The Morality of Euthanasia[#]

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1. Introduction

Euthanasia – active as well as passive – remains a controversial issue in medical ethics. The overall purpose of this paper is to provide a better understanding of the most common views on active and passive euthanasia, by discussing their pros and cons. This should, hopefully, enable the reader to reflect more rationally about these issues. I myself hold that active euthanasia under a circumscribed set of circumstances is morally permissible, and that active euthanasia ought to be legalised. It is my considered view that careful reflection upon the arguments for and against active euthanasia points in that direction, and it is a secondary aim of the paper to explain this.

I shall not attempt to survey or comment on the vast range of literature produced by moral philosophers and medical ethicists on these issues.[1] Rather, my focus will be on the arguments and reasons for and against various forms of euthanasia that I have encountered in discussions with health care professionals and others over the years. This focus on the oral rather than the written tradition will, I hope, make the paper more interesting for those whom euthanasia is the

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[1] For the convenience of the reader I have supplied a select bibliography at the end of the paper.

most relevant to: terminal patients themselves, their relatives, as well as health care professionals.[2]

2. Key terms

A few words about how I shall use key terms will be necessary. The most widely accepted practice is that of *passive euthanasia*. To perform passive euthanasia is, roughly, to countenance the death of someone by withholding or withdrawing life-sustaining treatment, or by administering pain-killing drugs in doses that accelerate death.[3]

I have here merely provided an open-ended list of examples of passive euthanasia, and there might very well be other kinds of practices that one might also want to include. This should not concern us here, however. It will suffice that we have a rough idea of what passive euthanasia is, and we need not worry about marginal cases that are hard to classify.

Passive euthanasia is distinct from *assisted suicide*, which is helping someone to commit suicide, for example by making medicine in lethal doses available to him or her. Though assisted suicide is interesting in its own right, I will not discuss it here.

Passive euthanasia and assisted suicide are usually considered the least morally controversial practices. Passive euthanasia, nonetheless, receives much wider acceptance than assisted suicide, particularly doctor assisted suicide. Much more disputed than either of these is *active euthanasia*. In active euthanasia you directly cause the death of someone, for instance by administering a lethal dose of some drug.

Let me now add some remarks on these very rough definitions. First, I intend that my manner of defining key terms reflect common linguistic practice; they reflect, I believe, the ways in which many people talk about passive and active euthanasia. Second, despite what I just said, my proposed definitions are not universally shared. Thus, one should not expect that key terms in the controversy over

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[2] For obvious reasons, it is difficult to document what the oral tradition includes. All the views I discuss are also to be found in the literature, however.

[3] Note that one might find some of the practices categorised as passive euthanasia morally acceptable, while rejecting others.

euthanasia always mean what I assume them to mean here. Third, some of the practices classified as passive euthanasia seem to involve conspicuously active steps taken by physicians or other health care professionals. This might seem confusing and inadequate: why classify something as passive euthanasia, when it does not seem to be passive at all?

There is no real problem in this, however. The point of separating passive from active euthanasia is really just to keep apart a class of actions or practices that many people hold is *morally acceptable* (viz. passive euthanasia), from another class of actions that many people find *morally unacceptable* (viz. active euthanasia). For convenience, we give these two classes of actions names, and we might as well choose the names actually in use. It is a further question, to which I shall return, what morally important difference there is between passive euthanasia and active euthanasia.

3. Views on euthanasia

Let me now present three important views on passive and active euthanasia. One view is this:

> *The extreme view*
> Passive euthanasia and active euthanasia are *never* morally acceptable, and these practices should not be legal.

Not many people sincerely hold this view, although some might inadvertently voice their support for it. I shall later make clear why I nonetheless include it; it is theoretically important in the overall argument for the view I shall defend below. Though far from universally shared, probably the most commonly held view on euthanasia is this:

> *The moderate view*
> Passive euthanasia is often morally acceptable, and ought to be legal whereas active euthanasia is not morally acceptable, and ought not be legal.

With the Dutch example as the most notable exception, medical associations around the world, including the Danish Medical Association, advocate versions of the moderate view.

However, despite its wide and powerful official support, the moderate view is difficult to defend in a theoretically satisfactory manner. This is particularly so if one rejects the extreme view for what seems to be rather tempting reasons. I shall return to this issue. Let me first state the third and in my opinion most reasonable view on euthanasia:

> *The liberal view*
> Passive as well as active euthanasia might be morally acceptable, provided that certain conditions are fulfilled. It should therefore, under such circumstances, be legal for doctors to perform these kinds of euthanasia.

These three views, as the reader will notice, really covers two different questions. One question concerns whether or not a particular kind of euthanasia, say active euthanasia, is morally permissible. The second question is whether or not a certain practice ought to be legal, that is, whether for example the practice of providing active euthanasia on request by a competent patient ought to be legal or not. These questions are distinct, even if they are related to each other in various ways. Thus, one might oppose legalising active euthanasia, while conceding that the practice as such (considered on its own, and practiced illegally) is not morally objectionable. This makes room for further combinations of views, some of which I shall briefly comment on below.

While defining the liberal view, I have left open what conditions count as reasonable. This is partly to make the definition less cumbersome, and partly because it is in itself a controversial issue over which liberals may disagree. However, for the purposes of the discussion below, I have the following in mind: very roughly, for euthanasia of any kind to be morally acceptable, it must be the patient's *expressed and considered wish* that the specific kind of euthanasia of the patient's choice is performed, *and* it must be the case that there is *no other way to improve the situation* for the patient.

Accordingly, I wish to restrict my discussion to what I shall call *the paradigm case*. The paradigm case is a case in which all of the following is assumed to be true: (i) a patient is dying from some incurable disease, (ii) she experiences quite substantial suffering, either in the form of intractable pain, or because she perceives the remaining part of her life

to be utterly meaningless or degrading and for that reason not worth living, (iii) nothing further can be done for her which will more than marginally improve her situation, (iv) she is fully competent and makes repeated and considered requests for a specific kind of euthanasia.

Active euthanasia, as well as passive euthanasia, is morally justified in the paradigm case, or so I shall argue at least. But let me first address an immediate objection. Most end of life decisions are different from the paradigm case, and one might for this reason question its importance. My reply is that even if comparatively rare, the paradigm case has a theoretical importance, as I hope the discussion below will make clear.

Although I shall argue that euthanasia is permissible in the paradigm case, I actually do not believe that euthanasia is permissible *only* in the paradigm case. For example, in some cases, passive euthanasia will be morally permissible even when a patient is not fully competent and therefore has not made repeated and considered requests that passive euthanasia is performed. On reflection, few would find this controversial. What is more contentious is the view that active euthanasia might be permissible in cases where patients suffer unbearably, but are not competent. I think that a good case can be made in favour of this view, but this is not the place to make it. I also tend to think that active as well as passive euthanasia might be morally permissible in certain cases that meet all the conditions except condition (i). Alas, to prevent my discussion from becoming exceedingly complex, and from taking up far too much space, I shall devote the vast majority of my discussing to the paradigm case.

4. Basic considerations

I shall now turn to a discussion of the views I have just outlined. Complex moral views may in principle be defended in numerous ways – it is not that there is always one moral reason, or one neat set of moral reasons, that every liberal or every moderate accepts as decisive reasons in favour of their view. However, it is impossible to defend or even discuss complex views such as these without making appeals to at least some *general ethical principles*, that is, general principles about what we ought to do, morally speaking. Hence, in my

discussion, I shall assume that we accept the following two principles:

> *Principle of well-being*
> Patients' well-being ought to be promoted (if not for its own sake, then because of the derivative importance of well-being). (same)
>
> *Principle of autonomy*
> Patients' autonomy ought to be respected (if not for its own sake, then because of the derivative importance of autonomy, i.e. the fact that promoting and respecting someone's autonomy generally speaking enhances this person's well-being).

The main reason I find it justifiable to assert the principles of well-being and autonomy is that it is my experience that virtually no-one seriously denies these principles. Very often disputes about the exact interpretation or the grounds of the principles arise, but these are different matters that need not detain us here. It is enough that most people in fact accept these principles.

5. Why we should not accept the extreme view

As I said, almost no-one accepts the extreme view, and we do not need to consider the extreme view as a serious contender. However, it is instructive and theoretically fruitful to consider the problems confronting the extreme view. First, we might ask what more basic principles one might appeal to in an attempt to explain and justify the extreme view. While there are several possible answers to this question, two are particularly prominent.

The first, and less plausible, is a version of the *sanctity of life principle* which holds that *life as such is valuable* to such an extent and in such a way that, in life and death situations, preventing the death of a patient is of overriding importance. Even though this version of the sanctity of life principle might have been influential in medical practice at earlier times, it is hard to accept for a number of reasons. Trying to be in compliance with this principle would commit us to devote enormous amounts of health care resources in futile attempts to keep alive desperately ill and incurable patients.

At a deeper level, the basic problem with the sanctity of life principle in this version is the implication that, in life and death situations, patients' well-being and patients' autonomy are at most of secondary importance in the cases, where, ironically, one would think that concern for well-being and autonomy were most urgent. This is related to a well-known implication of the principle. What matters according to the sanctity of life principle, it seems, is mere *biological existence*. The focus is solely on whether or not a person's *body* is biologically alive or not. The focus is not on what has been termed the *biographical life* of the person whose body it is, where the biographical life is the life as experienced from within, so to speak.

However, there is a second and more powerful way of defending and understanding the sanctity of life principle. The basic idea here is that acts that are directed at ending the life of a human being are wrong. That life is sacred does not mean that we should at any cost uphold life. Rather, it means that we are never permitted to take steps to end life. As is readily seen, this version of the sanctity of life principle does not immediately support the extreme view. We might sometimes let nature take its course. But we are not permitted to act in nature's place, at least not with the aim of ending the life of a patient. I return to these ideas in later sections.

6. Pressure on the moderate

Most people reject the extreme view, as I have mentioned several times earlier. I suggest that this is, among other reasons, because they reject the version of the sanctity of life principle which would otherwise support the extreme view. I also think that asked *why* they reject the sanctity of life principle, they would, on reflection, cite just the reasons that I mentioned above: the sanctity of life principle appears unpalatable precisely because it would commit us to futile attempts to preserve mere biological existence, whereas what really matters for humans - well-being and the exercise of autonomy - is simply ignored.

Most people who reject the extreme view do not instead favour the liberal view. Rather, they prefer the moderate view. That is, they approve of passive euthanasia, but not active euthanasia. However, the acceptance of the principle of

autonomy and the principle of well-being creates a pressure on the moderate. Someone might say:

> *Look, you moderate! You think that passive euthanasia is sometimes morally acceptable. This is because you accept the principle of autonomy and the principle of well-being.*
>
> *But then why not go all the way? Why not accept the liberal view? Clearly, having rejected the sanctity of life principle, the principles of autonomy and well-being are reasons in favour not only of accepting passive euthanasia, but also of accepting active euthanasia.*

In short, the moderate view threatens to be unstable. As soon as one accepts it, one has to abandon it again in favour of the liberal view. Or, more accurately, if one rejects the extreme view *because* of a concern for patient's autonomy and well-being, one is in need of a good reason for not going all the way to the liberal view. As I shall argue in the next sections, such a reason is hard to find.

7. The moderate: allowing to die, not killing

I shall now discuss some of the most commonly attempted ways to steer in between the extreme view and the liberal view. The challenge is that of defending the acceptance of passive euthanasia, while still rejecting active euthanasia and doctor assisted suicide. In the recent history of the subject, many appeals have been made to the following principle:

> *The doctrine of doing and allowing*. It is morally worse to bring about some bad effect by way of an action than by way of an omission.

Assuming that we accept the doctrine of doing an allowing, a defence of the moderate view might go roughly as follows:

> *Active euthanasia is morally unacceptable because it involves actions rather than omissions, whereas passive euthanasia might be morally acceptable because no actions are undertaken to end the lives of patients.*

Or as it is often said: in passive euthanasia one merely lets patients die, and this is why it is morally acceptable. Unlike active euthanasia, one does not kill patients, which would be morally intolerable.[4]

The doctrine of doing and allowing might be offered as a second and better interpretation of the sanctity of life principle. The idea would then be that human life is sacred in the sense that acts bringing an end to human life are wrong, or at least wrong in comparison to omissions having the same outcome.

Surely the doctrine of doing and allowing captures part of what is believed to be the crucial distinction between active and passive euthanasia. Nonetheless, there are several serious obstacles to defending the moderate view by appeal to the doctrine of doing and allowing.

First, we might note that depending on the details of how one draws the distinction between actions and omissions, it might be that not all instances of passive euthanasia come out as cases of omissions. This, however, need not be a deep problem for the moderate, since it merely underscores the need for finer discrimination among the various forms of passive euthanasia.

There is a second and in my view much more serious problem for the moderate. The appeal to the doctrine of doing and allowing in a defence of the moderate view seems to presuppose that death is bad. Otherwise, why should it be worse to bring about death by an action than by an omission? Now, it might seem an entirely natural and obvious assumption that death is indeed bad. But on reflection, this is not necessarily so. Remember that we consider what I called the paradigm case, in which a patient is assumed to suffer irredeemably and requests some form of euthanasia. It is not obvious that death is bad for a patient under such circumstances. I think many moderates would concede that, in the paradigm case, death might indeed be a good thing from the patient's point of view.

Nonetheless, the moderate appealing to the doctrine of doing and allowing needs to identify a bad outcome of an act

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[4] An good paper on this distinction is Quinn, W. S. (1989). "Actions, Intentions, and Consequences: The Doctrine of Doing and Allowing." Philosophical Review: 98 287-312..

of active euthanasia, otherwise the doctrine of doing and allowing does not apply in the intended way. Perhaps the moderate could try to appeal to something like the following principle:

> *The intrinsic badness of death*. The occurrence of someone's death is intrinsically bad.

When I say that death is *intrinsically* bad, I mean that is it bad in itself. This amounts to saying that even if death is welcome and desirable from the point of view of a patient, it is nonetheless bad. Not for this or that person, but just bad. Hence, saying that death is intrinsically bad is saying that the badness of death does not reside in the fact that death is bad *for* a person in that death robs this person of the rest of his life. Thus, when holding that death is intrinsically bad, one asserts that there is something bad or detrimental about death over and above the fact that death may put an end to what we find valuable about life.

The importance of this lies in what we saw above. It is likely that everyone in the debate will concede that from the patient's point of view death might be welcome and desirable (that is, good). Yet, if the moderate asserts that death is intrinsically bad he might have provided what he needs to apply the doctrine of doing and allowing.

On reflection, however, it seems hard to believe in the intrinsic badness of death. How plausible is it to view death as bad, even in cases where death is desired by an autonomous patient, and where a peaceful death is clearly in the interest of the patient (and, we might add, when everyone agrees that this is so)? Can we seriously regard death as bad in any respect when it occurs under those circumstances? Indeed, how could death be bad at all in cases where death is neither bad for the person that dies, nor for anyone else? How could death be bad when it is not bad for anyone?[5]

Third, it is my experience that many defenders of the moderate view actually do not themselves believe that death is intrinsically bad. This is part of the reason why they accept

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[5] For an excellent discussion of related issues, McMahan, J. (1988). "Death and the Value of Life." Ethics: 99 32-61.

see

certain forms of passive euthanasia. After all, the principle of doing and allowing would, at best, explain why active euthanasia is more wrong than passive euthanasia. It does not in itself explain why passive euthanasia should be tolerated. And if the principle of doing and allowing in this context requires the assumption that death is intrinsically bad, then why should we accept passive euthanasia? Why let something intrinsically bad happen if it could easily be prevented?

Thus, we can conclude that the attempt to defend the moderate view by introducing the doctrine of doing and allowing is fraught with difficulties. There is, however, a related doctrine that might initially seem more promising:

> *The doctrine of the double effect*. Bringing about a bad effect with the intention of doing so is morally worse than bringing about this effect merely as a foreseen, but not intended, consequence of one's actions (or omissions).

If we accept the doctrine of the double effect, a defence of the moderate view might go as follows:

> *In passive euthanasia the physician's intention is not to end the life of a patient. Rather, the intention is, say, to avoid burdening a patient with pointless treatment. This might be morally acceptable. Active euthanasia, on the other hand, is not morally acceptable, since active euthanasia involves the intention that a patient's life is ended.*

Notice that it *does* seem intuitively plausible that a distinguishing feature of active euthanasia is the intention to bring an end to the patient's life, a feature active euthanasia undeniably involves. However, on closer inspection, the doctrine of double effect does not really supply what the moderate needs.

Again, at least some instances that are classified as passive euthanasia and held to be morally acceptable by the moderate, most likely involves the intention that the patient dies. Consider for example a decision not to resuscitate a patient who suffers a heart attack, or a decision to remove a patient from a life support system. Those responsible for such

decisions cannot fail to know that the result of their decision is that the patient dies. Nonetheless, the guiding intention behind choices such as these *can* be to save the patient from treatment that is in any case unlikely to save the life of the patient, or to benefit the patient in other ways. Often, however, the death of a patient under such circumstances *is* seen as a welcome and intended outcome of one of these forms of passive euthanasia, or so I claim at least. If I am right in this, then many actual cases of passive euthanasia do not prove to be morally justifiable according to the defence of the moderate I outlined above, since this defence assumes that acting with the intention to end the life of a patient always is morally wrong.

As before, this might merely indicate the need for the moderate to be more selective as to which kinds of passive euthanasia he accepts.

However, there is a further and deeper difficulty affecting the moderate's use of the doctrine of the double effect, a difficulty that by now might be familiar. Applying the doctrine of the double effect to distinguish passive from active euthanasia clearly assumes that the death of a patient is a *bad outcome*, even when the patient herself clearly expresses a desire to die, and when everyone admits that dying peacefully would be in the interest of the patient. In short, the moderate´s appeal to the doctrine of the double effect presupposes the intrinsic badness of death, which is, as, we have seen, a problematic view.

The mildly surprising result of our discussion of the doctrine of doing and allowing and of the doctrine of the double effect is that the moderate can use neither in a defence of her position.

Let me mention a final and somewhat desperate theoretical resort, which I believe might be available for the moderate. The moderate might try to appeal a principle like the following:

> *The intrinsic wrongness of killing*. The killing of someone is in itself a morally wrong type of act. Letting someone die, on the other hand, need not be morally wrong in itself.

According to this view, certain actions are morally forbidden merely in virtue of their *type* or *kind*. These actions are neither outlawed by morality because of their *consequences* (since everyone might agree that the consequences of such actions might be desirable), nor because of the *intentions* that they embody (as these intentions may simply be to bring about an outcome that everyone recognises as good or desirable). Rather, it is the actions themselves, independently of why we do them and what happens when we do them, which are somehow morally wrong.

As was the case with the intrinsic badness of death, we could see the intrinsic wrongness of killing as an interpretation of the sanctity of life principle, or as an extraction of what was plausible about that principle. It is not that lives must never be lost, or that deaths must never occur. Rather, lives must never be taken in certain direct ways: killings should never occur, not even in cases where the death of a patient is seen as desirable by everyone, including the patient.

Should we accept the intrinsic wrongness of killing? Or if not, why should we reject it? I myself find it very hard to believe that an action can be morally wrong merely in virtue of its type. If wrong, it must be wrong because of what the action aims at, or because of what it achieves. Thus, we cannot hold that an action is wrong if we recognize that it is done with morally praiseworthy intentions and accept that it has only morally good consequences. However, I also tend to believe that arguments stop here. If someone were to insist that certain actions are intrinsically wrong in the way I have described, I wouldn't know how to rebut this view.

8. The moderate: wrongdoing and the goals of medicine

For the reasons I have tried to indicate, I do not regard the previously discussed attempts to defend the moderate view as successful. Let us now move to other common ways of defending the moderate view. In discussions with physicians, I have often encountered the following line of reasoning:

> *One cannot require that anyone undertakes to perform a morally wrong act, like that of performing active euthanasia.*

As soon as you think about it, the failure of this line of argument is obvious. The argument illicitly assumes part of what is at stake, namely that assisted suicide or active euthanasia is morally wrong. However, we are looking for reasons to think that these actions indeed *are* wrong. We cannot, in our arguments, simply assume that they are. In other words: *if* active euthanasia were morally wrong, then there would be a case for saying that physicians are not obliged to perform active euthanasia, just as there would be a reason to oppose the legalisation of active euthanasia. This, however, does not establish that active euthanasia is morally wrong, and it does not provide a reason for thinking that it is.

It is worth making a small digression here. It is often held that if active euthanasia were legalised, then at least it should not be mandatory for physicians to participate in such schemes. At the very least, any physician should retain the right *not* to perform active euthanasia, if doing so were against his or her moral convictions. I agree that this liberty should be granted, but this is primarily because I fear that without it the medical profession would be even more adverse to legalising active euthanasia. It is not, to be clear, because I accept a general principle saying that if some medical practice does not concord with the values of a physician, then this doctor is automatically freed from his or her moral duty to participate in the practice.

To illustrate, consider blood transfusion. Suppose some doctor were to find blood transfusions morally wrong (for religious or other reasons). However, in a case where a transfusion is needed and requested by this doctor's patient, certainly he or she does not have the moral right to refuse the transfusion. Of course, when we say this (and I here assume that virtually anyone agree), we assume that blood transfusions are indeed morally faultless. The point is that if we make a similar assumption regarding active euthanasia, it seems that we should conclude that physicians do *not* have a moral right to refuse this service, when requested and needed by a patient (always assuming that other relevant conditions for the permissibility of active euthanasia are fulfilled).

Let me now end the digression, and return to the discussion of ways in which the moderate might try to explain why he will not accept active euthanasia. One

argument very often employed against active euthanasia is this:

> *The basic goal of medicine is to prevent and cure disease. Therefore, the physician should not kill patients and, accordingly, active euthanasia is not acceptable for physicians.*

There are several problems with this. First, at best the suggested argument shows that active euthanasia is not the primary task of physicians. This, however, does nothing to indicate that this practice is morally wrong, or even that it is morally wrong for *physicians* to take part in it. Compare this to fire brigades. Their primary goals might be considered to be to extinguish fires. Obviously this does not make it morally wrong for firemen to participate in other activities.

In response to this someone might wish to make a stronger claim about the proper goals of medicine. It might be said that the goal of medicine is not merely to prevent and cure disease, but also not to take part in active euthanasia. That is, abstaining from certain practices, among these the practice of active euthanasia, is part of what medicine aims at.

Perhaps some physicians actually think this of their profession, and this might partly explain their resistance to active euthanasia. Nevertheless, this stronger claim about the goals of medicine only defers the problem. We can now ask why we should embrace this interpretation of the goals of medicine (even if we grant that the stronger claim truly describes the goals that the profession might be said to have). From a moral point of view it is very reasonable to say that the goals of medicine ought to be to improve patient well-being, within the constraints of patient autonomy. I believe that many would on reflection find this view reasonable.[6] Far from prohibiting active euthanasia, this understanding of the goals of medicine indeed permits it. In the absence ofconvincing reasons to think that active euthanasia is morally wrong, why accept a goal of medicine prohibiting active euthanasia? It seems now that the claim that it is part of the proper goals of medicine that physicians do not take

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6 For further defence of this view, see Kappel (1997).

part in active euthanasia is question begging. It simply assumes part of what is at stake, i.e. that active euthanasia is morally wrong, and that it is therefore a legitimate goal of the medical profession not to indulge in such practices.

In conclusion, we can say that arguing from the goals, or purported goals of medicine, against active euthanasia is not a successful strategy.

9. The moderate: Active euthanasia fails to respect autonomy and fails to promote well-being

As I made clear above, the main case for holding active euthanasia to be morally acceptable and, consequently, for supporting its legalisation, rests upon the overriding concern for patients' well-being and autonomy. One possibility for the moderate, therefore, is to question these grounds for active euthanasia, something which is indeed often encountered in discussions on the topic. Thus, one common objection to active euthanasia is this:

> *There is no real prospect that people can autonomously decide that they want active euthanasia. Hence, respect for patient autonomy does not really support active euthanasia.*

For example, it is often said that when patients requesting active euthanasia are admitted to a hospice, they often withdraw their request for active euthanasia. Whether this is true or not, the thought behind the suggestion is interesting. The implication of this would be that patients are in a sense mistaken when they request active euthanasia. Their true will is different.

There is no question that facilitating patient decision-making is a great challenge in today's medicine. It is no doubt also true that it might be difficult for someone to decide that her life should be ended, in particular when one is afflicted by serious disease. This said, however, why believe that it can *never* be someone's sincere and true desire that her life is brought to an end? Why believe that no dying patient can competently make this choice, even if we try as much as we can to assist her in the decision-making process?

If the moderate for some reason were to insist that dying patients cannot make autonomous choices, he faces other problems. If it is true across the board that dying

patients are not competent decision-makers, then this is true for passive euthanasia as well as for active. But why then respect the decisions of patients who resolve that no more treatment should be given? Why think these patients make a competent choice when they urge that nature should take its course?

Admittedly, this problem might seem smaller for the moderate in case he does *not* think that passive euthanasia requires the consent of a dying patient, not even in cases where the patient is in fact fully competent to give or withhold consent to some form of passive euthanasia. I do not know if many moderates would defend this form of paternalism. Clearly, however, if someone were willing to defend the moderate view in such a way, she would save her view against a serious objection only by embarking on a form of medical paternalism that most people would find hard to accept.

The problems for the moderate don't stop here. Suppose, for the sake of argument, that dying patients can *never* make competent choices regarding life and death options. Then how should these choices be made? There is much to be said for the view that a surrogate decision must be made by someone else, and that it should be made in the light of what is perceived to be in the *best interest of the patient*. But now recall that everyone, even the moderate, concede that for dying patients for whom there is no hope of cure or further improvement, death may be a desirable outcome.[7] More specifically, sometimes some form of passive euthanasia is in the best interest of the patient, whereas at other time active euthanasia might be. Hence, if we generally deny that dying patients are capable of competent choices regarding their own lives, then we should chose for them in the light of what is in their best interest. This, however, is a reason *for* making available active euthanasia. It is not a reason for prohibiting it.

When concerned with death from 'natural causes' virtually everyone agrees that death may be merciful, and that living longer does not always mean having a better life.

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[7] Cf. Buchanan, A. E. (1989). Deciding for Others: The Ethics of Surrogate Decision Making. New York, Cambridge Univ Pr.

Nonetheless, when it comes to discussions of active euthanasia, defenders of the moderate view regularly deny this otherwise uncontested point:

> *Active euthanasia doesn't really enhance dying patients' well-being. Hence, concern for the well-being of dying patients does not really speak in favour of active euthanasia.*

The problem with this objection to active euthanasia is why we should accept it as true. Sometimes allusions are made to the Christian idea that suffering is part of a full human existence. A certain amount of suffering is essential to the good life, it might be said. Therefore suffering should not be avoided at any cost, and the sort of suffering that cause people to request active euthanasia may, properly understood, not detract from but add to the quality of their lives. A slight variation on the same theme is the idea that *preparedness* to suffer is a virtue that is essential to the good life. Someone who wants to avoid the sort of suffering that might be involved in dying does not exhibit the right sort of preparedness to endure agony. Yet a third variation over the same theme appeals to the rewards that the experience of suffering is thought to bring. When undergoing suffering one learns to appreciate deeper and more valuable aspects of human existence, and this enables one to live a richer and more valuable life.

I concede that there might be *some* truth in these observations about the place of pain and anguish in human life. Extreme aversion to the slightest amount of hardship might be a fruitless and even dangerous character trait. Often the hardships that one undergoes do function as eye-openers. Nevertheless, I do not think it is justified to claim on these grounds that active euthanasia never enhance well-being, particularly not in the paradigm case that we are considering here. First, the case for active euthanasia concerns quite severe suffering, either in the form of pain and bodily deterioration, or in the form of a deep sense of meaninglessness. Even if there were some benefits to such experiences, it is not credible that the benefits always outweigh the burdens. Second, active euthanasia in the paradigm case concerns patients who will die in a short span of time, regardless of what is done. Hence, they will not have

the opportunity later to benefit from whatever valuable insights their suffering might otherwise have made available for them.

Yet another suggestion, in defence of the moderate's insistence that active euthanasia is not in the interest of patients, is that patients, when they request euthanasia, misunderstand their own true interests. For example, it might be suggested that while patients are fully competent and not subject to undue external pressure, their request for active euthanasia is nonetheless irrational. They request active euthanasia because they are unreasonably afraid of the process of dying, or because they exaggerate the severity of the suffering that awaits them. Again, the reply will be that while this may be what lies behind requests for active euthanasia, as well as behind requests for passive euthanasia, it is hard to believe that dying patients *always* mistake their own true interests when they request active euthanasia. Moreover, if they did, this would pose a problem not only for active euthanasia, but also for various forms of passive euthanasia. Remember also that active euthanasia is thought to require the independent confirmation that a patient's suffering is substantial and irredeemable. This considerably reduces the likelihood that a patient's irrational desire to die will go unnoticed.

Finally, what some might have in mind, when they deny that active euthanasia might benefit patients, is that *better alternatives* than active euthanasia are available, or at least that they ought to be available. Given the poor conditions that dying patients are offered in modern health care systems, active euthanasia would perhaps mark an improvement of their situation. What this indicates, however, is simply a failure of modern health care systems. Our care for the dying is far from satisfactory, and we should eliminate that problem by improving this part of the health care system, rather than by offering patients active euthanasia. Thus, true concern for the well-being of dying patients does not support active euthanasia. True concern for these patients supports improving care for them.

I agree that care for the dying could in many cases be improved and should be. Active euthanasia is not a substitute for this. Yet, I do not accept the assumption behind the argument just presented: that dying patients only requests

active euthanasia because their care is less than optimal. In other words, even when optimal care is provided, some dying patients might still prefer to die by active euthanasia. At least, I see no reason to rule this out in advance, just as I see no reason not to make active euthanasia available if this is what a patient sincerely wants.

10. The moderate: active euthanasia is too costly

Perhaps the most influential arguments in defence of the moderate view appeal to what is believed to be negative consequences of *legalising* active euthanasia.[8] One widely shared concern is this:

> *A legal framework permitting active euthanasia would have to be rigorous and somewhat complex. But you cannot easily manage rigorous and complex legal rules concerning sensitive matters such as these. Therefore, active euthanasia should not be legalised.*

This applies to the *legalisation* of active euthanasia only, not to the practice as such. Thus, one could concede that the costs of legalising active euthanasia are too high, while at the same time agreeing that individual acts of active euthanasia are not morally wrong.

No doubt managing regulations for active euthanasia will be costly. Some decision-processes will be slower, and they might have to involve more people. The same is true of regulations concerning e.g. medical research and organ transplantation. In the cases of medical research and organ transplantation, however, most people think that the costs are worth undertaking. It is not obvious why we should not take the same view about active euthanasia. After all, active euthanasia is thought to meet very sincere needs of a vulnerable group of patients, even if this group might turn out to be small. It is worth noticing, moreover, that detailed and rigorous legal rules concerning the use of *passive*

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[8] It is not always the legalisation as such which is thought to be the source of undesirable effects. Sometimes it is the mere fact that the practice of active euthanasia is common, or that it is common and widely acknowledged. For ease of presentation, I shall often ignore these complications.

euthanasia, if there were any, would also be costly. Thus, when the introduction of a legal framework permitting active euthanasia is perceived as too expensive, it is in part because comparison is made to the relative absence of a detailed legal framework governing the use of various forms of passive euthanasia. But we should not reject a practice merely because this practice including the proper regulations it would require seem relatively costly in comparison with a practice that might be insufficiently regulated.

There are other common claims about what is believed to be adverse effects of introducing a practice of active euthanasia. A very common worry is this:

> *The legalisation of active euthanasia will affect patient-provider relationship negatively. Hence, we should not legalise active euthanasia.*

The main assumption in this objection is puzzling. Suppose I have come to an understanding with my doctor that if I am about to die, and I suffer irredeemably and for that reason ask him that he take steps to end my life, then he would be willing to consider my request. Why think that this would make me anxious? Why think it would tend to undermine my trust in my doctor, or my relation to him? If anything, a mutual understanding of this kind seems more likely to enhance my trust in my doctor. Similarly, it would seem to improve my relationship with my doctor if I knew that he would not continue my medical treatment beyond the point where I had no longer any prospect of benefiting from it. In particular, it would be beneficial for the relationship to my doctor if I could trust that he would respect *my* decision that no treatment is to be given if it merely prolongs suffering. It is not surprising, therefore, that no-one claims that passive euthanasia on request from dying, but fully competent, patients undermine patient-provider relationships. What is difficult to understand, however, is the repeated claim that the availability of active euthanasia would indeed have such an effect.

Perhaps a different version of the same general worry deserves more attention. It might be suggested that while access to active euthanasia might not have a negative impact on relations between patients and health care providers as

individuals, it will be detrimental to our general trust in the health care system at large.

I can see one way in which this could be true. Suppose that the health care system at large were *already* subject to deep-seated mistrust (whether justified or not). Suppose, in other words, that most people already assume that hospital staff is corrupt and evil, that members of the medical profession are not trustworthy, and that many forms of serious abuse take place at hospitals on a regular basis. In this case, no doubt the introduction of access to active euthanasia would be perceived by the general population as deeply troubling, and in a sense for good reason.

However, I doubt that the general population have these grave doubts about the integrity of health care providers and the health care system at large. For this reason I do not believe that access to active euthanasia would lead to a deterioration of general trust in the integrity of the health care system as such. Moreover, if someone were to insist that there is in fact a gulf of distrust that prevents the introduction of active euthanasia, the reply to this person would be that rather than let unfounded public distrust dictate health care policy we should address the distrust directly. And in the meantime, until confidence in the health care system had been restored, not only active euthanasia should be shunned, but also certain forms of passive euthanasia, and presumable other procedures such as medical research involving patients, and organ transplants. These would be dramatic measures, and I doubt that many that are adverse to active euthanasia would be willing to support them.

Another worry concerning possible adverse effects of introducing active euthanasia in a health care system is this:

> *If active euthanasia were practiced legally, patients would experience a sense of being an unwanted burden to family and relatives, to the health care system, or even to society at large. This would be a cause of considerable distress for vulnerable patients, and would in itself be a reason not to permit active euthanasia.*

There is, I believe, some reason to take this problem seriously. Nonetheless, it is far from obvious that the problem cannot be alleviated by providing proper information about the

purpose of making active euthanasia legally available, about what the practice of active euthanasia consists of, and in particular about which conditions must be fulfilled for someone's request for active euthanasia to be met. This would reassure people that active euthanasia is an option they might want to consider for their own benefit in case they are fatally ill and under extreme suffering, but not otherwise.

Compare this issue to similar problems concerning organ donation. Probably a minority of people worry that their organs might be removed from their bodies against their wishes, or even before they are dead. Health care professionals might dismiss these speculations as completely unsubstantiated, but nonetheless they are likely to be a cause of concern for a limited number of people. I think that the proper response to worries about abuse of organ donations is to supply earnest information about how transplantations take place and, in particular, about what the legal safeguards are. The solution is not to ban organ donations. The case that a similar strategy is not feasible in response to worries about active euthanasia remains to be made.

A related but slightly different charge is this:

> *In extreme cases, patients might even be led to request active euthanasia, not because they want to, but to save others from the trouble they think they cause them. Therefore, to protect vulnerable patients, active euthanasia ought not to be legal.*

In reply to this, note first that we are focusing here on the paradigm case. We assume, therefore, that a patient is dying from an incurable disease, that she suffers because of pain or because she finds that what is left of her life is meaningless, and that nothing more can be done to alleviate her situation. Further, we assume that the patient is fully competent and make repeated requests for active euthanasia. The objection now adds to this picture that the patient in question is *also* moved by a concern for others, say her relatives. She does not request active euthanasia only because of the distress caused by the fact that she is dying from an incurable disease, but in addition because of how this affects people she cares about.

To me this seems to be a case in which the patient has ample reason to request active euthanasia, and a case in which others do not have a moral right to refuse it. The fact

that the patient is also moved by a concern for others does not nullify the fact that active euthanasia on request should be morally permissible. Of course, we might think that the patient's concern for others would not in itself be sufficient to ground a demand for active euthanasia. It is absurd, however, to think that it could retract from what is in its own right a sufficient set of reasons.

Perhaps someone would like to consider a case in which a patient requests active euthanasia *solely* out of concern for her relatives. We are then to imagine that even though the patient is dying and suffers considerably, this does not matter at all to her, or at least it is not a part of her reason for requesting active euthanasia. Thus, were it not for the grief and sadness on the part of the relatives, she would cheerfully live through the miseries of the last part of her life, and never even consider active euthanasia as a possibility.

For obvious reasons, the occurrence of a case like this seems to be extremely unlikely. Nonetheless, we might briefly consider the theoretical significance of such a case. What should our response be to someone who wants to die for reasons entirely unrelated to her own well-being, and who for some reason needs or requests our assistance? This question deserves a much fuller discussion than is possible here. Let me therefore merely state my opinion that in such cases we should try to make people change their minds. We should not provide active euthanasia in such cases. We should assume this position out of concern for these persons' well-being, and we should do so despite what might be their autonomous wish. Hence, in such cases, concern for well-being trumps concern for autonomy. Some defenders of the liberal view might want to say that only a person's competent decision counts. Just as there is a moral right to commit suicide, it is not morally wrong to kill someone else, provided only that this is the persons explicit and considered wish. Respect for autonomy trumps concern for well-being. As I have indicated, I disagree.[9]

Turn now to the practical importance of the case at hand. Suppose we introduce active euthanasia along the general guidelines that I have mentioned earlier. Consider

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[9] A brief defence of this general view is given in Kappel (1997).

then the case of someone who is in the position to make a legitimate appeal for active euthanasia, but who nonetheless makes the appeal for reasons entirely unrelated to concern for her own well-being. Suppose we decide that people ought not be permitted to receive active euthanasia on these grounds. How significant a practical problem do we face here?

Consider first that the nature of these cases strongly suggests that they must be extremely rare. Keep in mind that we are discussing what might happen within the boundaries of the paradigm case. Also, consider that no-one thinks that decisions concerning active euthanasia should take place in a conversational void. Health care professionals should not only provide an independent confirmation that a patient is dying from incurable disease and suffers substantially, but should also in repeated dialogues with the patient do whatever they can to confirm that the patient's request for active euthanasia is brought about by the right motivation. This serves to diminish the practical problem, but it does not guarantee that no-one could bypass whatever guidelines are set up and receive active euthanasia for the wrong set of reasons. I am inclined to think that we should not worry too much about this problem, however. We are not talking about a case in which someone is killed against his or her wish. Nor is it a case of someone who would otherwise have led a long and rich life, were it not for her decision to die. Remember finally that the moderate's recurring problem applies here. A patient might decide that nothing more should be done for her because the patient can't fail to notice and take seriously how difficult it is for the family to cope with the fact that she is dying. If the moderate wants to avoid such problems entirely, she would have to move towards the extreme view.

11. The moderate: active euthanasia is a slippery slope

Turn finally to the slippery slope argument, or *arguments*, as one should say, since we are really talking about a group of arguments here. The main idea is that accepting active euthanasia is in one way or the other the beginning of a slippery slope. In one version the argument goes like this:

> *Legalising active euthanasia incurs a large risk of abuse: doctors will eventually kill patients who do not qualify*

> *according to the regulations. For this reason, active euthanasia ought not to be legal.*

Note again that someone who advances this objection to the legalisation of active euthanasia might accept that active euthanasia *as such* is morally unobjectionable, and even that the common and acknowledged practice of active euthanasia is fine, as long as the proper regulations are observed. The objection, then, is merely that regulations will not be observed.

There are several problems in this line of reasoning. In discussions about active euthanasia, the claim that doctors pose a threat to patients in this way is usually advanced without the slightest bit of evidence being offered. Why think that doctors for one reason or another want to do away with their patients? And indeed, if one were to believe this, then why think that legalising active euthanasia in a circumscribed set of cases would make much difference? For the moderate, in particular, this version of the slippery slope argument poses difficulties, because of the moderate's acceptance of passive euthanasia. If one worries that active euthanasia may be abused by doctors, one should be just as worried about possible abuse of passive euthanasia. It could be argued that one should indeed be more worried about the latter, given the relative absence of a transparent framework regulating passive euthanasia.

A slightly different version of the slippery slope argument is this:

> *Legalising active euthanasia incurs a large risk that eventually new and more relaxed rules will replace the stricter rules. For this reason, active euthanasia ought not to be legal*

Again, endorsing this objection is consistent with accepting both that active euthanasia is morally permissible, and that it should be legalised, if only we could trust that things would stay like that.

We need here to be aware of different ways in which a set of regulations might be revised. Consider a slave society which is gradually becoming more just. As a first step, legislators propose that children of slaves no longer be slaves

themselves, though they will not have the right to own land, to hold political office, or to vote. Imagine now that members of the old aristocracy that used to profit from slaves were to argue that this proposal is the first step on a slippery slope. That though seemingly innocent, later revisions will follow and eventually, everyone in society will have the same rights and standing.

This is a case of what we might call *reasonable revisions* of a set of regulations. In my view it is plausible that if a relatively strict set of regulations governing the access to active euthanasia were introduced, this set would later be subject to reasonable revisions. Consider for example that the regulations I (or the character I called the liberal) have had in mind in this essay requires that a patient is fully competent. This rules out active as well as passive euthanasia in cases of incompetent patients, say newborn children who are afflicted with lethal incurable diseases. On reflection, many would find this too strict. At least some form of passive euthanasia ought to be available in such cases. And, on reflection, many people might resolve that since the aim of passive euthanasia in such cases is that the child's life is ended, this end might in some cases be better achieved by active euthanasia. Hence, they would favour that active euthanasia be available as an option is some cases of this kind.

I regard these revisions as reasonable, though the issues here deserve much more discussion. Thus, one response to the second version of the slippery slope argument is that one should not oppose a set of regulations by pointing out that revisions will later follow, if these revisions are reasonable. Hence, at the very least one would have to make a case that the revisions one have in mind are both likely to occur, and that they are not reasonable. It is my experience that slippery slope arguments rarely if ever meet these standards. It is as if moderates and others who are opposed to active euthanasia think that if active euthanasia is introduced, a corruption of our minds will take place. Hence, even though a strict set of guidelines regulating active euthanasia is in itself unobjectionable, evil forces will later introduce other principles that are clearly immoral. The obvious problem is why one should believe that this development will take place, or is even minimally likely to take place? Active euthanasia is first and foremost motivated by a concern for patient's well-

being and competent choices. It is a bit hard to believe that this will eventually distort our sense of what is morally right and wrong.

Notice finally that those who raise slippery slope objections against active euthanasia are often remarkably unconcerned about passive euthanasia. In the present situation characterised by a relative absence of strict procedures regulating passive euthanasia, there would seem to be ample reason to fear various forms of abuse. Doctors might let patients die who do not want to die, or who do not want to die now, or in that way. One could worry that if some reasonable guidelines for the use of passive euthanasia were installed, these guidelines could later perhaps be replaced by some unreasonable ones. In brief, it seems that slippery slope arguments that might be thought to count against active euthanasia are just as relevant for passive euthanasia. This is, of course, a problem for the moderate who can hardly reject active euthanasia out of slippery slope considerations, and at the same time ignore that similar issues arise concerning passive euthanasia.

This indicates that if one is sincerely concerned about the slippery slope argument in its various forms, one should reject the moderate view and move towards the extreme view. Since only few people want to do this, I suggest that most people are not really concerned about the slippery slope, despite the impression one might get from the public debates on active euthanasia. As I have indicated, I myself do not find that there are weighty reasons to worry that active euthanasia is the first step on a slippery slope.

12. Methodological afterthoughts

I want to end this essay with a few methodological remarks. I have now stated a case for the liberal view. The strategy has been simple. I have assumed that we accept the principle of well-being and the principle of autonomy. These principles count in favour not only of abandoning the extreme view, but also of accepting the liberal view, that is, of holding that active as well as passive euthanasia is morally permissible (on certain conditions), and that active euthanasia ought to be legalised. The moderate accepts all of this, except that he thinks that active euthanasia is not morally acceptable, and that it should thus not be legalised. In the bulk of the essay, I

have argued that the moderate view is impossible to defend. It is not possible to provide a satisfactory reason for the moderate's insistence that we should not accept active euthanasia. This is the main reason why I favour the liberal view.

Thus, my acceptance of the liberal view is based on arguments. There is, of course, nothing special about this; it is the way that moral philosophers work. Nonetheless, it is sometimes questioned whether moral debates really proceeds in this way, or even should proceed in this way. What I have in mind is the suggestion (which I have often encountered in discussions) that *first* comes the acceptance of active euthanasia, and only *next* comes the particular set of arguments that one accepts and cites in favour of active euthanasia.

Obviously, this is putting the cart before the horse. In my view, rational discussion of moral issues should not advance like that, and I believe that the discussion above demonstrates that they need not.

There is a related point. I have sometimes heard it suggested that everything depends on which basic moral view you subscribe to. If you are a utilitarian, so the suggestion goes, it is no wonder that you are also in favour of active euthanasia, whereas if you are a Kantian, things might look very different. Therefore, there is no need to take seriously the details of arguments such as those presented above, since everything turns on the basic moral outlook anyway.

Unfortunately, this way of viewing moral philosophy is common. It is nonetheless mistaken for at least two reasons. First, with very few exceptions, no serious moral philosopher is willing to accept a basic moral view independently of what this view commits him or her to accept elsewhere. So, if one is a Kantian it is partly *because* one believes that Kantianism leads to a independently plausible stance on, for example, active euthanasia. Hence, it is not that everything depends on the basic moral outlook. It is just as much that the basic moral outlook depends on everything else.

Second, I believe that most basic moral outlooks could converge on the conclusion I have advocated here. Kantians, contractarians, Aristotelians, and utilitarians could all accept the arguments on which my conclusion are based, though

this is a point that I do not have the space to explicate. I am not saying that everyone who subscribes to one of these ethical theories *must* agree with what I have said about active euthanasia, and much less that they actually do. What I say is merely that you can be a contractarian, a Kantian, an Aristotelian, or a utilitarian, and yet accept the views I have endorsed above. In this way, the defence of my conclusion is independent of any particular basic moral theory, contrary to what is sometimes suggested.

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