CHAPTER 43

Active and Passive Euthanasia

James Rachels

The American Medical Association takes the position that while at a patient's request a physician may withhold extraordinary means of prolonging the patient's life, a physician may not take steps, even if requested by the patient, to terminate that life intentionally. James Rachels, whose work we read previously, argues that killing is not in itself any worse than letting die, and therefore no moral difference between active and passive euthanasia is defensible.

The distinction between active and passive euthanasia is thought to be crucial for medical ethics. The idea is that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient. This doctrine seems to be accepted by most doctors, and it is endorsed in a statement adopted by the House of Delegates of the American Medical Association on 4 December 1973:

> 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 judgement of the physician should be freely available to the patient and/or his immediate family.

From James Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine* 292 (1975).

However, a strong case can be made against this doctrine. In what follows I will set out some of the relevant arguments, and urge doctors to reconsider their views on this matter.

To begin with a familiar type of situation, a patient who is dying of incurable cancer of the throat is in terrible pain, which can no longer be satisfactorily alleviated. He is certain to die within a few days, even if present treatment is continued, but he does not want to go on living for those days since the pain is unbearable. So he asks the doctor for an end to it, and his family joins in the request.

Suppose the doctor agrees to withhold treatment, as the conventional doctrine says he may. The justification for his doing so is that the patient is in terrible agony, and since he is going to die anyway, it would be wrong to prolong his suffering needlessly. But now notice this. If one simply withholds treatment, it may take the patient longer to die, and so he may suffer more than he would if more direct action were taken and a lethal injection given. This fact provides strong reason for thinking that, once the initial decision not to prolong his agony has been made, active euthanasia is actually preferable to passive euthanasia, rather than the reverse. To say otherwise is to endorse the opinion that leads to more suffering rather than less, and is contrary to the humanitarian impulse that prompts the decision not to prolong his life in the first place.

Part of my point is that the process of being "allowed to die" can be relatively slow and painful, whereas being given a lethal injection is relatively quick and painless. Let me give a different sort of example. In the United States about one in 600 babies is born with Down's syndrome. Most of these babies are otherwise healthy—that is, with only the usual pediatric care, they will proceed to an otherwise normal infancy. Some, however, are born with congenital defects such as intestinal obstructions that require operations if they are to live. Sometimes, the parents and the doctor will decide not to operate, and let the infant die. Anthony Shaw describes what happens then:

> When surgery is denied [the doctor] must try to keep the infant from suffering while natural forces sap the baby's life away. As a surgeon whose natural inclination is to use the scalpel to fight off death, standing by and watching a salvageable baby die is the most emotionally exhausting experience I know. It is easy at a conference, in a theoretical discussion to decide that such infants should be allowed to die. It is altogether different to stand by in the nursery and watch as dehydration and infection wither a tiny being over hours and days. This is a terrible ordeal for me and the hospital staff—much more so than for the parents who never set foot in the nursery.[1]

I can understand why some people are opposed to all euthanasia, and insist that such infants must be allowed to live. I think I can also understand why other people favour destroying these babies quickly and painlessly. But why should anyone favour letting "dehydration and infection wither a tiny being over hours and days"? The doctrine that says a baby may be allowed to dehydrate and wither, but may not be given an injection that would end its life without suffering, seems so patently cruel as to require no further refutation. The strong language is not intended to offend, but only to put the point in the clearest possible way.

My second argument is that the conventional doctrine leads to decisions concerning life and death made on irrelevant grounds.

Consider again the case of the infants with Down's syndrome who need operations for congenital defects unrelated to the syndrome to live. Sometimes, there is no operation, and the baby dies, but when there is no such defect, the baby lives on. Now, an operation such as that to remove an intestinal obstruction is not prohibitively difficult. The reason why such operations are not performed in these cases is, clearly, that the child has Down's syndrome and the parents and the doctor judge that because of that fact it is better for the child to die.

But notice that this situation is absurd, no matter what view one takes of the lives and potentials of such babies. If the life of such an infant is worth preserving, what does it matter if it needs a simple operation? Or, if one thinks it better that such a baby should not live on, what difference does it make that it happens to have an unobstructed intestinal tract? In either case, the matter of life and death is being decided on irrelevant grounds. It is the Down's syndrome, and not the intestines, that is the issue. The matter should be decided, if at all, on that basis, and not be allowed to depend on the essentially irrelevant question of whether the intestinal tract is blocked.

What makes this situation possible, of course, is the idea that when there is an intestinal blockage, one can "let the baby die," but when there is no such defect there is nothing that can be done, for one must not "kill" it. The fact that this idea leads to such results as deciding life or death on irrelevant grounds is another good reason why the doctrine would be rejected.

One reason why so many people think that there is an important moral difference between active and passive euthanasia is that they think killing someone is morally worse than letting someone die. But is it? Is killing, in itself, worse than letting die? To investigate this issue, two cases may be considered that are exactly alike except that one involves killing whereas the other involves letting someone die. Then, it

can be asked whether this difference makes any difference to the moral assessments. It is important that the cases be exactly alike, except for this one difference, since otherwise one cannot be confident that it is this difference and not some other that accounts for any variation in the assessments of the two cases. So, let us consider this pair of cases:

In the first, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident.

In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip and hit his head, and fall facedown in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing.

Now Smith killed the child, whereas Jones "merely" let the child die. That is the only difference between them. Did either man behave better, from a moral point of view? If the difference between killing and letting die were in itself a morally important matter, one should say that Jones's behaviour was less reprehensible than Smith's. But does one really want to say that? I think not. In the first place, both men acted from the same motive, personal gain, and both had exactly the same end in view when they acted. It may be inferred from Smith's conduct that he is a bad man, although that judgement may be withdrawn or modified if certain further facts are learned about him—for example, that he is mentally deranged. But would not the very same thing be inferred about Jones from his conduct? And would not the same further considerations also be relevant to any modification of this judgement? Moreover, suppose Jones pleaded, in his own defence, "After all, I didn't do anything except just stand there and watch the child drown. I didn't kill him; I only let him die." Again, if letting die were in itself less bad than killing, this defence should have at least some weight. But it does not. Such a "defence" can only be regarded as a grotesque perversion of moral reasoning. Morally speaking, it is no defence at all.

Now, it may be pointed out, quite properly, that the cases of euthanasia with which doctors are concerned are not like this at all. They do not involve personal gain or the destruction of normal, healthy children. Doctors are concerned only with cases in which the patient's life is of no further use to him, or in which the patient's life has become or will soon become a terrible burden. However, the point is the same in these cases: the bare difference between killing and letting die does not, in itself, make a moral difference. If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. If his decision was wrong—if, for example, the patient's illness was in fact curable—the decision would be equally regrettable no matter which method was used to carry it out. And if the doctor's decision was the right one, the method used is not in itself important.

The AMA policy statement isolates the crucial issue very well; the crucial issue is "the intentional termination of the life of one human being by another." But after identifying this issue, and forbidding "mercy killing," the statement goes on to deny that the cessation of treatment is the intentional termination of a life. This is where the mistake comes in, for what is the cessation of treatment, in these circumstances, if it is not "the intentional termination of the life of one human being by another"? Of course it is exactly that, and if it were not, there would be no point to it.

Many people will find this judgement hard to accept. One reason, I think, is that it is very easy to conflate the question of whether killing is, in itself, worse than letting die, with the very different question of whether most actual cases of killing are more reprehensible than most actual cases of letting die. Most actual cases of killing are clearly terrible (think, for example, of all the murders reported in the newspapers), and one hears of such cases every day. On the other hand, one hardly ever hears of a case of letting die, except for the actions of doctors who are motivated by humanitarian reasons. So one learns to think of killing in a much worse light than of letting die. But this does not mean that there is something about killing that makes it in itself worse than letting die, for it is not the bare difference between killing and letting die that makes the difference in these cases. Rather, the other factors—the murderer's motive of personal gain, for example, contrasted with the doctor's humanitarian motivation—account for different reactions to the different cases.

I have argued that killing is not in itself any worse than letting die; if my contention is right, it follows that active euthanasia is not any worse than passive euthanasia. What arguments can be given on the other side? The most common, I believe, is the following:

> The important difference between active and passive euthanasia is that, in passive euthanasia, the doctor does not do anything to bring about the patient's death. The doctor does nothing, and the patient

dies of whatever ills already afflict him. In active euthanasia, however, the doctor does something to bring about the patient's death: he kills him. The doctor who gives the patient with cancer a lethal injection has himself caused his patient's death; whereas if he merely ceases treatment, the cancer is the cause of the death.

A number of points need to be made here. The first is that it is not exactly correct to say that in passive euthanasia the doctor does nothing, for he does do one thing that is very important: he lets the patient die. "Letting someone die" is certainly different, in some respects, from other types of action—mainly in that it is a kind of action that one may perform by way of not performing certain other actions. For example, one may let a patient die by way of not giving medication, just as one may insult someone by way of not shaking his hand. But for any purpose of moral assessment, it is a type of action nonetheless. The decision to let a patient die is subject to moral appraisal in the same way that a decision to kill him would be subject to moral appraisal: it may be assessed as wise or unwise, compassionate or sadistic, right or wrong. If a doctor deliberately let a patient die who was suffering from a routinely curable illness, the doctor would certainly be to blame for what he had done, just as he would be to blame if he had needlessly killed the patient. Charges against him would then be appropriate. If so, it would be no defence at all for him to insist that he didn't "do anything." He would have done something very serious indeed, for he let his patient die.

Fixing the cause of death may be very important from a legal point of view, for it may determine whether criminal charges are brought against the doctor. But I do not think that this notion can be used to show a moral difference between active and passive euthanasia. The reason why it is considered bad to be the cause of someone's death is that death is regarded as a great evil—and so it is. However, if it has been decided that euthanasia—even passive euthanasia—is desirable in a given case, it has also been decided that in this instance death is no greater an evil than the patient's continued existence. And if this is true, the usual reason for not wanting to be the cause of someone's death simply does not apply.

Finally, doctors may think that all of this is only of academic interest—the sort of thing that philosophers may worry about but that has no practical bearing on their own work. After all, doctors must be concerned about the legal consequences of what they do, and active euthanasia is clearly forbidden by the law. But even so, doctors should also be concerned with the fact that the law is forcing upon them a moral doctrine that may be indefensible, and has a considerable effect on their practices. Of course, most doctors are not now in the position of being

coerced in this matter, for they do not regard themselves as merely going along with what the law requires. Rather, in statements such as the AMA policy statement that I have quoted, they are endorsing this doctrine as a central point of medical ethics. In that statement, active euthanasia is condemned not merely as illegal but as "contrary to that for which the medical profession stands," whereas passive euthanasia is approved. However, the preceding considerations suggest that there is really no moral difference between the two, considered in themselves (there may be important moral differences in some cases in their *consequences*, but, as I pointed out, these differences may make active euthanasia, and not passive euthanasia, the morally preferable option). So, whereas doctors may have to discriminate between active and passive euthanasia to satisfy the law, they should not do any more than that. In particular, they should not give the distinction any added authority and weight by writing it into official statements of medical ethics.

Note

1. Anthony Shaw, "Doctor, Do We Have a Choice?" *New York Times Magazine*, 30 January 1972, p. 54.

Study Questions

1. According to Rachels, in passive euthanasia does the physician do anything?
2. According to Rachels, under what circumstances is active euthanasia morally preferable to passive euthanasia?
3. Is someone who allows another person to drown morally guilty of killing the person?
4. Should the punishment be the same whether you drown someone or allow someone to drown?

CHAPTER 44

The Intentional Termination of Life

Bonnie Steinbock

Bonnie Steinbock, whose work we read previously, wrote the following essay responding to the previous article by James Rachels. Who has the better of the argument? That question is for each reader to answer.

According to James Rachels, . . . a common mistake in medical ethics is the belief that there is a moral difference between active and passive euthanasia. This is a mistake, [he argues], because the rationale underlying the distinction between active and passive euthanasia is the idea that there is a significant moral difference between intentionally killing and intentionally letting die. . . .

Whether . . . there is a significant moral difference . . . is not my concern here. For it is far from clear that this distinction *is* the basis of the doctrine of the American Medical Association which Rachels attacks. And if the killing/letting die distinction is not the basis of the AMA doctrine, then arguments showing that the distinction has no moral force do not, in themselves, reveal in the doctrine's adherents either "confused thinking" or "a moral point of view unrelated to the interests of individuals." Indeed, as we examine the AMA doctrine, I think it will become clear that it appeals to and makes use of a number of overlapping distinctions, which may have moral significance in particular cases, such as the distinction between intending and foreseeing, or between ordinary and extraordinary care. Let us then turn to the 1973 statement,

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from the House of Delegates of the American Medical Association, which Rachels cites:

> 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 attacks this statement because he believes that it contains a moral distinction between active and passive euthanasia. . . .

[He takes] the AMA position to prohibit active euthanasia, while allowing, under certain conditions, passive euthanasia.

I intend to show that the AMA statement does not imply support of the active/passive euthanasia distinction. In forbidding the intentional termination of life, the statement rejects both active and passive euthanasia. It does allow for "the cessation of the employment of extraordinary means" to prolong life. The mistake Rachels . . . make[s] is in identifying the cessation of life-prolonging treatment with passive euthanasia, or intentionally letting die. If it were right to equate the two, then the AMA statement would be self-contradictory, for it would begin by condemning, and end by allowing, the intentional termination of life. But if the cessation of life-prolonging treatment is not always or necessarily passive euthanasia, then there is no confusion and no contradiction.

Why does Rachels think that the cessation of life-prolonging treatment is the intentional termination of life? He says:

> The AMA policy statement isolates the crucial issue very well: the crucial issue is "the intentional termination of the life of one human being by another." But after identifying this issue, and forbidding "mercy killing," the statement goes on to deny that the cessation of treatment is the intentional termination of a life. This is where the mistake comes in, for what is the cessation of treatment, in these circumstances, if it is not "the intentional termination of the life of one human being by another"? Of course it is exactly that, and if it were not, there would be no point to it.

However, there *can* be a point (to the cessation of life-prolonging treatment) other than an endeavor to bring about the patient's death, and so the blanket identification of cessation of treatment with the

intentional termination of a life is inaccurate. There are at least two situations in which the termination of life-prolonging treatment cannot be identified with the intentional termination of the life of one human being by another.

The first situation concerns the patient's right to refuse treatment. . . . Rachels give[s] the example of a patient dying of an incurable disease, accompanied by unrelievable pain, who wants to end the treatment which cannot cure him but can only prolong his miserable existence. Why, they ask, may a doctor accede to the patient's request to stop treatment, but not provide a patient in a similar situation with a lethal dose? The answer lies in the patient's right to refuse treatment. In general, a competent adult has the right to refuse treatment, even where such treatment is necessary to prolong life. Indeed, the right to refuse treatment has been upheld even when the patient's reason for refusing treatment is generally agreed to be inadequate.[1] This right can be overridden (if, for example, the patient has dependent children) but, in general, no one may legally compel you to undergo treatment to which you have not consented. "Historically, surgical intrusion has always been considered a technical battery upon the person and one to be excused or justified by consent of the patient or justified by necessity created by the circumstances of the moment. . . ."[2]

At this point, an objection might be raised that if one has the right to refuse life-prolonging treatment, then consistency demands that one have the right to decide to end his or her life, and to obtain help in doing so. The idea is that the right to refuse treatment somehow implies a right to voluntary euthanasia, and we need to see why someone might think this. The right to refuse treatment has been considered by legal writers as an example of the right to privacy or, better, the right to bodily self-determination. You have the right to decide what happens to your own body, and the right to refuse treatment is an instance of that right. But if you have the right to determine what happens to your own body, then should you not have the right to choose to end your life, and even a right to get help in doing so?

However, it is important to see that the right to refuse treatment is not the same as, nor does it entail, a right to voluntary euthanasia, even if both can be derived from the right to bodily self-determination. The right to refuse treatment is not itself a "right to die"; that one may choose to exercise this right even at the risk of death, or even *in order to die*, is irrelevant. The purpose of the right to refuse medical treatment is not to give persons a right to decide whether to live or die, but to protect them from the unwanted interferences of others. Perhaps we ought to interpret the right to bodily self-determination more broadly, so as to include a right to die; but this would be a substantial extension of our present understanding of the right to bodily self-determination, and not a consequence of it. If we were to recognize a right to voluntary euthanasia, we would have to agree that people have the right not merely to be left alone but also the right to be killed. I leave to one side that substantive moral issue. My claim is simply that there can be a reason for terminating life-prolonging treatment other than "to bring about the patient's death."

The second case in which termination of treatment cannot be identified with intentional termination of life is where continued treatment has little chance of improving the patient's condition and brings greater discomfort than relief.

The question here is what treatment is appropriate to the particular case. A cancer specialist describes it in this way:

> My general rule is to administer therapy as long as a patient responds well and has the potential for a reasonably good quality of life. But when all feasible therapies have been administered and a patient shows signs of rapid deterioration, the continuation of therapy can cause more discomfort than the cancer. From that time I recommend surgery, radiotherapy, or chemotherapy only as a means of relieving pain. But if a patient's condition should once again stabilize after the withdrawal of active therapy and if it should appear that he could still gain some good time, I would immediately reinstitute active therapy. The decision to cease anticancer treatment is never irrevocable, and often the desire to live will push a patient to try for another remission, or even a few more days of life.[3]

The decision here to cease anticancer treatment cannot be construed as a decision that the patient die, or as the intentional termination of life. It is a decision to provide the most appropriate treatment for that patient at that time. Rachels suggests that the point of the cessation of treatment is the intentional termination of life. But here the point of discontinuing treatment is not to bring about the patient's death but to avoid treatment that will cause more discomfort than the cancer and has little hope of benefiting the patient. Treatment that meets this description is often called "extraordinary."[4] 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.

Contrasted with extraordinary treatment is ordinary treatment, the care a doctor would normally be expected to provide. Failure to provide ordinary care constitutes neglect, and can even be construed as the intentional infliction of harm, where there is a legal obligation to provide care. The importance of the ordinary/extraordinary care distinction lies partly in its connection to the doctor's intention. The withholding of extraordinary care should be seen as a decision not to inflict painful treatment on a patient without reasonable hope of success. The withholding of ordinary care, by contrast, must be seen as neglect. Thus, one doctor says, "We have to draw a distinction between ordinary and extraordinary means. We never withdraw what's needed to make a baby comfortable, we would never withdraw the care a parent would provide. We never kill a baby. . . . But we may decide certain heroic intervention is not worthwhile."[5]

We should keep in mind the ordinary/extraordinary care distinction when considering an example given by . . . Rachels to show the irrationality of the active/passive distinction with regard to infanticide. The example is this: a child is born with [Down] syndrome and also has an intestinal obstruction that requires corrective surgery. If the surgery is not performed, the infant will starve to death, since it cannot take food orally. This may take days or even weeks, as dehydration and infection set in. Commenting on this situation in his article in this book, Rachels says:

> I can understand why some people are opposed to all euthanasia, and insist that such infants must be allowed to live. I think I can also understand why other people favor destroying these babies quickly and painlessly. But why should anyone favor letting "dehydration and infection wither a tiny being over hours and days"? The doctrine that says that a baby may be allowed to dehydrate and wither, but may not be given an injection that would end its life without suffering, seems so patently cruel as to require no further refutation.

Such a doctrine perhaps does not need further refutation; but this is not the AMA doctrine. The AMA statement criticized by Rachels allows only for the cessation of extraordinary means to prolong life when death is imminent. Neither of these conditions is satisfied in this example. Death is not imminent in this situation, any more than it would be if a normal child had an attack of appendicitis. Neither the corrective surgery to remove the intestinal obstruction nor the intravenous feeding required to keep the infant alive until such

surgery is performed can be regarded as extraordinary means, for neither is particularly expensive, nor does either place an overwhelming burden on the patient or others. (The continued existence of the child might be thought to place an overwhelming burden on its parents, but that has nothing to do with the characterization of the means to prolong its life as extraordinary. If it had, then *feeding* a severely defective child who required a great deal of care could be regarded as extraordinary.) The chances of success if the operation is undertaken are quite good, though there is always a risk in operating on infants. Though the [Down] syndrome will not be alleviated, the child will proceed to an otherwise normal infancy.

It cannot be argued that the treatment is withheld for the infant's sake, unless one is prepared to argue that all mentally retarded babies are better off dead. This is particularly implausible in the case of [Down] syndrome babies, who generally do not suffer and are capable of giving and receiving love, of learning and playing, to varying degrees.

In a film on this subject entitled, "Who Should Survive?" a doctor defended a decision not to operate, saying that since the parents did not consent to the operation, the doctor's hands were tied. As we have seen, surgical intrusion requires consent, and in the case of infants, consent would normally come from the parents. But, as legal guardians, parents are required to provide medical care for their children, and failure to do so can constitute criminal neglect or even homicide. In general, courts have been understandably reluctant to recognize a parental right to terminate life-prolonging treatment.[6] Although prosecution is unlikely, physicians who comply with invalid instructions from the parents and permit the infant's death could be liable for aiding and abetting, failure to report child neglect, or even homicide. So it is not true that, in this situation, doctors are legally bound to do as the parents wish.

To sum up, I think that Rachels is right to regard the decision not to operate in the [Down] syndrome example as the intentional termination of life. But there is no reason to believe that either the law or the AMA would regard it otherwise. Certainly the decision to withhold treatment is not justified by the AMA statement. That such infants have been allowed to die cannot be denied; but this, I think, is the result of doctors misunderstanding the law and the AMA position.

Withholding treatment in this case is the intentional termination of life because the infant is deliberately allowed to die; that is the

point of not operating. But there are other cases in which that is not the point. If the point is to avoid inflicting painful treatment on a patient with little or no reasonable hope of success, this is not the intentional termination of life. The permissibility of such withholding of treatment, then, would have no implications for the permissibility of euthanasia, active or passive.

The decision whether or not to operate, or to institute vigorous treatment, is particularly agonizing in the case of children born with spina bifida, an opening in the base of the spine usually accompanied by hydrocephalus and mental retardation. If left unoperated, these children usually die of meningitis or kidney failure within the first few years of life. Even if they survive, all affected children face a lifetime of illness, operations, and varying degrees of disability. The policy used to be to save as many as possible, but the trend now is toward selective treatment, based on the physician's estimate of the chances of success. If operating is not likely to improve significantly the child's condition, parents and doctors may agree not to operate. This is not the intentional termination of life, for again the purpose is not the termination of the child's life but the avoidance of painful and pointless treatment. Thus, the fact that withholding treatment is justified does not imply that killing the child would be equally justified.

Throughout the discussion, I have claimed that intentionally ceasing life-prolonging treatment is not the intentional termination of life unless the doctor has, as his or her purpose in stopping treatment, the patient's death.

It may be objected that I have incorrectly characterized the conditions for the intentional termination of life. Perhaps it is enough that the doctor intentionally ceases treatment, foreseeing that the patient will die.

In many cases, if one acts intentionally, foreseeing that a particular result will occur, one can be said to have brought about that result intentionally. Indeed, this is the general legal rule. Why, then, am I not willing to call the cessation of life-prolonging treatment, in compliance with the patient's right to refuse treatment, the intentional termination of life? It is not because such an *identification* is necessarily opprobrious; for we could go on to *discuss* whether such cessation of treatment is a *justifiable* intentional termination of life. Even in the law, some cases of homicide are justifiable; e.g., homicide in self-defense.

However, the cessation of life-prolonging treatment, in the cases which I have discussed, is not regarded in law as being justifiable homicide, because it is not homicide at all. Why is this? Is it because the doctor "doesn't do anything," and so cannot be guilty of homicide? Surely not, since, as I have indicated, the law sometimes treats an omission as the cause of death. A better explanation, I think, has to do with the fact that in the context of the patient's right to refuse treatment, a doctor is not at liberty to continue treatment. It seems a necessary ingredient of intentionally letting die that one could have done something to prevent the death. In this situation, of course the doctor can physically prevent the patient's death, but since we do not regard the doctor as *free* to continue treatment, we say that there is "nothing he can do." Therefore he does not intentionally let the patient die.

To discuss this suggestion fully, I would need to present a full-scale theory of intentional action. However, at least I have shown, through the discussion of the above examples, that such a theory will be very complex, and that one of the complexities concerns the agent's reason for acting. The reason why an agent acted (or failed to act) may affect the characterization of what he did intentionally. The mere fact that he did *something* intentionally, foreseeing a certain result, does not necessarily mean that he brought about that *result* intentionally.

In order to show that the cessation of life-prolonging treatment, in the cases I've discussed, is the intentional termination of life, one would either have to show that treatment was stopped in order to bring about the patient's death, or provide a theory of intentional action according to which the reason for ceasing treatment is irrelevant to its characterization as the intentional termination of life. I find this suggestion implausible, but am willing to consider arguments for it. Rachels has provided no such arguments: indeed, he apparently shares my view about the intentional termination of life. For when he claims that the cessation of life-prolonging treatment is the intentional termination of life, his reason for making the claim is that "if it were not, there would be no point to it." Rachels believes that the point of ceasing treatment, "in these cases," is to bring about the patient's death. If that were not the point, he suggests, why would the doctor cease treatment? I have shown, however, that there can be a point to ceasing treatment which is not the death of the patient. In showing this, I have refuted Rachels' reason for identifying the cessation of life-prolonging treatment with the intentional termination of life, and thus his argument against the AMA doctrine.

Here someone might say: Even if the withholding of treatment is not the intentional termination of life, does that make a difference,

morally speaking? If life-prolonging treatment may be withheld, for the sake of the child, may not an easy death be provided, for the sake of the child, as well? The unoperated child with spina bifida may take months or even years to die. Distressed by the spectacle of children "lying around, waiting to die," one doctor has written, "It is time that society and medicine stopped perpetuating the fiction that withholding treatment is ethically different from terminating a life. It is time that society began to discuss mechanisms by which we can alleviate the pain and suffering for those individuals whom we cannot help."[7]

I do not deny that there may be cases in which death is in the best interests of the patient. In such cases, a quick and painless death may be the best thing. However, I do not think that, once active or vigorous treatment is stopped, a quick death is always preferable to a lingering one. We must be cautious about attributing to defective children *our* distress at seeing them linger. Waiting for them to die may be tough on parents, doctors, and nurses—it isn't necessarily tough on the child. The decision not to operate need not mean a decision to neglect, and it may be possible to make the remaining months of the child's life comfortable, pleasant, and filled with love. If this alternative is possible, surely it is more decent and humane than killing the child. In such a situation, withholding treatment, foreseeing the child's death, is not ethically equivalent to killing the child, and we cannot move from the permissibility of the former to that of the latter. I am worried that there will be a tendency to do precisely that if active euthanasia is regarded as morally equivalent to the withholding of life-prolonging treatment.

Conclusion

The AMA statement does not make the distinction Rachels . . . wish[es] to attack, that between active and passive euthanasia. Instead, the statement draws a distinction between the intentional termination of life, on the one hand, and the cessation of the employment of extraordinary means to prolong life, on the other. Nothing said by Rachels . . . shows that this distinction is confused. It may be that doctors have misinterpreted the AMA statement, and that this has led, for example, to decisions to allow defective infants to starve slowly to death. I quite agree with Rachels . . . that the decisions to which they allude were cruel and made on irrelevant grounds. Certainly it is worth pointing out that allowing someone to die *can* be the intentional termination of life, and that it can be just as bad as, or worse than, killing someone. However, the withholding of life-prolonging treatment is not necessarily the intentional termination of life, so that if it is permissible to withhold life-prolonging treatment it does not follow that, other things being equal, it is permissible to kill. Furthermore, most of the time, other things are not equal. In many of the cases in which it would be right to cease treatment, I do not think that it would also be right to kill.

Notes

1. For example, *In re Yetter,* 62 Pa. D & C. 2d 619 (C.P., Northampton County Ct. 1974).
2. David W. Meyers, "Legal Aspects of Voluntary Euthanasia," in *Dilemmas of Euthanasia,* ed. John Behnke and Sissela Bok (New York: Anchor Books, 1975), p. 56.
3. Ernest H. Rosenbaum, M.D., *Living With Cancer* (New York: Praeger, 1975), p. 27.
4. See Tristram Engelhardt, Jr.; "Ethical Issues in Aiding the Death of Young Children," in *Beneficent Euthanasia,* ed. Marvin Kohl (Buffalo, N.Y.: Prometheus Books, 1975). . . .
5. B. D. Colen, *Karen Ann Quinlan: Living and Dying in the Age of Eternal Life* (Los Angeles: Nash, 1976), p. 115.
6. See Norman L. Cantor, "Law and the Termination of an Incompetent Patient's Life-Preserving Care," in *Dilemmas of Euthanasia,* pp. 69–105.
7. John Freeman, "Is There a Right to Die—Quickly?," *Journal of Pediatrics,* 80, no. 5 (1972), 904–905.

Study Questions

1. Is killing someone always worse than letting the person die?
2. Is the physician's intention crucial to assessing the morality of the means used to bring about death?
3. Are we ever justified in performing actions with unfortunate consequences in an effort to achieve other purposes?
4. What should a physician do if a paralyzed patient on life support asks to be euthanized?