

- the first national broadcast of an actual mercy killing in the Netherlands).
47. *Compassion in Dying v. Washington*, 79 F. 3d 790, 830-32 (9th Cir. 1996).
48. *Ibid.*, 831.
49. *Ibid.*, 832.
50. This group once included such distinguished physicians and advocates of PAS as Dr. Timothy Quill, Christine Cassel, and Diane Meier. See Cassel et al., "Care of the Hopelessly Ill."
51. *Compassion in Dying*, 79 F. 3d at 832.
52. *Ibid.*, 831 ("In fact, the Court has never refused to recognize a substantive due process liberty right or interest merely because there were difficulties in determining when and how to limit its exercise or because others might someday attempt to use it improperly").
53. *Ibid.*, 827. Judge Reinhardt's optimism is contradicted by evidence amassed in the SUPPORT study. See note 15 above.
54. *Quill v. Vacco*, 80 F. 3d 716, 729 (2nd Cir. 1996).
55. 410 U.S. 113 (1973).
56. *Doe v. Bolton*, 410 U.S. 179, 184 (1973).
57. 410 U.S. 179 (1973).
58. *Ibid.*, 198.
59. *Ibid.*
60. See Frank G. Miller, "Legalizing Physician-Assisted Suicide by Judicial Decision: A Critical Appraisal," *Biolaw* (Jul.-Aug. 1996).
61. *Ibid.*, S-143.
62. For a comprehensive account of practices and laws governing the forgoing of life-sustaining treatment and surrogate decision making, see Alan Meisel, *The Right to Die*, 2d ed. (New York: Wiley Law Publications, 1995).
63. Miller, "Legalizing Physician-Assisted Suicide by Judicial Decision."
64. Meisel, *The Right to Die*.
65. Miller, "Legalizing Physician-Assisted Suicide by Judicial Decision."
66. *Quill v. Vacco*, 80 F. 3d 716, 729 (2nd Cir. 1996); see also *Compassion in Dying v. Washington*, 79 F. 3d 790, 822-24 (9th Cir. 1996).
67. Miller, "Legalizing Physician-Assisted Suicide by Judicial Decision," S-139.
68. *Quill v. Vacco*, 80 F. 3d 716, 729 (2nd Cir. 1996).
69. Dan Brock, "Voluntary Active Euthanasia," *Hastings Center Report* 22 (1992): 10. See also Brock, "Borderline Cases of Morally Justified Taking Life in Medicine," in Tom Beauchamp, ed., *Intending Death: The Ethics of Assisted Suicide and Euthanasia* (Upper Saddle River, NJ: Prentice Hall, 1996): 131-49.
70. For a helpful review of the arguments surrounding the distinction between "letting die" and PAS/euthanasia, see Kamisar, "Against Assisted Suicide—Even a Very Limited Form," 753-60. For those wishing to go deeper into these troubled waters, see B. Steinbock & Alastair Norcross, eds., *Killing and Letting Die* (New York: Fordham University Press,

1995). See also Beauchamp, ed., *Intending Death: The Ethics of Assisted Suicide and Euthanasia*.

71. Task Force, *When Death Is Sought*, 146-47.
72. David M. Eddy, "A Conversation with My Mother," *Journal of the American Medical Association* 272 (1994): 179 (illustrating the possibility of death by starvation).
73. Derek Humphrey, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*, 2nd ed., (New York: Bantam Doubleday, 1997).
74. Dick Lehr, "Death and the Doctor's Hand: Increasingly, Secretly, Doctors Are Helping the Incurably Ill to Die," *Boston Globe* (Apr. 25, 1993), p. 1 (featuring the experience of physicians who have helped patients to commit suicide).
75. *Restatement (second) of Torts*, sec. 13 (1965) (defining battery).
76. See also Seth Kreimer, "Does Pro-Choice Mean Pro-Kevorkian?: An Essay on Roe, Casey, and the Right to Die," *American University Law Review* 44 (1995): 803, 841.
77. The prospects for slippage here are excellent. The step from a requirement of terminal illness, viewed by these courts as canonical, to one of merely "untreatable" or "incurable" illness, already has been recommended by a panel of distinguished proponents of PAS. See Miller et al., "Regulating Physician-Assisted Death." It is interesting to note in this connection that one of Jack Kevorkian's earliest "patients," Janet Atkins, reportedly was playing tennis a week or two before her assisted suicide.
78. Baron et al., "A Model State Act to Authorize and Regulate Physician-Assisted Suicide," 11. At an American Philosophical Association symposium on PAS in December, 1995, Professor Brock conceded that political-strategic considerations played a significant role in his group's decision not to sanction PAS for the chronically mentally ill.
79. *Compassion in Dying v. Washington*, 79 F. 3d 790, 832-33, 836-37 (9th Cir. 1996).
80. Carl E. Schneider, "Making Sausage: The Ninth Circuit's Opinion," *Hastings Center Report* 27 (1997): 27-28 (reviewing the shortcomings of judges in coming to terms with the complexities of highly contextualized social problems such as PAS).
81. For similar reasons, I am highly skeptical of state ballot initiatives, such as the 1994 initiative in Oregon, which do not make use of the legislatures' superior fact-finding capabilities, or, for that matter, of the citizens' capacity for more deliberative approaches to democratic problem solving.
82. It does not speak well for the level of public understanding of this issue, as gauged by polls and referenda, that I, a middle-class public speaker at best, am unfailingly able to convert (or at least shake the confidence of) largely pro-PAS audiences by the end of a half-hour exploration of the social risks and available alternatives. For an excellent discussion of the promise of a more deliberative mode of democracy, see Amy Gutmann and Dennis Thompson, *Democracy and Disagreement* (Cambridge: Harvard University Press, 1996).

83. For an explication of the notion of a "tragic choice" in the sense that I employ here, see Guido Calabresi & Philip Bobbit, *Tragic Choices* (New York: W.W. Norton, 1978).
84. For a good example of how such "terminal sedation" can fit into an overall plan of palliative care, bringing relief to patients and families alike, see Ira Byock's compassionate and instructive account in *Dying Well: The Prospect for Growth at the End of Life* (New York: Riverhead Books, 1997), ch. 10.
85. Timothy Quill, "Death and Dignity: A Case of Individualized Decision Making," *New England Journal of Medicine* 324 (1991): 694.
86. Allowing for the occasional covert practice of PAS would, it is true, favor well-educated, middle-class individuals with access to willing physicians and would thus perpetuate an undesirable double standard that excludes the poor and unconnected from the benefit of a better death.

- (For a powerful formulation of this criticism, see Dworkin, "Introduction: The Philosophers' Brief," 41.) I take this double standard to be a definite liability of my approach, but one required by the moral necessity of avoiding other harms to other people. Describing my approach as informed by a "tragic" vision acknowledges the unhappy fact that no solution to the problem of dying in our society will be acceptable, fair, or humane to all. The most we can hope for here is "the least worst" policy.
87. In framing the question in just this way, Ronald Dworkin is guilty of posing a false dilemma in his otherwise admirable book. See Dworkin, *Life's Dominion*, p. 198.
88. This brief sketch of suggested reforms merely summarizes the careful work of the New York State Task Force. See *When Death Is Sought*, pp. 153-184.

Active and Passive Euthanasia

JAMES RACHELS

In this famous essay, Rachels argues that the traditional distinction between killing and letting die is untenable, that "killing is not in itself any worse than letting die." If so, then active euthanasia is no worse than passive euthanasia. Thus doctors may have to distinguish between active and passive euthanasia for legal reasons, but "they should not give the distinction any added authority and weight by writing it into official statements of medical ethics."

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 December 4, 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 judgment of the physician should be freely available to the patient and/or his immediate family.

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 option 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.*

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 let-

*Shaw A: Doctor, Do we have a choice? *The New York Times Magazine*, January 30, 1972, p. 54

ting "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. 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 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 should 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 face down 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 behavior 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 judgment 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 judgment? Moreover, suppose Jones pleaded, in his own defense, "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 defense should have at least some weight. But it does not. Such a "defense" can only be regarded as a grotesque perversion of moral reasoning. Morally speaking, it is no defense 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 judgment 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 defense 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 well 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.

The Distinction Between Refusing Medical Treatment and Suicide

NEW YORK STATE TASK FORCE ON LIFE AND THE LAW

In this report, the Task Force rejects the view that there is no significant difference between forgoing medical treatment and assisted suicide or euthanasia. It argues that equating the two would undermine patient autonomy and "make it impossible to limit physician-assisted suicide to competent, terminally ill patients, or to legalize physician-assisted suicide without also legalizing euthanasia."

The distinction between the refusal of life-sustaining medical treatment and suicide has been a critical component of all of our recommendations on end-of-life care. In our report on do-not-resuscitate orders, we grounded our legal analysis on the premise that suicide relates only to self-inflicted deaths and "not to a decision to refuse life-sustaining treatment." We reaffirmed this position in our report on the health care proxy, which found that "as a matter of public policy the taking of human life must not be granted legal sanction." Based on that conclusion, the health care proxy law, as enacted by the New York State Legislature, provides that "[t]his article is not intended to permit or promote suicide, assisted suicide, or euthanasia." Our proposed legislation on surrogate decision-making for incapacitated patients without advance directives contains a similar statement; the report accompanying the proposed legislation expressly states that surrogate decision-making is "not intended either as a step on the road to assisted suicide or as a vehicle to extend the authority of family members beyond the traditional boundaries established by consent to provide treatment or not to treat." Most recently, our report on assisted suicide and euthanasia proposed "a clear line for public policies and medical practice between forgoing medical interventions and assistance to commit suicide or euthanasia," and outlined the legal, ethical, and policy considerations distinguishing the two practices.

From The New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, Supplement to Report, April 1997.

We recognize that "the moral distinction between assisting to die and withdrawing treatment is hard to discern in certain cases." The alleged distinction between "acts" and "omissions," for example, is "particularly nebulous," given that physicians who comply with requests to refuse treatment are often required to undertake affirmative acts, such as disconnecting respirators or feeding tubes. Resting the distinction on a difference in intent is also not always persuasive, because "[i]n the act of disconnecting a life-sustaining ventilator . . . some physicians actually intend, not just to rid the patient of unwelcome technology, but to help the patient end her suffering by dying sooner.¹ Finally, as an empirical matter, it is undeniable that withdrawing or withholding life-sustaining treatment, at least in some cases, can play a causal role in any death that ensues. "When a doctor detaches a feeding tube from a patient who could have lived for an additional decade, albeit in a profoundly diminished state, she is certainly 'the cause' of death insofar as she determines when and how the patient dies."²

Nonetheless, the fact that the refusal of life-sustaining treatment and assisted suicide are similar in certain aspects does not mean that the practices implicate identical legal, clinical, ethical, and public policy concerns. The following factors, taken together, present compelling reasons to distinguish between the refusal of life-sustaining treatment and assisted suicide for law and public policy, despite the similarities that might exist in individual cases. Although these distinctions may not, in themselves, compel the conclusion that assisted suicide should