is established, the moral symmetry of active euthanasia and passive euthanasia is apparent.

It is beyond the scope of my thesis to argue either for or against euthanasia. Rather, I argue that if one finds passive euthanasia morally permissible in at least some cases, then one must also find active euthanasia morally permissible in the same sorts of cases. The distinction between active and passive euthanasia is not a morally significant one.

Before I go any further several terms must be explained: euthanasia, passive euthanasia, and active euthanasia.

The Concise Oxford Dictionary defines euthanasia as "gentle and easy death; bringing about of this, esp. in case of incurable and painful disease." But

this definition is too vague to be useful. For the purposes of this paper euthanasia is defined as either inducing or allowing someone's death for the benefit of that person. Philippa Foot puts forth a more elegant version of this definition, "by an act of euthanasia we mean one of inducing or otherwise opting for death for the sake of the one who is to die" (Foot, 1977, p.15). The important points of this definition are that euthanasia aims at benefitting the person who is to die and that the death may result from positive measures as well as omissions.

By (my) definition the purpose of euthanasia is to benefit the one who dies. It may seem strange to think of one's death as benefitting one, but for those suffering uncontrollable pain, death may be preferable to life and therefore a benefit. Of course, euthanasia is not restricted as an option to those suffering enormous physical pain. Persons with incurable illnesses that deny them control of bodily movements and functions, or result in mental deterioration, may also wish to die rather than live with dependence on others or the loss of their dignity. To argue that euthanasia is morally acceptable for persons in these situations is beyond the scope of this paper; I wish merely to explain that people in these situations sometimes wish to end their lives, and that reasons of autonomy and beneficence are often used to justify euthanasia in these cases.

It should be obvious from the previous paragraph that I am discussing the morality of voluntary euthanasia. In a case of voluntary euthanasia, the competent subject makes a decision to die or has in the past expressed, either verbally or in the form of a Living Will, the desire to die if particular circumstances should obtain. This is contrasted with nonvoluntary euthanasia, a situation in which the person whose death is being considered is unable to express a competent decision

to die for any of a variety of reasons and has not expressed such a desire in the past. In a case of nonvoluntary euthanasia it is assumed that if the person could express a competent decision, she or he would choose to die. It is arguable that a third category of euthanasia exists; involuntary euthanasia when the subject does not wish to die. Since, by (my) definition euthanasia is to benefit its subject, then this third kind of euthanasia, involuntary euthanasia, consists in killing, for his or her own good, someone who does not wish to die. This notion will appeal to none but the most paternalistic. Since both nonvoluntary euthanasia and what I have called involuntary euthanasia bring further moral and political complications to the euthanasia debate, I will, for the sake of simplicity, limit my discussion to voluntary euthanasia.

There is some controversy regarding the distinction between voluntary euthanasia and suicide. To commit suicide is to take one's own life. There are two differences between voluntary euthanasia and suicide. Suicide is carried out by the person who dies; euthanasia requires the assistance of at least one other person. The motive for taking one's life is irrelevant to the act being characterized as suicide; but the motive for bringing about the death of someone else must be mercy -- that is, to end the person's suffering -- if the act is to be characterized as euthanasia. Because of these differences, suicide is not identical with voluntary euthanasia. However, one could argue that voluntary euthanasia is a type of suicide; voluntary euthanasia is assisted suicide intended to end one's suffering. Advocates of euthanasia may argue that it is distinct from suicide, especially if they are concerned that the moral stigma of suicide will attach itself to euthanasia.

In addition to the voluntary/nonvoluntary distinction, euthanasia can be distinguished as active or passive. Crudely defined, active euthanasia involves doing something to cause death, such as giving a lethal injection, while passive euthanasia involves failing to do something to prevent death, such as refraining from hooking someone up to a respirator. I have chosen these examples to illustrate clearly the distinction between active and passive euthanasia, but many cases cannot be easily categorized as passive or active. For example, it is arguable that removing life support is passive because I am merely allowing death to occur. On the other hand, I could argue that this is active euthanasia, because in removing the life support I have taken positive steps to bring about death. This sort of argument can easily turn into a battle over semantics, so let me leave this discussion for the time being with the point that there is no bright line separating active euthanasia from passive euthanasia. In fact, there is little agreement on how this line should be drawn.

Those who advocate passive euthanasia but condemn active euthanasia sometimes defend their position on the grounds that one has the right to refuse treatment and that passive euthanasia is justified by this right. The right to refuse treatment, which is usually construed as a privacy right (discussed further below), can be used to defend some cases of passive euthanasia, specifically cases in which the patient refuses painful or intrusive active treatment which is unlikely to cure the patient but may lengthen his or her life.[1] But when the patient refuses, for no reason, life-prolonging treatment which is not painful or intrusive or

[1] Patients also refuse life-saving or life-prolonging treatment for religious reasons. For example, it is against their religious beliefs for Jehovah's Witnesses to have blood transfusions.

forbidden by his/her religion, then it is obvious that the patient's objective is to bring about his/her death. In these cases the patient refuses treatment in order to die. If one maintains that it is morally wrong to bring about one's own death, then refusing treatment for the purpose of dying would be morally wrong. Furthermore, not all passive euthanasia results from the patient's refusal of treatment; ceasing feeding and hydration cannot be justified by the patient's right to refuse treatment because feeding and hydration do not constitute treatment. Hence, passive euthanasia is not identical with refusing treatment. Some cases of refusing treatment do not constitute passive euthanasia because the patient's objective was not to die, for example, but, to avoid painful, intrusive procedures that will not cure the condition. And some cases of passive euthanasia do not involve a refusal of treatment, such as when a patient wishes to die and ceases to eat in order to die. Because of these distinctions one might argue that upholding a patient's right to refuse treatment is not the same as advocating passive euthanasia. Bonnie Steinbock does this in her illuminating article from 1975.[2] Steinbock claims that both Michael Tooley and James Rachels mistakenly equate upholding a patient's right to refuse treatment with advocating passive euthanasia in their essays arguing for the moral symmetry of active and passive euthanasia. Tooley and Rachels argue that the 1973 statement of the American Medical Association prohibits active euthanasia and condones passive euthanasia.

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[2] Bonnie Steinbock, "The Intentional Termination of Life," (1975).
James Rachels, "Active and Passive Euthanasia." (1975).
Michael Tooley, "An Irrelevant Consideration: Killing Versus Letting Die." (1974)
All of these essays appear in Steinbock's Killing and Letting Die, (1980).

Steinbock argues that while the AMA statement rejects both active and passive euthanasia, it allows for the cessation of extraordinary means of prolonging life, but the cessation of life-prolonging treatment is not necessarily passive euthanasia. Here is the statement adopted by the House of Delegates of the American Medical Association in 1973.[3]

> The intentional termination of the life of one human being by another--mercy killing--is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.
>
> The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family (Rachels, 1980).

Steinbock outlines two situations where the termination of life-prolonging treatment cannot be identified with the intentional termination of life; 1) when the patient refuses treatment, and 2) when treatment has little chance of improving the patient's condition and brings greater discomfort than relief.[4]

The competent adult's right to refuse treatment is generally regarded as a privacy right, the right to bodily self-determination. Steinbock argues that the right to refuse treatment does not entail the right to voluntary euthanasia: it is not a right to die. The purpose of the right to refuse medical treatment is to protect

[3] In 1982, the AMA's Judicial Council issued a statement which condones letting terminally ill patients die in specific circumstances: "For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to let a terminally ill patient die, but he should not intentionally cause death" ("Opinions of the American Medical Association," American Medical Association, Chicago, 1982, 9 - 10).

[4] Steinbock neglects to mention whether the patient's wishes to prolong life play any role in the decision to cease treatment in this case.

people from the interference of others. This differs from a right to euthanasia which also includes the right to be killed.

The other "legitimate" purpose to withdrawing treatment is to put an end to treatment that will cause an increase of discomfort with little chance of improving the patient's condition. Steinbock states that this kind of treatment is considered "extraordinary".

> The concept is flexible, and what might be considered "extraordinary" in one situation might be ordinary in another. The use of a respirator to sustain a patient through a severe bout with a respiratory disease would be considered ordinary; its use to sustain the life of a severely brain-damaged person in an irreversible coma would be considered extraordinary (Steinbock, 1979, p.72).

Ordinary treatment, on the other hand, is the treatment we would expect a doctor to provide. Failure to provide ordinary treatment is considered neglect. Steinbock points to an example of James Rachels' as demonstrating the cessation of ordinary care. Rachels asks us to consider the case of a Down's syndrome baby born with an intestinal obstruction. Without surgery, the infant will starve to death. A simple operation would remove the obstruction. Rachels maintains that the AMA statement condones refraining from operating on the baby. Steinbock argues that Rachels is wrong, that the AMA statement suggests that corrective surgery should be performed on the baby since this is not extraordinary treatment, and the surgery would ensure that the baby's death was not imminent. In most cases surgery on children requires the consent of the child's parents, but failure of the parents to provide necessary medical care is considered neglect. Steinbock adds that allowing the baby to die in this way is not done for the baby's sake.

Steinbock argues that withholding treatment in order to avoid inflicting pain on someone who is unlikely to benefit from the treatment is not the intentional termination of life, and therefore withholding treatment in this situation has no implications for the moral status of either active or passive euthanasia. For example, children born with spina bifida will die of kidney failure or meningitis in the first few years of life unless they receive surgery. Those who receive surgery and survive face a lifetime of illness, operations, and disability. The decision not to operate on these children is not the intentional termination of life, according to Steinbock, but the avoidance of painful, pointless treatment. The fact that withholding treatment is justified in this situation does not imply that killing these children is equally justified.

Steinbock's spina bifida example is not helpful. When Steinbock talks about ceasing treatment that is painful and is unlikely to improve the patient's condition, she seems to be talking about ceasing treatment in order to end the discomfort that the current treatment is causing the patient. But, in the case of children born with spina bifida, Steinbock is talking not just about their present pain, but their future pain and the poor quality of their lives in the future. Surely, this is an inappropriate example to use when we are being asked to consider the morality of ceasing treatment because it is painful. Steinbock is upping the ante by asking us to consider all of the discomfort these people are likely to experience in the future. Additionally, the fact that she alludes to the unhappy futures of children born with spina bifida damages her argument that the cessation of treatment in these cases is *not* the intentional termination of life. It sounds like she is saying that we should intentionally terminate these lives in order to spare these children

future pain. Steinbock has failed to discuss the fact that there may not be a complete overlap between the people who refuse treatment and those who would not benefit from further treatment and would likely suffer from the treatment itself. Surely you are more likely to refuse treatment if it is unlikely to benefit you and if it causes you to suffer. But, some people may want to live as long as possible. Is a doctor morally justified in discontinuing treatment because it seems useless, even if the patient wants the treatment continued? Steinbock makes no mention of this problem.

Steinbock argues that the doctor who ceases to treat the patient who refuses treatment is not culpable for the patient's death because the doctor is not at liberty to continue treatment. In order intentionally to let someone die, it must be the case that one could have done something to prevent the death. Even though the doctor intentionally ceases treatment, foreseeing that the patient will die, this does not mean that the doctor intentionally let the patient die.[5]

It is odd that Steinbock has neglected to discuss the patient's intention in refusing treatment. While Steinbock argues that it need not be the doctor's intent to kill the patient, it may be the patient's intent to die. John Blair discusses this situation in his criticism of Steinbock (Blair, 1982, "The Cessation of Life Prolonging Treatment," 1982). Blair argues that once the patient refuses treatment, the doctor's intentions are irrelevant, and it is only the patient's intentions that matter. He claims that discussion of the doctor's intentions is

[5] Steinbock fails to mention the culpability of the doctor who ceases treatment because it is painful and unlikely to improve the patient's condition.

misleading since the doctor, in most cases, is merely complying with laws against unwanted medical treatment.

> If he [the doctor] does have any major intentions in ending the treatment, they most likely involve the desire to avoid prosecution, and are not related to the patient at all. The responsibility for treatment is transferred to the patient under such legal definitions, and it is far from certain that the patient ceases treatment for any other reason than to hasten his death (Blair, 1982).

Steinbock might want to argue that the patient's intent is not to die, but merely to avoid suffering. If this is her argument, then it seems that we are quibbling. The intent in any kind of euthanasia is not merely to kill the patient, but rather to kill the patient in order to end the patient's suffering. Because of the possible difference of intent, an single event may be described as euthanasia (because of the patient's intent) and something that is not euthanasia (because the doctor did not intend the patient's death). So, we may end up with the cessation of Julie's treatment being characterized by Julie as euthanasia because Julie wanted her treatment ceased in order to die, while at the same time, Julie's doctor describes this act as the cessation of treatment because his intent is not to bring about Julie's death, but to avoid painful treatment. For Steinbock, the doctor's intent plays the decisive role in determining the morality of ceasing treatment, and she gives an incomplete picture by overlooking the fact that other people involved in the act may have some intent.

In any situation of euthanasia, either passive or active, one could argue that the intent is never solely to bring about someone's death. Rather, its purpose is to put an end to the subject's suffering. Bruce Reichenbach discusses the overlap of

intention in "Euthanasia And The Active-Passive Distinction" (Bioethics, 1.1, 1987). Reichenbach argues that in both killing and letting die a person can intend the death of another, and in both killing and letting die, one can intend not to bring about a patient's death, but to alleviate suffering.

Perhaps the best way of describing one's intent in any case of euthanasia is that one brings about the patient's death because it is the only way to end the patient's suffering. There is the immediate effect intended and its purpose, the goal to be achieved by the immediate effect.[6] If one ceases treatment in order to let the patient die and she recovers instead, one will not plot other ways of bringing about her death, because the intent of one's ceasing treatment was to bring about her death because it was the only way of ending her suffering.

According to Steinbock, in order to show that stopping life-prolonging treatment is the intentional termination of life, one would have to show that treatment was stopped in order to bring about death or else provide a theory of intentional action which shows that the reason for ceasing treatment is irrelevant to its characterization as the intentional termination of life.[7] Steinbock considers these suggestions to be implausible [8] and maintains that she is successful in demonstrating that there can be a point to ceasing treatment other than bringing about the death of the patient.

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[6] This analysis of intent was suggested to me by Susan Wendell.

[7] Steinbock uses the term "intentional" termination of life, but a more appropriate term is the "intended" termination of life. The intentional termination of life involves doing something which you know will bring about someone's death even though the termination is not your purpose. Whereas the intended termination of life involves doing something in order to bring about someone's death.

[8] Steinbock does not make it clear which suggestion she finds implausible, so I assume she means both.

Steinbock is successful in showing that there are reasons other than the death of the patient for ceasing treatment. However, she is less successful in demonstrating that passive euthanasia is morally better than active euthanasia, something she argues for in an indirect way.

Steinbock considers the question: If withholding treatment is not the intentional termination of life, does that make a moral difference? If treatment is justifiably withheld for the sake of the child, then perhaps an easy death is also justified for the sake of the child. Steinbock's response is that there is a moral difference between withholding treatment for the sake of the child and bringing about an easy death for the sake of the child. If it is possible to make the child's remaining time comfortable and pleasant, then this alternative is more decent and humane than killing the child. In this situation, withholding treatment is not ethically equivalent to killing the child.

Steinbock clearly expects us to agree with her about the moral difference between withholding treatment for the sake of the child and bringing about an easy death for the sake of the child. Unfortunately, she has given us no reason to believe that there is always a moral distinction between the two. She has merely suggested that in some cases a quick death is not the best solution. Steinbock does not consider the child whose remaining time cannot be made comfortable and pleasant. In reality, there are few people advocating a quick death for children whose remaining time can be made comfortable and pleasant. The whole purpose of euthanasia or mercy-killing is not to kill people just because they are going to die soon anyway, but to bring about the death of someone whose remaining days are likely to be painful--either physically or emotionally. Steinbock is creating a

"straw-man argument" in asking whether we should practice active euthanasia on the child who can be made comfortable until he or she dies. It is easy enough to see that these children are not candidates for active euthanasia, but euthanasia advocates are not suggesting that these children be killed; they would argue that people who do not want to live and are in intolerable pain should be considered for active euthanasia.

I am not claiming that ceasing treatment is identical with passive euthanasia; Steinbock has convinced me that there may be reasons for ceasing life-prolonging treatment other than to bring about death. But Steinbock has not proven that there is a significant moral difference between passive euthanasia and ceasing treatment because the patient refuses treatment and the treatment is unlikely to help the patient and likely to cause more discomfort than relief. The onus is on Steinbock to show that passive euthanasia is morally different (presumably worse) than ceasing treatment for these reasons, which she considers to be morally legitimate. Steinbock has argued that there is a difference in the reason for ceasing treatment, but she has not shown how this constitutes a moral difference between passive euthanasia and ceasing treatment for the reasons which she considers to be acceptable. Steinbock's claim is that James Rachels and Michael Tooley are wrong in equating passive euthanasia and the termination of life-prolonging treatment, and she succeeds in proving a conceptual difference between the two, but not a moral one. Nevertheless, Steinbock's arguments do not directly support the position that passive euthanasia is morally acceptable and active euthanasia is morally unacceptable. This is the position that I now want to address.

Many people hold the position that passive euthanasia is acceptable and active euthanasia is wrong, because they see active euthanasia as a type of killing and passive euthanasia as letting die. Additionally, they believe that killing is wrong and letting die is at least sometimes morally acceptable.

Robert Veatch agrees that the distinction between passive euthanasia and active euthanasia is usually based on the distinction between letting die and killing. He claims that most of us recognize a moral difference between killing someone and ceasing treatment, and even those who argue that there is no morally significant difference between the two would prefer to assist in passive rather than active euthanasia.

> Yet, if we were given the choice of turning off a respirator to allow a terminal patient to die or actively injecting an embolism, almost all of us would choose the first act, at least barring some extenuating circumstances which changed the moral calculations, such as the presence of extreme intractable pain and suffering (Robert Veatch, "Choosing Not To Prolong Dying," 1972, Beauchamp & Walters, p.302).[9]

John Ladd maintains that many doctors distinguish between passive and active euthanasia -- which he calls negative and positive -- as letting die and killing.

> It is a well-known fact that many practising physicians lean heavily on the distinction between negative and positive euthanasia; that is, between "letting a hopelessly incurable patient die" and " killing him". Polls of physicians indicate that a large proportion of them

[9] Joseph Fletcher, ("Ethics and Euthanasia", New York, 1973) would say that our squeamishness in choosing was a problem of psychology rather than ethics. Certainly Veatch's example is not a counterexample to the argument that the two acts are morally equivalent. We are, after all, creatures of conditioning.

approve in principle and are willing to practice negative euthanasia, whereas only a small proportion approve or are willing to practice positive euthanasia. Many laymen also hold the distinction to be a helpful and valid one (John Ladd, "Positive and Negative Euthanasia," 1979).

Both Veatch and Ladd are describing a popular opinion, rather than arguing that there is a good reason to distinguish between killing and letting die. But J. Gay-Williams and Michael Wreen make the case that killing is morally worse than letting die.

Gay-Williams ("The Wrongfulness of Euthanasia," 1983) does not consider passive euthanasia to be euthanasia because passive euthanasia does not involve killing.[10] Gay-Williams defines euthanasia as the intentional killing of a hopelessly ill person. According to Gay-Williams, euthanasia is morally wrong because it involves killing. He presents three arguments which he claims demonstrate that euthanasia is morally wrong: the argument from nature, the argument from self-interest, and the argument from practical effects.

1. Argument From Nature

Human beings are naturally biologically geared to the goal of survival. Euthanasia goes against this natural goal and therefore harms our natural dignity. In doing so, euthanasia denies our basic human character.[11]

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[10] Gay-Williams argues that failure to continue treating a patient when there is little chance of the patient benefitting is not passive euthanasia because it does not involve killing. The patient's death in this situation is an unintended consequence of action intended to spare the person pain and indignity and to avoid any further financial and emotional burden on the family. Gay-Williams argues neither for nor against the cessation of treatment in these "hopeless cases". He does not categorize this situation as letting die, in fact, in this article he makes no mention of letting die. But, this example is clearly a case of letting die, hence his inclusion in this discussion of the distinction between killing and letting die.

[11] See the discussion on Hume in Chapter 2.

2. Argument From Self-Interest

Given the possibility of mistaken prognosis or mistaken diagnosis, coupled with the fact that spontaneous remission does occur in many cases, we should leave open the possibility that the patient will recover. Euthanasia leaves no room for mistakes or miracles. Knowing that we have the option of euthanasia might cause us to give up too easily. Also, we might request euthanasia in order to reduce the burden on others.[12]

3. Argument From Practical Effects

Medical personnel might not try hard enough to save those who are seriously ill because they have the option of euthanasia. This more relaxed attitude might then carry over into less difficult cases leading to an overall decline in medical care. Another slippery slope argument applies here; if we practice voluntary euthanasia, this will lead to involuntary euthanasia with the attendant possibility of abuse, such as killing those who are a burden to us or to society, rather than just those who are a burden to themselves.[13]

In addition to his three main arguments, Gay-Williams also claims that suffering is a natural part of life which contains some value for the individual and others, and that euthanasia is wrong because it is killing.

Gay-Williams' arguments are directly opposed to my thesis that killing and letting die are morally equivalent. His main arguments are forms of popular arguments which are better dealt with in later chapters. I will tackle Gay-

[12] These arguments are addressed in Chapter 3.

[13] I deal with "slippery slope" arguments in Chapter 3.

Williams' last argument here, the argument from nature in Chapter 2 and the arguments from self-interest and practical effects in Chapter 3.

Gay-Williams' argument regarding the value of suffering is nonsense as it pertains to euthanasia. His claim is that suffering contains some value for the individual and others. The implication is that the avoidance of suffering is not a good reason for practising euthanasia. First, the only meaningful value suffering has, in the context of euthanasia, is the value the sufferer attaches to it. So, if I decide that my suffering is a bad thing, then the value that my suffering has is negative, regardless of the meaning anyone else wishes to attach to it. Second, even if my suffering had some positive value for someone else, this is not sufficient reason for me to be forced to undergo this suffering. In order for Gay-Williams' argument to have any force, he needs to argue for the value of suffering.

The best argument I have encountered in support of the killing/letting-die distinction is put forth by Michael Wreen in "Breathing a Little Life Into a Distinction" (1984). Wreen maintains that we have a right to life. "It is, without too much distortion, a right not to be killed. It is not, of itself, a right against all others, or even a right against any others, not to be let die." This right to life is violated if we are killed but not if we are let die.

While Wreen's argument may serve as a good general argument for distinguishing between killing and letting die, it is less effective in the realm of voluntary euthanasia. Even if we grant that there is a right to life which is a right not to be killed, the right-holder may wish to waive that right in a specific instance. It seems wrong-headed to argue that you may not kill me, on the ground

that I have a right not to be killed, even if that is what I, as a competent person, want.

Thus far, I have stated that the main reason people give for accepting passive euthanasia while rejecting active euthanasia is that letting die is sometimes morally acceptable while killing is always morally wrong, and I have provided a few examples to illustrate this claim. In my second chapter, I argue that there is no morally significant distinction between killing and letting die when all else is equal. This conclusion is based on Jonathan Bennett's analysis of causal responsibility, which I find particularly compelling because it draws a clear, objective line between killing and letting die. In my third chapter, I consider other moral factors, such as motive, intention, and tendencies, which may distinguish active from passive euthanasia. I also consider the role these moral factors play in distinguishing euthanasia from other types of killing and letting die. And I consider moral objections to active euthanasia from Tom Beauchamp and Alexander Morgan Capron, was well as responses from Helga Kuhse to these objections. In my fourth and concluding chapter, I discuss safeguards for regulating a practice of active and passive euthanasia.

Chapter 2 - Killing And Letting Die

In Chapter 1, I made the claim that there is no morally significant difference between active euthanasia and passive euthanasia. I pointed out that some people maintain that passive euthanasia is morally acceptable and that active euthanasia is morally wrong. It seems that the basis of this position is a belief that killing is wrong in and of itself[1] while letting die is morally acceptable in some circumstances. I presented some of the arguments for the killing/letting-die distinction.

In this chapter, I make the case against the killing/letting-die distinction. In Chapter 3, I examine other reasons for the moral distinction between active and passive euthanasia. And in Chapter 4, I discuss safeguards against wrongful deaths resulting from a practice of euthanasia.

Jonathan Bennett supports his claim that killing is no morally worse than letting die with an interesting account of causal responsibility based on behaviour options. Bennett analyzes the killing/letting die distinction in his 1966 essay "Whatever The Consequences" and the 1980 Tanner Lectures, "Morality And Consequences". Since Bennett's earlier analysis is simpler and serves as a starting-point for his later work, I shall begin with it.

In "Whatever The Consequences", Bennett examines the principle that "It would always be wrong to kill an innocent human, whatever the consequences of not doing so"(Bennett, 1966, p.110), which he mistakenly takes to be presupposed

[1] Most people would make some exceptions, e.g. self-defense, "just" war.

by the Doctrine of Double Effect.[2] Bennett uses the example of a pregnant woman who will die unless a craniotomy is performed on the fetus she is carrying. He maintains that it is a mistake to think that performing a craniotomy is worse than not doing the operation on the premise that it is worse to kill the fetus than to let the woman die. By refraining from performing the craniotomy, the obstetrician does indeed let the woman die because "he knowingly refrains from preventing her death which he alone could prevent, and he cannot say that her survival is in a general way 'none of my business'"(Bennett, 1966, p.118).

While Bennett maintains that we consider some cases of letting die to be cases of killing because of the agent's wicked intent (an issue I will deal with later in this chapter), he makes a rudimentary distinction between killing and letting die which might serve as a basis for moral judgment rather than merely reflect current moral judgment. This distinction is based on the agent's behavioural options and their connection to the result. According to Bennett, a proper analysis of the statement "Joe killed the calf", is

(1) Joe moved his body

(2) the calf died;

(3):"Of all the other ways in which Joe might have moved, *relatively* few satisfy the condition: if Joe had moved like that, the calf would have died"(Bennett, 1966, p.120).

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[2] The Doctrine of Double effect permits the killing of an innocent human when two conditions are met; the death is not *intended* as either a means or an end, but is merely *foreseen* as a side effect of an action which will also produce some good, and that the good produced must be proportionate to the bad effect --the death (John Finnis, Philosophy & Public Affairs, 2.2 [Winter 1973]).

The analysis of "Joe let the calf die" replaces (3) with (4); "Of all the ways in which Joe might have moved, *almost all* satisfy the condition: if Joe had moved like that, the calf would have died" (Bennett, 1966, p.120). Bennett concludes that when the killing/letting die distinction is stripped of implications which either do not apply to the example or lack moral significance,

> all that remains is a distinction having to do with where a set of movements lies on the scale which has "the only set of movements which would have produced that upshot" at one end and "movements other than the only set which would have produced that upshot" at the other (Bennett, 1966, p.120).

Hence, the distinction between killing and letting die is not a moral one. It is merely the difference between choosing from a relatively small group of behavioural options all of which lead to the same result -- someone's death -- and choosing from a relatively large group of behavioural options all of which lead to the same result. Since there is no moral significance in the distinction between killing and letting die, conservatives cannot call on this distinction in counselling the obstetrician.

Daniel Dinello ("On Killing And Letting Die", 1971) is critical of Bennett's analysis of killing and letting die. Dinello maintains that his counter-examples show that Bennett's conditions for the distinction are wrong. In his first example, Smith shoots and kills Jones after Jones has voluntarily swallowed poison. According to Bennett this would be a letting die, since almost all the moves Smith could make are such that if Smith moved like that, Jones would die (Dinello, 1971, p.129). In the second example, Smith and Jones are wired together such that one movement by one would electrocute the other. Jones moves, killing Smith. Again, Bennett would have to consider this a letting die, since almost any of Jones'

movements are such that if Jones moved like that, Smith would die. From these two examples Dinello concludes that "Bennett's conditions for drawing the distinction are clearly wrong,..."(1971, p.130). While Dinello does not explicitly state the problem with Bennett's analysis, it is safe to assume that he thinks Bennett's conditions fail to distinguish between killing and letting die, since the two examples Dinello considers to be killings are lettings die in Bennett's analysis.

Dinello lays out his own conditions for distinguishing between killing and letting die. X killed Y if X caused Y's death by performing movements which affect Y's body such that Y dies. Letting die is more complicated. X let Y die if:
a) there are conditions affecting Y which, if unaltered, will result in Y's death,
b) X has reason to believe that performing certain movements will
prevent Y's death,
c) X is in a position to perform such movements,
d) X does not perform these movements (1971, p.130).

Unfortunately, Dinello does not give any argument to support his analysis of the distinction between killing and letting die. While his conditions seem intuitively correct, they are not particularly helpful since they fail to distinguish among all cases where one has some responsibility for a death. In order for Dinello to grant that X killed Y, X must have caused Y's death by performing movements which affect Y's body such that Y dies as a result of these movements. I wonder how directly these movements must affect Y's body in order to be classified as killing movements. If I drain the swimming pool and fail to mention this to my blind father before he dives in, have I killed him? After all, I did not push him into the pool. According to Dinello, it might make sense to say that I let him die, as long as

I could have saved him but did not. In at least this case Dinello's conditions do not help us place this death clearly as a killing or as a letting die. Dinello could get around this problem by specifying that X's actions constitute killing if *X has established conditions* which if left unaltered will result in Y's death, given that b) X has reason to believe that performing certain movements will prevent Y's death, c) X is in a position to perform such movements, and d) X does not perform these movements. But, in adding another category of killing to his analysis, Dinello will be admitting that killing and letting die cannot be divided into two neat categories, and I think Dinello is unwilling to concede this point. Dinello's conditions do not make room for some ways of being highly responsible for a death. If I hire a thug to murder my husband, it is not my movements but the thug's which result in my husband's death. Clearly, I am responsible for this death, but "killing" and "letting die" are not adequate ways of describing my involvement. Hence, there are ways of being responsible for someone's death that do not fit Dinello's categories of killing and letting die.

Dinello also fails to support sufficiently his claim that the killing/letting die distinction is morally significant in some cases. We are asked to consider the cases of Smith, who will die in four hours if he does not receive a kidney transplant, and Jones, who will die in two hours if he does not receive a heart transplant. Dinello tells us that it would be wrong to kill Smith and save Jones rather than let Jones die and save Smith. He maintains that this example shows that it is intuitively clear that killing is worse than letting die (1971, p.131). Dinello fails to argue for this claim. In order to see that letting Jones die is better than killing Smith, one must already accept that letting die is morally better than

killing. It is not intuitively clear to me that it would be better to let Jones die than to kill Smith; both are equally wrong or equally permissible.

In Jonathan Bennett's later essay on killing and letting die ("Morality And Consequences", 1980) he criticizes the sort of analysis that Dinello makes. One of these criticisms is of the use of the verb "to cause". (According to Dinello, X killed Y if X caused Y's death by performing movements resulting in Y's death.) Bennett points out that our natural way of using the verb "to cause" does not seem to be theoretically grounded.

> If something happens because I did do A, it will very often be natural to say that I caused it to happen; and if it happens because I did not do A, it will often be natural to say that I didn't cause but allowed it to happen. But I cannot turn this to account in theory-building, because I cannot see how to make these idioms put their feet firmly enough on the ground (Bennett, 1980, p.51).

In addition to the lack of clarity of the meaning of "to cause", the criteria for determining whether an event is caused or allowed to happen are partly moral (Bennett, 1980, p.51).[3]

Prior to introducing his analysis of the contrast between positive and negative instrumentality, which he says is cousin to the difference between killing and letting die, Jonathan Bennett explains the need for an analysis like his. Bennett

[3] Unfortunately, Bennett does not provide any further explanation of this point. However, I suspect that he is talking about the kind of argument that Earl Winkler (1991) makes to support his view that "the killing/letting-die distinction sometimes actually turns upon and incorporates normative considerations" (p.316). Winkler maintains that determination of causal responsibility depends on normative considerations connected with expectations related to codified social roles/relationships, general requirements, and specific demands. For Winkler, the doctor who unplugs the respirator lets the patient die, while the relative who unplugs the respirator kills the patient because unplugging the respirator is the sort of thing we expect a doctor to do (p.320).

I think Winkler's approach is highly problematic, since, ultimately it prevents him from doing moral criticism in favour of supporting the status quo. Role expectations need to be considered in determining the morality of an act, but this is done more appropriately once causal responsibility is determined.

sets four conditions that an adequate analysis must meet. 1) It must provide a genuine distinction which separates two mutually exclusive species. 2) These two species must be jointly exhaustive of the genus he calls "prima facie responsibility" for a state of affairs, so that they include every case where a person has some degree of responsibility for a particular state of affairs. 3) The distinction must be defined in terms which are free of moral content, so that we can go on to do clear moral thinking about them without begging the questions. And 4) the distinction should be statable in clear, objective terms deeply grounded in the nature of things, so that its application is not controversial (Bennett, 1980, p.48).

Bennett claims that his analysis satisfies these conditions, while our usual contrast between doing and letting happen, killing and letting die, does not. As Bennett discusses how our usual contrast fails to satisfy his conditions, the importance of such conditions becomes more obvious.

Our traditional contrast, which Bennett describes as "the line which has causal verbs on one side of it and corresponding phrases about 'letting' things happen on the other side" (Bennett, 1980, pp.48-9), suffers from at least four serious deficiencies. 1) It fails to distinguish clearly two separate classes of events. Some killings are called lettings-die (such as unplugging the life-support system of a terminally ill patient), while some lettings-die are called killings (such as killing a plant by failing to water it). 2) Doing and letting happen do not exhaust the ways of being *prima facie* responsible. It is wrong to say that I "let" a particular event happen if I did not know it was liable to occur, but it may have

happened because I did not do something else.[4] On the other side of the line, events such as E sometimes occur because of something I did, and I may therefore be responsible for E, although it would be wrong to say that I did E. Take the earlier example of hiring a killer: I did not kill my husband but I am responsible for his death. 3) To some extent the line between doing and letting happen reflects prior moral judgment. For example, in determining whether I *killed* the houseplant we consider whether it was my responsibility to care for it. If the houseplant died of drought and it was not my responsibility to water it, then presumably I face the less serious charge of letting it die. 4) How to draw the line between killing and letting die is, in some instances, a controversial matter.

> For instance, we speak of pulling the plug on someone's respirator as a case of "letting" him die because we see his dying as something which is tending or trying or straining to happen, and we see what we are doing as the mere removal of an obstacle to that process (Bennett, 1980, p.50).

But Bennett cannot accept this perspective because it is not objective. "I cannot find that way of viewing the situation corresponds to anything in the objective world which I would be prepared to make room for in my moral thinking" (Bennett, 1980, p.50). I am not quite sure what Bennett means by the preceding statement, but I share his suspicions on the notion that dying is a process that is trying to occur.

I suspect that these removal-of-obstacle intuitions correspond to beliefs about "God's will", "what Nature intends", or at a secular level, about the distinction between extraordinary and ordinary means of keeping someone alive. Those who subscribe to the first and second beliefs would maintain that God

[4] Presumably Bennett thinks that in some such cases I am *prima facie* responsible.

wills, or that Nature intends the person on the respirator to die and that unhooking the respirator removes the obstacle to the workings of God or Nature. The problem with this kind of perspective, as pointed out by David Hume, is that all human technology can be viewed as interfering with the workings of God or Nature. He takes us to the logical conclusion of this view.

> If I turn aside a stone which is falling upon my head, I disturb the course of nature, and I invade the peculiar province of the Almighty by lengthening out my life beyond the period which by the general laws of matter and motion he has assigned it (Hume, "On Suicide," 1777, p.107).

Anyone with a potentially fatal disease is on the road to dying, and failing to treat such an illness can be seen as refraining from interfering with the will of God or Nature. Taking this view to the extreme, any illness or injury is the will of God or Nature and any remedial efforts constitute interference with that which is meant to be. According to Hume, the more rational view is that God governs the animal world by endowing all animals, including humans, with physical and mental powers and the material world through general laws; hence all events are the actions of God. Our efforts to sustain the patient on the respirator, the patient's living, or the patient's dying are all in accordance with the will of God or Nature, or else they would not occur.

Secularists who view the unplugging of the respirator as the removal of an obstacle to the patient's death may distinguish between the use of ordinary and extraordinary means of keeping the patient alive when death is imminent. The American Medical Association seems to make this distinction.

> The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate

family (James Rachels, "Active and Passive Euthanasia," 1979, p.490).

Perhaps what is meant by extraordinary means are treatments used to keep a patient alive when the dying process is trying to happen, and what is meant by ordinary means are those used to sustain people when the process of living is still trying to happen. These definitions are not particularly helpful because there is no objective way of determining where the process of living leaves off and the process of dying begins. Moreover, the distinction between ordinary and extraordinary means is itself controversial, as evidenced by the recent debate as to whether intravenous feeding is an ordinary or extraordinary means of keeping a terminally-ill patient alive.

Bennett is critical of other terms commonly used to make the distinction between doing and letting happen. In using the terms "refrain" or "forbear", we ignore cases where a person does not do something but cannot be said to have refrained from doing that particular thing because he or she never considered doing it. On the other side of the line, the verb "to cause" is, as I mentioned earlier, problematic because its use is not supported by strong philosophical theory and is sometimes determined by moral criteria: i.e., we determine that someone has caused an event if we think the person is morally responsible for the event: for example, your cat is dead and we think it is your fault, so we say that you killed your cat, rather than saying that the cat died.

Bennett prefers the contrast between positive and negative instrumentality to our traditional doing and letting happen, because it satisfies the four criteria

outlined earlier. Before we go on to positive and negative instrumentality we must look at Bennett's definition of instrumentality.

> I take someone to be instrumental in the obtaining of a state of affairs S if S does indeed obtain, and if the person's conduct makes the difference either between S's being impossible and its being on the cards, or between its being less than inevitable and its being inevitable; that is, it either hoists S's probability up from 0 or hoists it up to 1 (Bennett, 1980, p.61).

Bennett, in order to simplify things, restricts instrumentality to its stronger sense, i.e., to the difference between something's being less than inevitable and its being inevitable.

The concept of representing one's instrumentality in an event's occurring on a logical-space square is essential to understanding the distinction between positive and negative instrumentality.[5]

> We construct a square representing all the ways the person could have moved at the relevant time, with each point in it representing one completely specific, absolutely detailed proposition. There is a unique line across the square which has on one side of it all and only the propositions which satisfy the condition:
>
> If it were the case that ..., S would obtain,
>
> and on the other side of it all and only the ones satisfying the condition:
>
> If it were the case that ..., S would not obtain (Bennett, 1980, p.62).

[5]Although Bennett gives a rather lengthy and detailed background on negative propositions, I do not think it is essential to understanding positive and negative instrumentality; hence I will omit explanation of it.

It is the fall of this line through the square of one's possible conduct that determines whether one's instrumentality is positive or negative.[6]

To demonstrate the concept of representing positive and negative instrumentality on a logical-space square, Bennett uses the example of John dislodging a rock which lies in the path of a vehicle rolling down to a cliff. Because there are very few movements John could have performed which would have led to the vehicle's destruction, the line divides his possible-conduct square such that the side containing the vehicle-survives options is much larger than the side containing the vehicle-is-destroyed options. John is positively instrumental in the destruction of the vehicle because "of all the ways in which he could have moved, only a tiny proportion were such as to lead to the vehicle's destruction" (Bennett, 1980, pp.62-3). To demonstrate negative instrumentality, Bennett changes the scenario so that the vehicle is rolling down to the cliff and John fails to stop it by placing a nearby rock in its path. In this situation a tiny proportion of his behaviour options would result in the vehicles's survival, the vast majority of his possible movements would result in the vehicle's destruction. Hence, John is negatively instrumental in the destruction of the vehicle.

As Bennett points out, his way of distinguishing between positive and negative instrumentality "depends utterly on the concept of the possible movements

[6] It is key to Bennett's discussion that each proposition which describes a possible movement has the same degree of specificity so that we can compare the amount of logical space taken up by propositions which lead to the event obtaining with the amount of logical space taken up by propositions which lead to the event not obtaining.

Bennett describes positive and negative instrumentality on several levels. I have chosen to discuss the simpler, more intuitive one here, but I imagine that metaphysicians might not find it particularly satisfying. They can look at Bennett's more complex and more logically sound description in "Morality and Consequences", pp 52-65.

of a body..." (1980, p.65). Because it deals with objective, specific ways of moving, this dependence on body movements provides his analysis with the objectivity that rival analyses lack.

Bennett's analysis also allows for the possibility of no movement at all. In most actual cases, stillness is just one way of being negatively instrumental, but a case can be constructed where the event will occur if the person is still and will not occur if he/she moves at all. Here is Bennett's example.

> Henry is in a sealed room where there is fine metallic dust suspended in the air. If Henry keeps utterly still for two minutes, some of the dust will settle; and if it does, some is bound to fall in such a position as to close a tiny electric circuit which ... well, finish the story to suit your taste, but make it something big; and let's call its occurrence S. Thus any movement from Henry, and S will not obtain; perfect immobility and we shall get S (Bennett, 1980, p.66).[7]

If Henry moves, S will not occur. If he is still he is positively instrumental in S. Immobility is the only behaviour which results in S; everything else leads to S not occurring (Bennett, 1980, p.67).

Bennett's discussion of stillness is important because stillness, in Henry's case, is a way of being responsible for an event. The Henry example also distinguishes between letting happen and negative instrumentality since, in keeping perfectly still, Henry lets the dust fall, but is positively instrumental in S. Bennett maintains that it is an advantage of his analysis that it can separate immobility

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[7] Bennett misdescribes the example when he writes "...any movement from Henry, and S will not obtain "(p.66), then a few paragraphs later, "...if he [Henry] moves he is negatively instrumental in S's obtaining"(p.67). How can S occur if Henry moves? We have been told that any movement from Henry and S will not obtain.

from non-doing and non-interference, since immobility is not necessarily the same as non-doing or non-interference (Bennett, 1980, p.67).

In concluding his analysis, Bennett points out that the distinction between positive and negative instrumentality lacks moral significance.

> If someone is prima facie to blame for conduct which had a disastrous consequence, the blame could not conceivably be lessened just by the fact that most of his alternative ways of behaving would have had the same consequence (Bennett, 1980, p.69).

Bennett argues that since the positive/negative distinction is without moral significance, its rivals also lack moral significance. He illustrates his argument with reference to killing and letting die, a special case of doing and letting happen. First, he explains that his argument leaves out positive instrumentalities which are not killings and negative ones which are not lettings die. Some positive instrumentalities are not killings and some negative instrumentalities are not lettings die because they are very weak instrumentalities -- they increase the probability of the event's occurring but they do not make the difference between an event being less then inevitable and its being inevitable.

> If my opening the gate at the railway crossing hoists your chance of being hit by a train from 0 to 10%, then if you are hit by a train I am positively instrumental in your dying, but I have not killed you. And if my not giving you a certain medicine raises from 0 to 10% your chance of dying this week, then if you do die this week I am negatively instrumental in this, but I have not let you die, even if I have the requisite knowledge, responsibility, and so on (Bennett, 1980, p.69).

Because these weak instrumentalities are neither killings nor lettings die, they cannot help us in making a moral distinction between killing and letting die.

Bennett also leaves positive lettings die and negative killings out of his argument. His examples of positive lettings die are letting a climber fall to his death by cutting his rope and letting a terminal patient die by unplugging his respirator. His example of a negative killing is killing one's baby by not feeding it. Bennett claims that in these cases, the same conduct is both a killing and a letting die, and is therefore not in question when one argues that killing is intrinsically worse than letting die. His argument, then, deals only with negative lettings die and positive killings.

Bennett defines letting die as it relates to negative instrumentality.

> Lettings die are negative instrumentalities marked off by special features which tend to increase moral weight and certainly do not lessen it. If I am negatively instrumental in a premature death, the addition of facts which imply that I let the person die will tend to make my culpability greater, not less; for they are facts such as that I had the relevant knowledge, had some responsibility in the matter, and so on (Bennett, 1980, p.70).

This definition supports Bennett's lemma that letting die is no better than the relevant negative instrumentality.

The features which, according to Bennett, make killing a special form of positive instrumentality are: 1) the absence of an intervening agent and 2), the absence of intervening coincidences. An example of an intervening agent is the hired killer. If I have someone else kill you, I am positively instrumental in your death but I did not kill you. As Bennett points out, hiring a killer is not morally

better than killing (Bennett, 1980, p.71). To illustrate what the absence of intervening coincidences involves, Bennett starts with a story of a positive killing; "I kick a rock which starts a landslide which drowns you as you stand in the stream fishing" (Bennett, 1980, p.71). If the story is changed and the landslide occurs only because my kicking the rock coincides with a clap of thunder, then I did not kill you but I was positively instrumental in your death.

> If I am right, then killing involves more than being positively instrumental in his dying --it requires also that the causal chain run through a stable and durable structure rather than depending on intervening coincidental events (Bennett, 1980, p.71).[8]

The lack of an intervening agent and intervening coincidences does not seem to make a moral difference; hence, positive instrumentality in someone's dying is no better than killing (Bennett, 1980, p.71).

Bennett's argument looks like this:

1. Letting die is no better than the relevant negative instrumentality.

2. Negative instrumentality in someone's dying is no better in itself than positive instrumentality.

3. Positive instrumentality in someone's death is no better than killing.

4. Therefore, letting someone die is no better in itself than killing the person (Bennett, 1980, p.70).

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[8] Bennett seems to be talking about some deep objective difference between killing and positive instrumentality, but the difference between the causal chain running through a stable and durable structure and its depending on intervening coincidental events is entirely knowledge dependent. We determine whether a causal chain is stable or involves coincidence depending on what we expect to happen.

While I am satisfied with the structure of Bennett's argument, I have some reservations about his support for the lemma that the relevant positive instrumentality is no better than killing. It is his second distinguishing feature of killing, the absence of intervening coincidences, which I find troublesome.

Going back to Bennett's earlier definition of instrumentality, we see that to be instrumental in an event is for one's conduct to increase the probability of the event occurring from its being impossible to its being possible, or from being less than inevitable to being inevitable (Bennett, 1980, p.61). So, if my conduct makes someone's death inevitable or even increases the probability of the person's death, I still bear some causal responsibility for the death occurring regardless of an intervening coincidence.

But, at first glance, the absence of intervening coincidences does seem to make killing morally worse than positive instrumentality, or rather, the presence of intervening coincidences makes positive instrumentality morally better than killing. One reason for thinking this is that the presence of an intervening coincidence reduces my causal responsibility for the death. For example, if I shove my husband against the balcony railing and he plummets to his death because my shove coincides with a small earthquake which causes the balcony railing to give way, then I am positively instrumental in his death, but I have not killed him so long as my shove alone was not enough to send him to his death. In this case the intervening coincidence is the earthquake. If the earthquake had not occurred, my husband would still be alive on the balcony, instead of lying dead on the pavement.

Now, let me change the story so that no intervening coincidence occurs. I, much stronger than I appear, push my husband over the railing to his death. Surely

I am less culpable in the first scenario than in this second scenario: my shove would not have been fatal had the railing remained secure. In the second scenario, my actions alone are sufficient for my husband's death.

While this example demonstrates a change in my causal responsibility for my husband's death, the question remains whether there is a corresponding change in moral responsibility. I might argue that in the first scenario my husband would not have died had the earthquake not occurred, but the fact remains that neither would he have died had I not shoved him: my shoving him increased the probability of his dying. At first glance it seems that my actions in the second scenario -- pushing my husband over the balcony -- are morally worse. But, it is not the action that is morally worse, in both cases my action is of the same sort; I shove my husband against the balcony railing. The moral difference between the earthquake scenario and the no-earthquake scenario is that in the first case, I am less morally responsible because I could not be expected to know that my action would result in my husband's death. If there had been no earthquake, the death of my husband would not have occurred. Since I am a very strong person in the second scenario, I should have expected that shoving my husband toward the balcony railing might result in his toppling over the railing to his death. The moral difference between these scenarios is a result of the difference in the probability of the outcome and the general moral principle that people are morally responsible for the probable consequences of their actions. Even though the outcome (consequence of my action) was the same in both scenarios, it was highly unlikely in the first and quite likely in the second. As a result, my action in the second scenario is judged to be morally worse than my action in the first scenario.

What effect does this have on Bennett's lemma that positive instrumentality is no better than killing? The difference between them is that killing requires the absence of both intervening agents and intervening coincidences. My earthquake examples demonstrate that an intervening coincidence decreases my moral responsibility because I cannot be expected to know and, therefore, be held responsible for the highly improbable consequences of my action which will be brought about by an intervening consequence. But, I can be expected to know and, therefore, be held responsible for the probable consequences of my action.

Let us return to Bennett's examples of positive killing and positive instrumentality to see if we come up with another obvious moral difference. To illustrate positive killing, he describes a scenario in which he kicks a rock which starts a landslide which drowns you as you standing fishing in a stream. The relevant example of positive instrumentality is that you drown in the stream because of a landslide which occurs only because his kicking of the rock coincides with a clap of thunder. In these examples killing seems no worse than positive instrumentality. In both cases, the agent's moral responsibility is virtually nil. The picture I had in mind when I first read these examples was of Bennett aimlessly kicking a small rock as he casually strolled down a path through the woods above a stream in southwestern Ontario. Transplant the scene to mountainous British Columbia and we have Bennett kicking a rock in a recreational area which is prone to landslides. Most British Columbians are familiar with these areas where the roadsigns read "Danger, falling rocks". Now we have a moral difference because we can expect people to know that kicking a rock in a landslide area is likely to cause a landslide and a landslide in a recreational area is likely to kill

someone.[9] In this context, killing is morally worse than the relevant positive instrumentality. The lesson here is that one of the factors which affects moral responsibility is the probability of the consequences of one's actions. When the landslide is a highly probable consequence of one's actions, then one bears more responsibility for its occurrence and the resulting consequences than if a landslide is an unlikely consequence of one's actions.

Now, let us go back to Bennett's other distinguishing feature of killing, the absence of an intervening agent. At first glance, the person who hires the contract killer seems just as morally responsible as the contract killer. But if I hire someone to kill my rival, then I am positively instrumental in the death. If I do it myself, then I have killed the person. In some cases, you might argue that I bear more moral responsibility if I hire someone to do the dirty work. Consider the recent case of Pamela Smart, a teacher in the United States who persuaded her teenaged lover to kill her husband. The judge in the case argued that not only was Smart more morally responsible for the death than the killer, but that what she had done was worse than if she had committed the killing herself, because she had corrupted the young man by persuading him to kill her husband. Newspaper reports from the trial indicate that the young man would not have carried out the murder without his lover's urging. I think the judge was right on both points. This is a case of positive instrumentality that seems morally worse than the relevant killing -- Smart killing her husband.

[9] Someone might argue that they did not know that kicking a rock might start a landslide, but this would not serve as an adequate excuse for the average adult, since people have an obligation to inform themselves on these issues.

Taken together, the landslide example, the earthquake example, and the hired killer example suggest that positive instrumentality in a death can be better than killing, killing can be better than positive instrumentality in someone's death, and positive instrumentality in a death and killing can be morally equivalent. I would speculate that most cases of killing are morally worse than most cases positive instrumentality. However, even if proven, this would not prove that positive instrumentality is better in itself than killing in itself. In cases where the relevant positive instrumentality is better than killing, it is likely to be due to an additional factor such as the improbability of the consequences of the act. As the landslide example demonstrates, when the consequences of one's action are equally probable, then one is equally morally responsible for the outcome regardless of whether one is positively instrumental in a death or has killed a person. It happens to be the case that in most incidents of killing the agent can be expected to know that death is a highly probable outcome whereas in most cases of positive instrumentality, death would be considered a less probable outcome.[10] This does not prove Bennett's premise false, rather it supports the slightly modified premise that positive instrumentality, in itself, in someone's death is no better than killing in itself.

With the above modification, Bennett's premise is supported and his argument is sound, thus we can accept his conclusion that letting someone die is no better in itself than killing the person.

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[10] Note that the scale of probability of consequences is not perfectly calibrated with that of moral responsibility. Probability of consequences has finer gradations than moral responsibility. If the consequence of your action is virtually impossible, you are probably off the hook. But you may also not be considered morally responsible for consequences which are only highly unlikely.

This conclusion is rather unsavoury. If Bennett is right, then it seems that allowing children to starve to death in the third world is just as bad as shooting them to death. Bennett would agree that these two options are morally equivalent if all else is equal. That is, if your intention is the same, if the consequences are the same, if the motive is the same, if your relationship to the children is the same, if the cost and benefit ratios are the same, if all other moral factors are the same, then it is just as bad (or good) to allow children to starve to death as it is to kill them.[11] The moral factors most relevant to euthanasia will be discussed in the next chapter.

My second criticism has to do with Bennett's use of the concept of causality upon which the second feature of killing depends. In order to determine that one's instrumentality is free of intervening coincidences, we must be able to recognize the "normal" causal chain of events that would otherwise occur. In Bennett's words; killing "requires also that the causal chain run through a stable and durable structure rather than depending on intervening coincidental events" (Bennett, 1980, p.71). My criticism is not of Bennett's use of the concept of causality, but of its use here without explanation of its difference from the use of the verb "cause" which he criticizes early in his essay. When explaining the drawbacks of the causing/letting happen line, Bennett says that the uses of cause as a verb with a person as the subject as in "He causes the door to close" have "no plausible, strong, clear philosophical theory to back them up" (Bennett, 1980, p.51). The onus is on Bennett to explain why his later use of the term "causal chain" (Bennett,

[11] I do not want to make the assumption that it is generally morally wrong to bring about someone's death.

1980, p.71) is acceptable and theoretically grounded. Bennett might defend himself by arguing that there is a significant difference between the concept of a person causing an event and the concept of an event causing an event, in that the former is partly moral and the latter is not at all moral. For example, if I am positively instrumental in my husband's death, those who think I am blameworthy will say that I caused his death. This element of moral judgment plays no role in event-causation, since we do not consider events to be culpable. However, Bennett must make his argument explicit before we need accept his second distinguishing feature of killing -- that the causal chain of events run through a stable structure.

Another problem is Bennett's contention that some acts are both a killing and a letting die. His examples of such acts are; "positive lettings die, such as letting a climber fall to his death by cutting his rope, or letting a terminal patient die by unplugging his respirator" and "negative killings, such as killing your baby by not feeding it" (Bennett, 1980, p.70). Looking at Bennett's definitions of killing and letting die relative to positive and negative instrumentality, I find support for the view that cutting the rope and unplugging the respirator are killing, while failing to feed my baby is a letting die. Letting the climber fall to his death by cutting his rope is a positive instrumentality free of intervening coincidences and intervening agents. Unplugging the respirator of a terminal patient also fits Bennett's definition of a killing.[12] And failing to feed one's child is a letting die in that the parent is negatively instrumental, knows that the child needs food, is responsible

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[12] One might argue that in both the rope-cutting and the unplugging of the respirator an intervening coincidence must occur in order for someone to die. The climber must lose her footing and the person on the respirator must suffer respiratory distress. Perhaps Bennett is considering coincidences that occur simultaneously with the act. His example of the person drowning because of the kicking of the rock coinciding with the clap of thunder follows this pattern.

for the child's welfare, and so on. But, failing to feed one's child does not fit Bennett's description of killing, because it is a case of negative rather than positive instrumentality, just as cutting the climber's rope and unplugging the patient's respirator do not fit his definition of letting die because they are positive rather than negative instrumentalities.

It seems that Bennett could have just as easily claimed that these acts fall somewhere in between killing and letting die, rather than being both killings and lettings-die. He has given the reader no reason to accept one interpretation over the other. Regardless of which categorization one accepts, these examples support Bennett's contention that killing and letting die fail to exhaust the categories of ways of being *prima facie* responsible for someone's death.

Or, it could be the case that Bennett's definitions of killing and letting die are inadequate in that they fail to draw a clear line between killing from letting die. In Bennett's defense, early in the essay he points out the difficulties of trying to categorize ways of being responsible for a death along the lines of killing and letting die. In giving definitions of killing and letting die, he is attempting to show how our traditional concepts of killing and letting die relate to his more precise concepts of positive and negative instrumentality. In Bennett's initial criticism of the killing/letting die distinction, he points out that one of the shortcomings of this distinction is its inability to separate killings and lettings die.

> First, it separates two non-overlapping classes of verbal expression, but not two non-overlapping classes of event. There are killings which get described as lettings die (such as pulling the plug on the life-support system of a terminal patient), and there are lettings die which get described as killings (such as killing a houseplant by not watering it) (Bennett, 1980, p.49).

Regardless of which condition is being breached, Bennett has succeeded in showing that there is something about the killing/letting die distinction which fails to meet the conditions he sets out.

The beauty of Bennett's negative/positive line is that it makes room for ways of being responsible for an event without having to categorize these ways along the limited lines of doing and letting happen, or killing and letting die.

To summarize so far, Bennett has succeeded in providing an objective analysis to replace the traditional one of doing and letting happen. This analysis makes it clear that there is no moral distinction between doing and letting happen. Hence, killing in itself is not morally worse (or better) than letting die. Other factors such as the agent's intention, prior responsibility, and so on determine the moral status of the agent's behaviour.

Warren Quinn ("Actions, Intentions, And Consequences: The Doctrine Of Doing And Allowing," 1989) criticizes Bennett's analysis of the distinction between positive and negative instrumentality. Quinn favours the Doctrine of Doing And Allowing (DDA), a theory that discriminates against harm resulting from action, in favour of harm resulting from inaction (Quinn, 1989, p.291). According to the DDA, negative agency, which is usually a matter of not doing something, is morally better than positive agency, which is usually a matter of doing something (Quinn, 1989, p.291), although some inactions function morally as positive agency because of factors increasing the agent's moral responsibility (Quinn, 1989, p.300).

Quinn says Bennett is a severe critic of the DDA who dismisses Donald Davidson's conception of action. According to Quinn, Davidson conceives of individual actions as concrete particulars that can be described as follows,

> To say that John hit Bill yesterday, is to say that there was a hitting, done by John to Bill, that occurred yesterday. To say that John did not hit Bill, on the other hand, is to say that there was no such hitting (Quinn, 1989, p.294).

According to this conception of action, the distinction between positive and negative agency is the distinction between something happening because of what the agent does and something happening because of what the agent did not do but might have done. Quinn surmises that Bennett is critical of Davidson's conception of action because it fails to provide a clear criterion for distinguishing action from inaction in all cases. "Bennett is reluctant to assign moral work to any distinction that leaves some cases unclear, especially where there is no theoretically compelling reductionistic theory for the clear cases" (Quinn, 1989, p.295). Quinn thinks that such a standard is too strict.

> Almost no familiar distinction that applies to real objects is clear in all cases, and theoretical reducibility is a virtue only where things really are reducible. In any case, the imposition of such a standard would shut down moral theory at once, dependent as it is on the as yet unreduced and potentially vague distinctions between what is and is not a person, a promise, an informed consent, etc. (Quinn, 1989, p.295).

This is the more powerful of Quinn's criticisms because it questions Bennett's conditions for his analysis.

The question we must ask at this point is, which is better, the traditional distinction advocated by Quinn or Bennett's somewhat odd distinction? The

traditional distinction leaves some cases unclear and may lack a theoretical foundation. Bennett's distinction distinguishes clearly between different ways of being responsible for an event and is theoretically based on the possible movements of a person's body and their relationship to a particular event. More importantly, Bennett's distinction is free of any moral judgment, allowing us to do our own moral thinking about a person's connection to an event, while the distinction advocated by Quinn does some of our moral thinking for us since it assumes that doing is generally worse than allowing. Unless Bennett's analysis is flawed in some way, I would choose it over the traditional analysis such as advocated by Quinn. While Bennett's standards, as described early in this chapter, may be unattainable in some areas of moral theory, they are reasonable standards to set regarding the problem of doing and allowing.[13] (Bennett does not suggest that his standards be applied to all areas of moral theory.)

Quinn suggests that Bennett's standards are too strict to be workable, but Bennett proves him wrong by coming up with a workable distinction between positive and negative instrumentality which meets his standards. It is now up to Quinn to show that Bennett's distinction is flawed. He attempts this by claiming that in some cases the application of Bennett's distinction leads to conclusions which are counter-intuitive.

> The trouble is that this distinction gets certain cases intuitively wrong. Bennett imagines a situation in which if Henry does nothing,

[13] In a nutshell, Bennet's conditions for an adequate analysis of killing and letting die are that 1) it must clearly distinguish two mutually exclusive species, 2) these species must jointly exhaust all the ways of being *prima facie* responsible for a state of affairs, 3) the distinction must be defined in non-moral terms, and 4) the distinction should be statable in clear, objective terms.

> just stays where he is, dust will settle and close a tiny electric circuit which will cause something bad --for example, an explosion that will kill Bill. If Henry does nothing, he is by Bennett's criterion positively instrumental in Bill's death (Quinn, 1989, p.295).

So far, so good. Henry would be positively instrumental in Bill's death because, of all the behaviour options available to him, only one would result in Bill's death: his immobility.

Quinn continues:

> But suppose Henry could save five only by staying where is -- suppose he is holding a net into which five are falling. Surely he might then properly refuse to move even though it means not saving Bill. For his agency in Bill's death would in that case seem negative... (Quinn, 1989, p.296).

Henry's agency might seem negative to Quinn but it has nothing to with negative instrumentality. Bennett would still say that Henry was positively instrumental in Bill's death, and probably positively instrumental in saving the five. Quinn is confusing Bennett's non-moral positive and negative instrumentality with his own moral terms, positive and negative agency.

It is clear that in assigning the terms positive and negative agency, Quinn is making a judgment about the agent's moral responsibility for the event. In giving Henry a morally acceptable motive for remaining immobile, he is letting him off the hook for causing Bill's death, and he wants to express Henry's reduced moral culpability by calling his agency negative. But Quinn has not succeeded in demonstrating that Bennett's distinction "gets certain cases intuitively wrong" (Quinn, 1989, p.295). Any moral judgment of Henry's involvement in Bill's death is

quite separate from Henry's instrumentality in the event. To link the two is to beg the question of whether killing is morally worse than letting die.

Quinn makes the same mistake in describing an opposite case in which the device will go off only if Henry moves. He is correct in saying that Bennett would judge Henry's instrumentality as negative. But he is wrong in thinking that Henry's agency in Bill's death seems positive if it is wrong for Henry to set off the device by going to rescue five others (Quinn, 1989, p.296). Again, it seems Quinn is assuming that his notion of positive agency is equivalent to Bennett's concept of positive instrumentality and that negative agency lines up with negative instrumentality.

None of the criticisms that Dinello, Quinn, or I have made against Bennett's analysis of the distinction between positive and negative instrumentality are particularly damaging. My only reservation is that an analysis which depends on the concept of the possible movements of a body seems rather out of place in moral theory, but this is probably a problem with my thinking about moral theory rather than a problem with Bennett's analysis. It may very well be a virtue of Bennett's work, that it forces us to think critically about our moral conditioning in the way we perceive killing and letting die.

In conclusion, Bennett is successful in demonstrating that there is no morally significant difference between killing and letting die. In situations where a particular act of killing can be judged morally worse than an otherwise identical act of letting die, the moral difference is due to circumstances rather than to any intrinsic moral disvalue attached to the act of killing itself.

Chapter 3 - Moral Factors Affecting Active and Passive Euthanasia

In the last chapter, I argued that killing in itself is no morally worse than letting die, hence any moral distinction between active and passive euthanasia cannot be based on a moral difference between killing and letting die if all other factors are equal. In this chapter I will examine other moral factors which may account for a legitimate distinction between active and passive euthanasia. These factors include: motives, intentions, means, outcomes, and tendencies (long-term consequences of the action). In discussing the tendencies of a practice of active euthanasia I will examine arguments put forth by Tom Beauchamp, Alexander Morgan Capron, and Helga Kuhse. I will also consider what role each of these moral factors plays in distinguishing euthanasia from other types of killing and letting die.

Motives

Whose motives are at issue may be controversial. It seems that the motives of those who assist, bring about or allow the death of the patient are the ones to be examined. When the patient is responsible for his or her own death, then we are talking about suicide. Euthanasia -- whether it be active or passive -- implies the involvement of other people, hence the patient's motives are not at issue in determining the morality of euthanasia[1], but the motives of those who assist in

[1] The patient's motive for wanting to die is important in so far as it should be based on true beliefs. Agents of euthanasia should make themselves aware of the basis for the patient's desire to die and ensure that it is not faulty reasoning or false belief. For example, patients might be under a false belief that their condition will cause them intolerable pain and suffering.

bringing about the person's death are relevant. These people are usually health-care workers, close friends or family members.

The agent's motive is probably the single most important factor to consider when trying to determine whether an act of killing or letting die falls into the category of euthanasia. In a case of euthanasia the agent acts from compassion and beneficence[2], the agent is motivated to end the patient's life as a means of relieving the patient's suffering, and this is what distinguishes euthanasia from all other acts of killing and letting die.

Determining the motive(s) of the agent is required in order to determine whether the particular case of killing or letting die is indeed euthanasia. One step in determining if the patient's death is the result of euthanasia is to rule out motives other than compassion and beneficence. For example, if the agent has something to gain (materially at least) from the patient's death, this may not prove that the agent's motivation is greed, but we should be suspicious of the agent's motive. We should also be suspicious if the agent disliked the patient or had little or no knowledge of the patient's condition. Knowing that the patient was suffering, sympathy for the patient, or a history of a loving relationship with the patient would serve as indicators of compassionate motivation.

It is difficult to see how the motives could be different for active euthanasia and passive euthanasia. In both types of euthanasia, one would expect that those assisting in euthanasia are acting from beneficence. As stated at the outset, I am dealing only with voluntary euthanasia -- cases where the patient

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[2] In a case of voluntary euthanasia, an additional reason is respect for the patient's autonomy, since the patient makes the decision to die and the agent carries out that decision.

wants to die or has expressed this desire in the form of a Living Will or something similar. If the motive is other than mercy, beneficence, or respect for the patient's autonomy, then we are not dealing with euthanasia. Euthanasia, by definition, requires that one act for the sake of the patient.

Those who maintain a difference in the motivation for active euthanasia and the motivation for passive euthanasia usually maintain that active euthanasia is only a guise for ridding society of those people who are considered a burden. This sort of killing does not fall into the category of euthanasia and is therefore irrelevant to this discussion. Abuses may occur in the practice of either active or passive euthanasia, and I will discuss these later on.[3]

Intentions

As with motives, the intentions that are at issue in determining the morality of euthanasia are the intentions of those assisting in bringing about the patient's death.[4] In order to determine if death is brought about through an act of euthanasia (rather than another kind of killing or letting die which may or may not be morally acceptable), we need to determine whether the agent's intent was to end the patient's suffering. We should be asking questions such as "Were other means (other than death) of ending the patient's suffering available?," "Could the agent reasonably be expected to know about these means?," "Could the agent obtain these means?," "Would these other means have been acceptable to the patient?," "Did the agent pursue these means?". If the answer to any of the first four questions is

[3] I discuss abuses in this chapter under the heading Tendencies.

[4] In order for the death to be classified as euthanasia, the patient's intent must be to die in order to avoid suffering, whether it be physical or emotional. I briefly discuss the tension between the agent's intent and the patient's intent in Chapter 1.

negative or the answer to the last question is positive, then it is quite likely that the agent's intent was to bring an end to the patient's suffering.

Bruce Reichenbach maintains that there can be a difference in intention between active and passive euthanasia.[5] In some cases of active euthanasia, the patient's death is intended. In passive euthanasia, the patient's death is foreseen but not intended.

> Treatment of the terminally ill is ended or not commenced because of its futility and painfulness or because the efforts and facilities might be put to better use. The aim or intention is to avoid needless pain or bills or to alleviate human misery, not to kill the patient (Reichenbach, 1987, p.58).[6]

On the other hand, Reichenbach argues, the intention in both active and passive euthanasia can be the same, both are intended to relieve pain and suffering; death is foreseen but not intended.

I think all cases of euthanasia are cases of Reichenbach's second kind. It is clear that in both active and passive euthanasia the intention is to bring about the patient's death in order to relieve the patient's suffering rather than merely to bring about the patient's death.[7] If, by a strange twist of fate, the lethal injection

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[5] Bruce R. Reichenbach, "Euthanasia and Active-Passive Distinction," Bioethics, 1.1, 1987 (p.50-73).

[6] Although financial concerns may cause the patient, and her/his loved ones, a great deal of stress, this is not the sort of suffering that, on its own, justifies passive euthanasia.

[7] One can argue, successfully in some cases, that the intention behind the euthanasia of comatose patients is to bring about the death of the patient rather than to relieve the patient's pain and suffering. It is beyond the scope of this paper to deal with nonvoluntary euthanasia. Besides, the euthanasia of comatose patients may be either passive or active, hence asymmetry is not at issue.

intended to put the patient out of his misery actually cures the patient's condition instead of killing him, we would not try another method of euthanasia, such as smothering him with a pillow, because the reason for bringing about the patient's death is gone. The same point applies to passive euthanasia: if a patient's condition reversed after drug therapy was ceased, we would not remove feeding and hydration tubes if they were still required to keep the patient alive.[8] The intention in both active and passive euthanasia is to relieve suffering.

Means[9]

The means used in euthanasia are likely to be different from the means used in other types of killing and letting die, because euthanasia is most likely to be carried out by health care professionals in an institutional setting on people who are physically ill.[10]

Perhaps the most important factor distinguishing the means used in euthanasia from the means used to carry out other types of killing and letting die is that the agent in euthanasia is often a health care professional. While a contract killer is likely to shoot someone, and a crime of passion may be carried out by slitting someone's throat, and killing in self-defense may be brought about by

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[8] One may argue that cessation of feeding and hydration is not passive euthanasia, but assisted suicide, because of our obligation to feed those who cannot feed themselves. I would argue that just because the act would fit into the category of assisted suicide does not remove it from the category of passive euthanasia. Passive voluntary euthanasia is assisted suicide with the additional factors of beneficent motivation, the intent to relieve suffering, etcetera.

[9] The means may tell us something about the agent's motive. For example, assume that the agent is not a health care professional and bashes the patient in the head with a blunt instrument when she could have just as easily given him a drug overdose. This should make us very suspicious of the agent's motives, because she could have chosen a less painful method of bringing about the patient's death.

[10] This is the most likely euthanasia scenario, although other likely scenarios may involve a friend or relative bringing about the death of someone at home who is not physically ill but suffering in some way.

bashing one's attacker over the head with a tire-iron, a health care professional knows how to, and is likely to, administer a lethal injection or remove an intravenous hook-up. Because of their professional training, health care workers know how to bring about the death of patients in relatively painless, quick, and clean ways.[11] Even when the agent of euthanasia is not a health care worker, we would expect him or her to use relatively painless, humane, and, where requested, quick methods of bringing about death.

The patient's illness may allow the agent of euthanasia to use other means of bringing about death than are available to agents of other types of killing and letting die. For example, if the patient requires a respirator in order to breathe, the agent may refrain from hooking one up. Now, of course, one may argue that the death of a gravely ill person is not always euthanasia, just as one may argue that euthanasia may also be performed on those who are not currently seriously physically ill.[12] My point is that the patient's illness may present some additional means for bringing about death, particularly means which are commonly regarded as passive euthanasia (provided the other moral factors which qualify a death as passive euthanasia are also present).

The means provide a difference between active and passive euthanasia. It is impossible to take all the means of euthanasia and slot them into an active or passive category. For example, it is not clear whether unplugging a respirator is active or passive. So, for the sake of this discussion, I will stick to the means

[11] In addition to training, health care workers usually have access to relatively quick, clean, humane, painless methods of killing and letting die.

[12] An AIDS patient currently exhibiting good health may wish to die before the next, or possibly first, bout of ill health.

that are easier to label as either active or passive. There are thousands of ways of bringing about someone's death, but I will limit my discussion to the more common means used in euthanasia.

The cessation of feeding and hydration, refraining from resuscitating someone who is experiencing cardiac or respiratory distress, and refraining from treating life-threatening infections are all fairly common methods of passive euthanasia. The administration of lethal drugs, either orally or by injection, is the most common method of active euthanasia.

Supporters of the active/passive distinction often argue that in the case of passive euthanasia, the patient dies of her illness, whereas in the case of active euthanasia, the patient dies as a result of someone's actions. Nancy Dickey, a family doctor and member of the American Medical Association's Council on Ethical and Judicial Affairs, falls into this camp.

> When there is little possibility for extending life under humane and comfortable conditions, a physician may permit a terminally ill patient to die. He may allow a relentless course of an illness to proceed to death, but taking a giant step beyond that and *choosing* the moment of death by active intervention is unacceptable ("Commentary." Hastings Center Report, December 1987).

Let us assume for a moment that the following claim is true: In passive euthanasia, the patient dies of his or her illness, while in active euthanasia, the patient dies as a result of someone's actions. The cause of death may be different, but this does not necessarily result in a moral distinction between the two. The reason for thinking that there is a moral distinction is the alleged moral difference between killing and letting die. As I argued in the previous chapter,

there is no morally significant difference between killing, in itself, and letting die, in itself. Hence, the fact that active euthanasia is a form of killing and passive euthanasia a form of letting die cannot provide the basis for a moral distinction between passive active euthanasia.

Illness may not be the cause of death in all cases of passive euthanasia; certainly when feeding and hydration are ceased, it is not illness, but the lack of nutrition that causes death. Even if we grant that in some cases of passive euthanasia the patient dies of his or her illness, it is often the case that these people would have lived longer if not for the action or inaction of someone else, hence the illness is not the sole cause of death. In these cases, someone is morally responsible, to some degree, for the patient's death.

The means are important factors in determining the relative morality of passive and active euthanasia. As James Rachels points out, in some cases passive euthanasia would be cruel because the patient is suffering terribly and hence a quick death -- active euthanasia -- is more merciful.[13] Given that candidates for euthanasia are suffering in some way, it is fair to say that in a general way active euthanasia is morally better than passive, because its means are usually more humane.[14]

<u>Outcomes</u>

The ultimate outcome of euthanasia is no different from the outcome of any other type of killing or letting die: death. In a case of euthanasia, those affected by

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[13] James Rachels, "Active and Passive Euthanasia."

[14] It is possible that a patient may prefer passive rather than active euthanasia. In a case like this it would be morally wrong to use active means rather than passive.

the death are more likely to be better prepared for it. This is a difference which makes euthanasia morally better than most other types of killing or letting die.

Active and passive voluntary euthanasia have the same outcome. Both allow for the patient and her/his loved ones to prepare for death. Although passive euthanasia is slower, this does not translate to giving the patient and others more time to prepare for death, since the patient who opts for active euthanasia may also opt to postpone it until she has done all of the things she needs to do to prepare for her death, such as change her will, say goodbye, make amends.

Tendencies

When comparing the tendencies of a practice of euthanasia to the tendencies of other types of killing and letting die, it is necessary to consider only the practice of types of killing and letting die that are socially sanctioned or at least candidates for legitimate social sanction, such as capital punishment, killing in war, killing in self-defense[15]. It makes little sense to discuss the morality of a *practice* of murder; since murder by definition is morally wrong, it is unlikely that a practice would develop in Canada.

In order to compare the tendencies of practices of killing with the tendencies of a practice of euthanasia, we need to examine empirical data which, to my knowledge, is not available. The next best thing is to consider probable consequences of these practices.

Probably the most common concern about any practice of moral killing is that it will lead to immoral killing. Basically, the "wedge" argument is that killing

[15] There does not appear to be any practice of letting die other than passive euthanasia.

in the form of voluntary euthanasia may be only the thin end of the wedge whi
includes other types of killing which may not be morally permissible. If we, as a society, condone euthanasia, we may, over time, also condone immoral types of killing.

In order to see how euthanasia compares with other practices of killing in terms of probable tendencies, we need to consider whether or not euthanasia is likely to lead to a greater willingness to kill to the same degree as other practices of killing.

Tom Beauchamp[16] argues that even though some forms of killing and letting die have societal approval, they do not form the thin edge of the wedge in the same way that active euthanasia would. He says that the defenceless and the dying are significantly different from the aggressors we kill in "just" wars and self-defense.[17] The aggressors' actions are morally blameworthy and justify our counteractions. However, candidates for euthanasia are being killed because their lives are considered to be no longer worth living.

> Here we are required to accept the judgment that their lives are no longer *worth living* in order to believe that the termination of their lives is justified. It is the latter sort of judgment which is feared by those who take the wedge argument seriously. We do not now permit and never have permitted the taking of morally blameless lives (Beauchamp, 1978, p.254)

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[16] Tom Beauchamp, "A Reply to Rachels on Active and Passive Euthanasia," 1978. Beauchamp is arguing that active euthanasia is the thin end of the wedge, but he also acknowledges that passive euthanasia may play the same role.

[17] Beauchamp does not mention capital punishment or abortion here. Perhaps he would put those convicted of a capital offense in the same category with other aggressors. The fetus would likely fit into the defenceless category.

But, Beauchamp fails to discuss the significance of the patient's role in euthanasia. In the case of voluntary euthanasia, it is the patient who decides that his or her life is no longer worth living. So, the fact that people are being killed or let die because their lives are considered to be no longer worth living is not particularly significant as long as they are the ones making that judgment. One could argue, as does Helga Kuhse (1978), that if legitimating some forms of killing erodes societal principles against killing human beings, then killing those who want to live, such as criminals convicted of a capital offense, would be at least as likely to erode those principles as killing those who want to die.

The long-term consequences of a practice of active euthanasia may very well be different from the tendencies of a practice of passive euthanasia. Tom Beauchamp maintains that there is no "bare difference" between active and passive euthanasia, but that there are other problems associated with active euthanasia which may convince some that we should practice only passive euthanasia. Although Beauchamp is not committed to the view that a practice of passive euthanasia alone is better than a practice of both passive and active euthanasia, he thinks that a combination of rule utilitarianism and the wedge argument outlined above should cause advocates of active euthanasia serious concern. Beauchamp is concerned that our basic principles against killing will be eroded once killing is legitimated in the form of a practice of voluntary active euthanasia. From voluntary active euthanasia, we will go to involuntary active euthanasia, to killing those who may not find life meaningless, but are a burden to others.

The problem with this argument is that if active euthanasia poses this danger, passive euthanasia poses a similar danger. Allowing the death of those who

want to die may lead to allowing to die those who are a burden to their families and society. However, if the wedge argument is sound, then we should be concerned about the increased number of people who would be at risk if a practice of active euthanasia is adopted. A practice of active euthanasia might result in a greater number of people dying, since only ill people are candidates for passive euthanasia, but we are all potential candidates for active euthanasia in the sense that all of us can be killed. And the people who are most likely to be killed are those who are considered to be a burden.

We have to ask whether a practice of active euthanasia is likely to lead to the so-called mercy killing of people who do not want to die. I am assuming that a practice of active euthanasia would involve a series of safeguards aimed at preventing this. One possibility is that the patient would meet with one or two trained counsellors who would have to be convinced that the patient really did want to die.[18]

Although the wedge argument points to a more serious long-term consequence for active euthanasia than for passive euthanasia, this is not a sufficient reason for adopting a practice of passive euthanasia only, given that safeguards can be established to prevent the killing of those who do not want to die.

The basic principle of rule utilitarianism is that society ought to adopt a rule if its consequences are better for the common good than any comparable rule, that is, that a rule is morally justified if and only if there is no other competing

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[18] This still allows for the possibility of coercion which I address later in this chapter.

rule whose acceptance would have greater utility. Beauchamp asks us to compare the relative utility of a no-active-euthanasia rule and a restricted-active-euthanasia rule. He points out that a restricted-active-euthanasia rule would eliminate some intense and uncontrollable suffering. But, the disutility of introducing legitimate killing into the moral code might be greater than the utility of reducing suffering. If one holds the wedge argument to be conclusive, then since legitimating active euthanasia could lead to reduced respect for human life, the rule utilitarian should reject active euthanasia.

Beauchamp has given no good reason to support the wedge argument that permitting active euthanasia will lead to reduced respect for human life, and as a result, other types of killing. Even if the wedge argument is sound, one would have to prove that passive euthanasia would not bring about the same results in order to show a morally relevant difference between them.[19]

Beauchamp provides a further utilitarian reason against adopting a policy of restricted active euthanasia. Some wrongly diagnosed patients will live if their treatment is ceased, while all wrongly diagnosed patients who choose active euthanasia will die, hence a no-active-euthanasia policy will save more lives than a policy which permits active euthanasia. Beauchamp admits that this group is likely to be small and that there may be counterbalancing factors such as pain and respect for autonomy. However, he thinks that this reason is morally relevant and must be considered when choosing between a policy of passive euthanasia and one which allows both passive and active.

[19] Beauchamp acknowledges that passive euthanasia may be the thin end of the wedge.

Helga Kuhse deals with the problem of mistaken prognosis in her essay "The Alleged Peril of Active Voluntary Euthanasia: A Reply to Alexander Morgan Capron" (1987). She admits that a few additional lives will be saved under a policy allowing only passive euthanasia only, but this number is not sufficient to reject active euthanasia because of the serious blow this would deal to respect for autonomy. Kuhse maintains that patients should be allowed to evaluate the evidence in their own cases and act on that evidence, even though there is a small chance that the evidence will be misleading.

I agree with Kuhse that the autonomy of the patient must not be compromised. While it seems likely that more people who are mistakenly diagnosed will die under a policy of active euthanasia, this is not a sufficient reason to condemn active euthanasia. Patients must be informed that doctors are fallible and that their prognoses may be mistaken, and they should take this into consideration when making their decision to die, whether actively or passively.

Beauchamp concludes that if the empirical question regarding the wedge argument is settled, and we find that basic principles against killing are not eroded by active euthanasia and that the problem of mistaken prognosis is outweighed by factors of pain and autonomy, then there is no good reason to accept the active/passive distinction. Additionally, those who maintain the distinction must show why a practice of passive euthanasia would not start eroding respect for life if they maintain that active euthanasia would erode respect for life.

I doubt that the empirical question regarding the wedge argument can be settled in the near future; social scientists would need to study a society which allows only passive euthanasia and a society which allows both passive euthanasia

and active euthanasia. These societies would have to be very similar in other relevant respects in order for social scientists to determine if permitting active euthanasia led to a disregard for human life which resulted in acceptance of other types of killing. In the meantime, we have no reason to believe that this would happen. Helga Kuhse addresses several other arguments in favour of a moral distinction between active and passive euthanasia. Kuhse is responding to arguments set out by Alexander Morgan Capron.[20]

Capron argues that allowing doctors to act as killers poses a peril to the physician-patient relationship, in that patients would no longer trust their doctors. Kuhse argues against this that the physician-patient relationship might be enhanced if patients knew that they could count on their doctors for assistance when they wanted to die. Kuhse claims that the important point relating to euthanasia and the physician-patient relationship is not whether we have physician-assisted killing or physician-assisted letting die, but that patients know that doctors will respect and act on their patients' choices.

I think Kuhse's points are correct. In addition, I would argue that if Capron is correct in claiming that active euthanasia would erode the trust between doctors and their patients, then passive euthanasia poses a similar threat. It is Capron's responsibility to argue that passive euthanasia does not pose a similar threat.

Capron argues that permitting active euthanasia sends the double message that physicians should take lives and save lives. "In the long run, that is sure to

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[20] Alexander Morgan Capron, "The Right to Die: Progress and Peril," The Euthanasia Review, Vol.2, Spring/Summer 1987.

[21] "Physician-assisted killing" and "physician-assisted letting die" are terms used by Capron.

become: why bother, why struggle in difficult cases? Society is equally accepting when you, the physician decide to do the patient in!" (Capron, 1987, p.55). Capron maintains that this "double message" may prevent doctors from making extraordinary attempts to save lives. Kuhse counters that this point is also an argument against passive euthanasia. I would add that Capron's argument is irrelevant to voluntary euthanasia. Surely doctors who are assisting patients who want to die can distinguish them from patients who want to live.

Capron argues that, given the doctor's temptation to dispose of patients when faced with a case that has gone poorly, [22] more patients will be disposed of under a practice of active euthanasia than under a practice of passive euthanasia. Kuhse argues that even if this temptation does exist, since doctors are rational people, they would be more likely to let these patients die than to kill them. Killing patients is much more likely to lead to an investigation than would letting die.

Capron claims that active euthanasia is an abuse of nature in that it seems to assert our omniscience as to the time death should occur, while passive euthanasia admits to our limited powers. Kuhse argues that in both active and passive euthanasia we choose an earlier death rather than a longer life, hence, if active euthanasia is an abuse of nature, then so is passive euthanasia. Additionally, if we abuse nature by shortening life, we also abuse nature by prolonging life.[23] Kuhse questions Capron's view of nature, arguing that nature gives us autonomy, and since to choose the time of one's death is merely the exercise of our autonomy, it

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[22] Capron does not explain what he means here, but I assume he is talking about some mistake on the doctor's part, some sort of malpractice situation.

[23] This point and the one following are similar to Hume's arguments against the immorality of suicide, which I outline in Chapter 2.

is not an abuse of nature. Kuhse claims, correctly, that Capron recognizes the autonomy of the patient as the basis of the patient's right to refuse life-sustaining treatment.[24]

Capron raises the same kind of "wedge" argument as Tom Beauchamp (although Capron calls it a "slippery slope" argument). Since active euthanasia is justified because it relieves pain and suffering, then non-voluntary euthanasia is justified by the same principle, and we will begin performing euthanasia on those who cannot voice their wishes. Kuhse counters that passive euthanasia faces the same problem.

Capron's other concern in regard to the "slippery slope" is that if respect for voluntary choice is the rationale for euthanasia, then we should not limit euthanasia to the fatally ill. In order to be consistent we are forced to consider those who face long illnesses or those who are deeply saddened by the death of a spouse as candidates for euthanasia. Advocates of euthanasia will have to explain why terminal patients deserve a doctor's help in dying more than others who face a bleak future. Capron's underlying point here seems to be that permitting active euthanasia in these cases is unacceptable, but that consistency would demand it once active euthanasia is permitted in any situation. Kuhse argues that this is another problem that also faces passive euthanasia: supporters of passive euthanasia will have to deal with the question of whether only the fatally ill deserve physician-assisted letting die.

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[24] "Admittedly, we are most concerned about patient choice when it involves the avoidance of a painful or undignified dying process. But the right we proclaim rests on the bedrock of personal autonomy" (Capron, 1987, p.47).

I find both Capron's argument and Kuhse's response rather confusing. Capron seems to be asking why only the terminally ill should receive assistance with euthanasia, and the obvious answer is that in most cases they need it; they cannot die without assistance. He mentions two other categories of euthanasia candidates: depressed people and those who are incurably but not fatally ill. One could argue that these people do not need a physician's assistance in order to die: they are physically able to end their lives without assistance, and if they need assistance then they should probably be considered candidates for euthanasia. Kuhse's response seems incomplete. In arguing that deciding whether those who are not suffering from fatal illnesses are deserving of physician-assisted euthanasia is also a problem in letting die, Kuhse seems to ignore the fact that those with incurable, but not fatal, illnesses should also be allowed to choose active euthanasia. People with illnesses or conditions that will not kill them but are unlikely to improve and likely to bring great suffering should have the option of euthanasia for the same reasons as the fatally ill; they are suffering, their condition is unlikely to improve, and they want to die.

Also, I would argue that the person who is temporarily depressed should not be given assistance in dying. It is quite usual for people to be depressed for a year or two because someone close to them has died, as well as for many other reasons, and it is ridiculous to suggest that just because active euthanasia is morally permissible it should be available to people who are temporarily depressed. People who are depressed because of some traumatic event are likely to overcome their depression. As for those who suffer from incurable mental illnesses which cause them great suffering, these people pose no special problem

for voluntary active euthanasia. If their mental powers are such that they can express a desire for euthanasia or have expressed a desire in the past should they find themselves in this situation, then they are in the same position as any other candidate for euthanasia, whether it be active or passive.[25]

Capron claims that societal safeguards, such as hearings in order to determine the justification for killing and the competence of the individual, will be required if active euthanasia is permitted. These hearings and other safeguards will implicate society in the decision to kill these patients. Kuhse asks the question: If patient autonomy is a good thing, then why would it be bad for society to be involved in processes required to uphold patient autonomy.

I think Kuhse is right, in that if active euthanasia is not a bad thing, then societal involvement in the proceedings which ensure that active euthanasia is carried out in accordance with pre-determined regulations cannot be a bad thing. Safeguards should be set up for both active and passive euthanasia.

Capron is concerned that patients would be coerced to consent to active euthanasia. Because a greater number of people can be killed than let die, this is a more serious problem for active euthanasia. Capron argues that candidates for passive euthanasia can be protected against coerced consent by emphasizing the patient's right to decide. Kuhse agrees that active euthanasia offers greater scope for abuse because of the greater number of candidates for active euthanasia. She notes that any of us can be killed, but in order to be a candidate for passive

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[25] Of course, it is difficult to determine whether someone is competent to make the decision to die. Current legal standards of competence are inappropriate, particularly since they judge general competence rather than relevant competencies. I am indebted to Barbara Secker for pointing this out to me.

euthanasia, one must have a condition which is fatal if left untreated. But Kuhse maintains that candidates for active euthanasia can be protected the same way as candidates for passive euthanasia.[26] Additionally, Kuhse claims that a policy of no-active-euthanasia is too costly in terms of autonomy and patient welfare, because of the number of people who want active euthanasia and would be denied it.

Capron maintains that there is little need for active euthanasia because pain and other unpleasant symptoms can generally be relieved. Additionally, people have the option of suicide. Even though there may be a few people with uncontrollable pain who cannot commit suicide, these people should not have the option of active euthanasia because of all the arguments Capron has already cited. Kuhse maintains that Capron's arguments against active euthanasia are not convincing. She adds that even if there are only a few people who want this service, there is still a need for it. And if autonomy and patient welfare justify passive euthanasia, then active euthanasia is justified for the same reasons.

Kuhse suggests a thought experiment where we can choose either a world in which we can choose active euthanasia or a world in which passive euthanasia is our only euthanasia option. Assume that we do not know whether or our lives will be rich, happy and full or quite wretched. Assume that we know nothing about our deaths, whether they will be quick and painless or long and painful. Kuhse maintains that even if there is a small chance that consent will be coerced it makes more sense to choose a world in which one may choose active euthanasia.

[26] Kuhse does not explain how this should be carried out and neither does Capron. I discuss possible safeguards in my fourth chapter.

> Would it not be much more reasonable to opt for a world in which we could choose active voluntary euthanasia if we wanted or needed to, rather than a world in which we would be denied this choice -- even if there is a small change (sic) that we might be among those whose consent will not be totally free? As far as passive euthanasia is concerned, we have already answered this question in the affirmative, and I can see no practical or logical reason as to why we should give a different answer in the case of active voluntary euthanasia (Kuhse, 1987, p.74).

I agree with Kuhse that a policy forbidding active euthanasia would be too costly in terms of patient welfare and autonomy. However, emphasizing the patient's right to choose is unlikely to help disabled and elderly people who already get messages from society that they are a burden. A practice of active euthanasia may give them the added message that they should end their lives. Imagine the disabled person who sees others less disabled than herself requesting assistance in dying; she may feel pressure to justify her decision to continue living. The devaluing of elderly and disabled persons is a serious societal problem, but it is not one unique to euthanasia, nor should a practice of active euthanasia be condemned for this reason alone. Devaluing the elderly and the disabled is something that occurs in many different ways and must be addressed on several fronts.[27] Prohibiting active euthanasia would prevent some elderly and disabled persons from ending their lives for the wrong reasons, but it is less effective and more costly than positive measures that would emphasize their value.

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[27] Thanks to Susan Wendell, Sharyn Clough, and Ian Hollingshead for their contributions to this discussion.

In conclusion, many of the arguments against active euthanasia are also arguments against passive euthanasia and, hence, cannot be used to maintain a moral distinction between the two. Those who would condemn active euthanasia on grounds other than the killing/letting-die distinction have yet to prove that active euthanasia is morally worse than passive euthanasia. Since the killing/letting-die distinction is unsubstantiated, there is no good reason to assert a moral difference between active and passive euthanasia.

In my next chapter, I discuss safeguards for a practice of euthanasia to ensure that patients make good decisions and to ensure that those decisions are carried out.

Chapter 4 - Safeguards For A Practice of Euthanasia

In the previous chapter I touched on the possible abuses of a practice of active euthanasia. In this, my concluding chapter, I discuss safeguards to ensure that only those who really want to die have their lives ended by euthanasia -- be it active or passive -- and that candidates for both types of euthanasia have genuine freedom of choice in making their decision to die. This is not intended to be a comprehensive proposal for regulating euthanasia; rather it is a response to some of the objections raised in the previous chapter.

In the first part of this chapter I deal with patients who are currently expressing a desire to die. Later in the chapter I discuss safeguards for those who have, in the past, expressed a desire to die and are now unable to express such a desire because of incompetence, or an inability to communicate.

Freedom of Choice

North Americans tend to have a great deal of respect for doctors and, as a result, usually let doctors or other health care workers make their health care decisions for them. This has extended to decisions about euthanasia, so that the friends and family of patients often ask the doctor if s/he thinks the patient should be allowed to die. A better situation would be that the patient consults health care workers, friends, and family members and then makes her/his decision.

One role of the doctor and other health care workers is to provide the patient with sufficient information about her/his medical condition, including a prognosis, and treatment options. Patients have very real concerns about pain, mental deterioration, loss of physical control and mobility. Medical professionals

should explain, to the best of their ability, what the patient can expect to happen and how the patient might be able to cope. Health care workers should also provide the patient with information about care facilities, support groups and programmes, the cost of these facilities and programmes and any financial assistance that might be available to the patient.

If the patient decides to die, then the role of health care workers is to explain the means used in both passive and active euthanasia, and for each of these methods, how it works, the length of time it will take the patient to die, what the patient can expect to happen before s/he dies, and whether any one method would be particularly suited to the patient. Once the patient chooses the method, then the health care workers' role is to assist in bringing about death. Whether the health care worker who carries out the procedure is a doctor or a nurse will depend on the method chosen. For example, nurses typically remove intravenous tubes, and both doctors and nurses give injections. If the patient's physician has a strong moral or religious objection to euthanasia, then s/he has an obligation to transfer the patient to a physician who will advise and help them concerning euthanasia. If another health care worker has a strong moral or religious objection to bringing about a patient's death, then s/he should be excused from assisting.[1]

[1] This may be a problem for patients, especially in rural areas where there are often too few doctors and in areas where pro-life groups are very active. An analagous situation concerns the controversy over abortion. Currently, women in some parts of Canada have trouble finding doctors who will perform abortions, even though this procedure is legal and paid for by medicare. In some communities, anti-abortion activists have employed pressure tactics such as picketing the offices and homes of doctors who are known to perform abortions. As a result, some doctors refuse to perform abortions even though they have no moral or religious objections to abortion. Patients requesting euthanasia may have difficulty obtaining aid in dying for the same reasons that women have had difficulty getting abortions.

In addition to information about medical care, euthanasia candidates may need assistance from a counsellor in order to make their decision about dying. The counsellor's role would be to facilitate the patient's decision by helping her/him assess the information about his/her medical condition, care and resources available. While the patient may be convinced that s/he wants to die, discussing that decision with a trained counsellor may either cause the patient to change her/his mind or feel more confident about the decision. In addition to facilitating the patient's decision, and thereby increasing the patient's freedom of choice, the involvement of a trained counsellor provides another safeguard, in that the counsellor should be able to assess whether the patient has been fully informed and whether the patient really does want to die. If the counsellor discovers that the patient is being coerced by someone, the counsellor may be able to mitigate the coercion.

In addition to being coerced by friends, family, and health care workers, patients may feel pressured to end their lives because of the high cost of continuing care, or because palliative care is not available in their community. In Canada, universal health care programmes pay for most health care costs incurred by patients in hospitals and long-term care facilities. In addition to this, governments need to provide more assistance to those requiring home care and hospice care. I would argue that terminal patients who do not have access to affordable, comprehensive health care have great difficulty making a good decision about euthanasia. For some, a decision to continue living poses an unbearable financial burden to themselves and their families.

Elderly people and disabled people may feel pressure to opt for euthanasia on the grounds that they are "a burden to society". Perhaps one way of overcoming this self-perception is to integrate these segments of the population more fully into mainstream society through work programmes, social programmes, and by making all public places physically accessible to people with disabilities. Integration might lead to greater respect and appreciation of elderly people and disabled people, both from themselves and from the rest of society.

Safeguards

In the last chapter I mentioned the fact that all of us are candidates for active euthanasia, in that all of us can be killed. As a result, a practice of active euthanasia poses a more serious problem than a practice of passive euthanasia in terms of the number of people who might be coerced by others or might make a hasty decision.

Since one of the main reasons for advocating a practice of euthanasia is respect for the autonomy of the patient, I hesitate to recommend a process that questions the patient's decision to die. However, it is necessary to establish that the patient really does want to die. Possible problems are that someone else wants the patient to die and is trying to convince the patient and his/her physician that this should be carried out at once; the patient has faulty assumptions about future care and quality of life; the patient thinks s/he is doing a favour to others (i.e., friends, family, health care workers) by dying.

One way of preventing a wrongful death once a patient has expressed a desire to die is to have the patient meet with a trained counsellor who determines whether the patient really does want to die. This might be the same counsellor

mentioned above who could facilitate the patient's decision. Note that the counsellor's job is not to determine whether the patient has made the "right" decision, but to determine whether the patient has been coerced, and whether the patient has been provided with sufficient information to make the decision. If the counsellor determines that the patient has been coerced, s/he should point that out to the patient as well as take steps to mitigate the coercion, e.g. discussing it with the patient, confronting the coercer, and informing other people, such as the physician. The counsellor can also provide additional information about care or ensure that the information is provided to the patient. If the counsellor is not convinced that the patient wants to die, then the patient could be given the option of a second meeting with the same counsellor or meeting with another counsellor. It is important that the counsellor be impartial in that s/he has nothing to gain from the patient's decision.

The possibility of the patient making a hasty decision is a thornier issue. An example of the sort of concern one might have in this regard is the patient making a request for euthanasia very soon after being diagnosed with a terminal illness, or a painful or disabling, incurable condition. The patient may have sufficient information and may be quite competent to make the decision, but is making it before s/he has an opportunity to digest the information and, possibly, to adapt to the situation. Balanced with the need to have patients make good decisions about euthanasia is the need to respect the autonomy of the patient and to be beneficent. It would be highly problematic to deny a competent person's request to die on the grounds that s/he has not yet made a serious attempt to live with the condition, since this would force the patient to live with pain and suffering, and that is

precisely what advocates of euthanasia think people should not have to do. One solution to this problem is to establish a brief waiting period between the time the patient receives her/his diagnosis and the request for euthanasia, and another brief waiting period between the time the request is finalized and the act of euthanasia is carried out. The sort of time-line I envision is that four weeks after diagnosis, assuming that the patient has expressed the desire to die and has received all of the information about his/her condition and treatment possibilities as outlined in the first section of this chapter, the patient meets with a counsellor so that the counsellor can determine that the patient does want to die.[2] The act of euthanasia can be carried out a minimum of two weeks after this meeting as long as the counsellor is satisfied that the patient wants to die. Of course, the patient has the option of changing her/his mind up to this point. A longer time-line may ensure a better decision, but it would also ensure more suffering for the patient.

Past Requests

Some patients are unable to express a request to die because of mental incompetence or physical inability to communicate. If these people have made a request in the past to die should current conditions obtain, then these requests should be honoured. Many people now have a Living Will, a document which lists the conditions under which the person would choose to die. The Living Will may

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[2] Four weeks may be too soon after diagnosis for some patients to make a good decision. Susan Wendell points out that someone newly diagnosed as incurably quadraplegic needs time to recover from depression before s/he can begin to accept the limitations of a new life. This takes longer than four weeks. There may be other conditions/illnesses where psychologists know from past experience that patients are likely to need a particular length of time to deal with the diagnosis and are likely to change their minds about wanting to die. If psychologists know what the average time period is for patients to recover from the depression, then it would be reasonable to refrain from euthanasia during this time period.

also stipulate whether death should be brought about through active or passive means. When the patient has a Living Will and is now in a situation where s/he cannot express a request to die, and the conditions listed in the Living Will seem to obtain, then a quasi-judicial hearing should be held to determine the authenticity of the Living Will and whether the conditions stipulated indeed obtain. The main purposes of this hearing are to protect health care workers who bring about the patient's death and to ensure that the patient's conditions outlined in the Living Will have been met.

People who have Living Wills need to make their physicians and families aware of them so that their requests will be honoured. It is quite possible that someone may have a Living Will that is never acted on because no one other than the patient knows about it. In some states, Living Wills need to be renewed every five years. This is a reasonable precaution to ensure that the person has not changed her/his mind.

Unfortunately, lots of people do not have a Living Will even though they are quite sure that they would not want to go on living under certain conditions and have told friends and relatives about their concerns.[3] In this sort of situation, a hearing is required in order to assess the patient's desires by interviewing people who are in a good position to know what the patient wanted. These people would probably be friends, relatives, and the patient's physician.[4]

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[3] This scenario might seem unlikely to those who tend to be well organized, but many of us never get around to drawing up a Living Will or even an ordinary will, even though we have pretty clear ideas about what should happen to us and our belongings.

[4] Note that this discussion concerns people who have, in the past, expressed a desire to die should particular circumstances obtain. We may assume that given person X's disposition, values, and lifestyle, X would not want to live now that she has been extremely disabled. But, if X has never talked to anyone about wanting to die if she should end up this way, X is not a candidate for voluntary euthanasia. Voluntary euthanasia requires that the patient makes a request to die, or has expressed such a

In this chapter, I have touched on safeguards to ensure that a practice of euthanasia does not result in the death of people who do not want to die, to ensure that those who want to die have sufficient information to make that decision, and to ensure that those who want to die have their wishes carried out. These safeguards are designed to prevent possible abuses which have already been identified. Other safeguards will likely be required as other potential abuses are revealed by practical experience.

Conclusions

I have identified the killing/letting die distinction as the main reason for the moral distinction between active and passive euthanasia. In Chapter 2, I argued that there is no morally significant distinction between killing and letting die, hence, this cannot provide the basis for a moral distinction between active euthanasia and passive euthanasia. In Chapter 3, I considered other moral factors which might account for accepting a practice of passive euthanasia while rejecting active euthanasia, and concluded that these factors do not support a position of asymmetry and, in fact, lead to the conclusion that if passive euthanasia is morally acceptable, then active euthanasia is also acceptable. In Chapter 4, I have discussed some safeguards to ensure that any practice of euthanasia is as beneficial as possible and that abuses are minimized.

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desire in the past.

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