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MORAL RESPONSIBILITY
IN PHYSICIAN-ASSISTED DEATH

By

ROBIN L. TAPLEY, B.A., M.A.

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AUTHOR: Robin L. Tapley, B.A. (McGill University), M.A. (University of New Brunswick)

SUPERVISOR: Dr. W. Waluchow

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Abstract

This thesis is an investigation of the moral responsibility of physicians in assisted death. I begin with a discussion of the problem that drives the debate concerning end of life decision making. I conclude that the problem faced by those attempting to make decisions at the end of life is the bad death. A bad death is marked by a long, debilitating, incapacitating, dying process.

Given the problem of the bad death, I discuss what responsibilities the physician might have toward a dying patient. I conclude that the responsibility of a physician is to the wellness of his or her patient, whether that patient is dying or not. For the dying patient, continued existence, or a bad death may count as harm, and a good death as a benefit. Since promoting wellness for a patient means maximizing the benefits and minimizing (or eliminating) the harms, wellness for a dying patient might mean the avoidance of the bad death and the active pursuit of the good death, which I call death management. Since the physician's responsibility is to promote wellness, the physician has a responsibility to promote the good death for a dying patient.

Much of my argument hangs on the concept of "dying". I argue for a particular definition of dying and the conceptual distinction between death management and suicide.

I defend the claim that physicians have a responsibility to provide death management against the moral difference thesis which holds that it is morally worse to actively kill someone than to merely let that person die. I argue against this thesis and defend instead the moral equivalence thesis which holds that there is no moral difference between bare acts and bare omissions. I also discuss the doctrine of double effect, which represents a potential challenge to my argument. However, I show that the doctrine of double effect is, in fact, not applicable to cases of death management.

I conclude with a brief look at some of the concerns should death management become a social policy or legally sanctioned practice. My replies are necessarily brief, but sufficient to show that these concerns are not fatal to the legitimacy of death management.

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This Thesis is Dedicated
to
Gilles Marcotte
and to
my Mother and Father
for their
unfailing love
and support

TABLE OF CONTENTS

INTRODUCTION 1

CHAPTER 1: GOOD DEATH, BAD DEATH 10
- EVOLUTION OF THE BAD DEATH 11
- TECHNOLOGY AND THE BAD DEATH 19
- THE PROBLEM OF THE BAD DEATH 24
- USING TECHNOLOGY FOR THE GOOD DEATH 25
- OBJECTIONS TO THE USE OF TECHNOLOGY TO PROMOTE THE GOOD DEATH 31
- CONCLUSION 35

CHAPTER 2: RESPONSIBILITY 37
- THE LANGUAGE OF RESPONSIBILITY 40
- ROLE-RESPONSIBILITY 49
- WELLNESS AS THE ROLE-RESPONSIBILITY OF A DOCTOR 49
- WELLNESS IN CONTEXT 53
- WHEN TO INVOKE LIABILITY-RESPONSIBILITY AND DETERMINATIONS OF FAULT 57
- PHYSICIAN RESPONSIBILITY: FITTING TOGETHER THE PIECES 67
- PHYSICIAN LIABILITY-RESPONSIBILITY AND DEATH MANAGEMENT 70
- RESPONSIBILITY AND DIRECTIVES FOR ACTION 73
- CONCLUSION 78

CHAPTER 3: THE CONCEPTUAL DISTINCTION BETWEEN SUICIDE AND DEATH MANAGEMENT 82
- THE RELEVANCE OF THE DISTINCTION 93
- SOME HARD CASES 103
- CONCLUSION 114

CHAPTER 4: ACTIVE VERSUS PASSIVE EUTHANASIA 118
- INFORMED REFUSAL 119
- ACTIVE VERSUS PASSIVE DEATH 126

Callahan's Objections to Rachels 130
Response to Callahan's Objections to Rachels 134
The Crux of the Rachels-Callahan Debate 145
The Bare Difference Argument Tested 147
Conclusion 155

Chapter 5: The Doctrine of Double Effect and Death Management 161
For the DDE 162
Limitations of the DDE 171
The DDE and Death Management 174
Responsibility Versus the DDE 177
Conclusion 178

Chapter 6: Concluding With Concerns 181
Abuses and Safeguards 186
The Slippery Slope 193
Resources and Palliation 199
Final Thoughts 202

Bibliography 203

INTRODUCTION

Euthanasia is a complex issue. The more we talk about it, the more complex it becomes. Mixed up in our discussion are many other issues like suicide, the morality of intervention to either assist or prevent a death, the withdrawal of life support, the intention of a doctor in acting to end a life, and so on. Consequently, it is difficult to know exactly what the issue is, or where to begin. But begin we must. The moral standing of euthanasia is hotly debated. Some believe that suffering in death is simply the way of nature. Others see the suffering as needless if death is the unavoidable conclusion to the suffering. Still others argue that on the basis of autonomy, we ought to be in charge of our deaths. Those who disagree fear that the inevitable, but misguided, expansion of such a rationale will be used to justify otherwise unjustifiable deaths. Needless to say, euthanasia is an emotional issue, as well as a philosophical concern. One approach to addressing the issue of euthanasia is to deal with all the separate arguments and work our way into the core of the problem. I have chosen another approach. I begin with what I perceive to be the core concern from which the attractiveness of euthanasia springs. Once the heart of the issue is exposed, all the other attendant issues fall into place.

In Chapter one, I deal with isolating the problem. Why is it that euthanasia is such a troublesome issue? Why is it that we want to consider euthanasia as an option of choice? I answer these questions by identifying the bad death. The bad death is largely the result of our advances in medical technology, and our changing attitudes about death. The bad death is characterized by a long, slow, debilitating process of dying. I contend that it is the *sort* of death we die that engenders us with fear and dread more than the *fact* of death itself. I discuss the pre-modern and the modern death. The pre-modern death was typically characterized as a quick death. This sort of death has been called the "tame" death, or the "peaceful" death. Societal and technological changes have given rise to the bad death — the modern death. I propose that a solution to facing the bad death is the creation of a good death. Promoting a good death and taking steps to avoid a bad death constitutes what I call death management. Death management is an active, intentional, assisted kind of euthanasia.

In Chapter two, I discuss my terms of reference and the basic moral ideas that I will use in the determination of whether or not death management is morally permissible. Since death management requires the participation of a health care professional (most likely a doctor) the main focus of the moral assessment of death management is on the responsibilities of the doctor. "Responsibility" is a complex moral (and legal) term. I attempt in this chapter to clarify the various uses of the term and to settle on how we might go about evaluating a physician in the case where she or he either participates in, or opts out of, death management. The conclusion I draw is that the doctor has a responsibility to advance a patient's wellness. What counts as wellness for a particular patient will depend on certain relevant circumstances. For example, what counts as wellness will be different for the paraplegic than it is for the terminally ill patient. Now in order to help effect wellness for a patient, the doctor must act responsibly. This means, among other things, that the doctor ought not be in a position to be held liable for any harm that befalls the patient.

For a patient who is dying, I will argue, wellness can mean achieving a good death and avoiding a bad death. It is the doctor's responsibility to assist in achieving wellness, therefore it is the doctor's responsibility to assist in the achievement of the good death and the avoidance of the bad death. In pursuing the good death, the doctor must act responsibly. In order to act responsibly the doctor must take care to avoid acting with intention to do wrong, with recklessness, or with negligence. If a doctor does act in one of those ways, then any resulting harm can be that doctor's fault, and the doctor can be held liable for the harm.

I argue that it is the moral responsibility of the doctor to participate in death management when it is requested by the patient. In order for this argument to hold, two crucial things must be shown. First, my argument rests on a distinction between suicide and death management. It is in the Chapter three that I attempt to spell out exactly what this distinction is. The most crucial factor in the case of death management is that the patient is already dying. In a case of suicide, on the other hand, the person in question is not already dying. Describing the distinction in this way means that I have to investigate thoroughly what it means to be dying. I define dying as bodily systems decay leading to a significant systems breakdown unmitigated by significant renewal such that the life expectancy is foreshortened. This definition is really a combination of two factors. The first concerns the idea that our bodily mechanisms are, while we are living, in a constant cycle of decay and renewal. When the decay begins to overcome the process of renewal, the beginning of the dying process is, in part, marked. The other component to the definition of dying is the foreshortening of life expectancy. Foreshortening occurs when the distant, temporally undeterminable, fact of death becomes a temporally determinable reality of death.

The conclusions drawn from the arguments regarding responsibility also hang on the fact that in order for a doctor to participate effectively in death management, active and/or direct measures will probably have to be taken. Traditionally, active measures resulting in a patient's death have been thought to be morally wrong while passive measures have been recognized as regrettable but acceptable nonetheless. In Chapter four, I attempt to refute this moral difference thesis. For the most part, I follow the lead of James Rachels and conclude that there is no moral difference between a bare act and a bare omission and that active measures in death management are as warranted as are passive measures. In fact, I shall argue, active measures are often required morally if a doctor is to fulfil her responsibility to further her patient's wellness. Conclusions like these require defense against all sorts of challenges. I have attempted a response to several of these challenges, and confirm my original conclusion that the moral difference thesis is, in the context of death management, a non sequitur and a hindrance to morally responsible conduct.

In Chapter five I deal specifically with the doctrine of double effect which is commonly thought to represent a challenge to my argument. The doctrine is based in the distinction between direct and oblique intention. When a course of action has more than one effect, and at least one of the effects is a harm, the course of action may still be permissible providing it meets the criteria spelled out by the doctrine. I argue that the doctrine of double effect is not a challenge to the permissibility of death management. In fact, it is my position that the doctrine of double effect is not relevant to the moral assessment of death management since all the concerns raised by the doctrine are dealt with through the concept of responsibility.

In the final chapter I acknowledge that the permissive stance towards death management for which I have argued creates a host of further problems if death management is accepted as a general practice, or becomes part of a legally sanctioned policy on euthanasia. While it is not within the scope of this project to deal fully with these issues, I do briefly sketch a response to three categories of problems. In the first set are concerns about abuse should death management be adopted as a legally sanctioned practice. There are difficulties in writing and enforcing laws concerning euthanasia. As well, there are predicted problems with the pressure that the practice of death management will put on vulnerable people to choose that option when they otherwise would not have done so. The second set of concerns revolves around slippery slope arguments against the institution of a permissive policy on euthanasia. Once we take the first step in allowing humanely motivated killing, we will not be able to restrain the move towards accepting other forms of killing. The third and final set of issues concerns how other medical practices, treatments, and the quality of care will fare in the wake of legitimized euthanasia. It is feared that valuable resources will be stripped from areas like palliation and poured into euthanasia programs. There is also the concern that the general quality of care will be lowered, if the emphasis of care is not kept strictly on saving lives, and people are expected to avail themselves of the euthanasia option.

In an attempt to outline a response to these problems, I draw on what little empirical evidence is available to us. The experience with euthanasia in the Netherlands, where it has been essentially decriminalized, is the only documented evidence with which we can begin to judge the suppositions about what would happen were euthanasia to be legally sanctioned. Using this empirical evidence and plausible alternative visions of the future I try to assuage some of the fears surrounding the sanctioning of death management. I conclude that, while the problems with death management as a practice are large and frightening, they are not completely insurmountable. At the very least, they are of insufficient weight to warrant outright rejection of death management as a morally responsible response to the bad death.

It is very important to come to a decision about death management. If the bad death is tantamount to forced, unwanted, and unbearable continued existence, then the bad death is a serious problem. It cannot be ignored simply because it is not *necessarily* (though, as I argue in Chapter One, it probably is) the most prevalent type of death. That *some* people are dying what is undisputably a bad death is sufficient to make it a serious problem, worthy of our serious attention. The attention we devote to such a problem will be infused with emotional discomfort and possibly colored by personal anecdotes. Such factors may confuse and blur our philosophical vision of what we are really talking about when we discuss euthanasia and death management. I have not tried to make the issue of death management appear sterile and devoid of human feeling. In fact, I have, for the most part attempted to recognize that while this is a philosophical issue that needs to be dealt with in a philosophical manner, it is also an intensely lived reality for some people. It is concern for the human condition, or rather, what the human condition can deteriorate to for some people that drives my discussion of death management.

It is my contention that death management, as I have defined it, is a plausible, reasonable, and morally responsible response to a frightening problem. First, by speaking of "death management", as opposed to "euthanasia" or "assisted suicide", one is able to single out clearly one kind of situation in which bringing about the death of another person is within the moral responsibility of a doctor. "Euthanasia" is a term which covers too many relevantly different kinds of distinctions, and "assisted suicide" is a term which brings with it a serious bias against the proposed practice. By singling out a special kind of euthanasia which I call death management, and showing how the latter is conceptually different from assisted suicide, I hope to introduce a large measure of clarity into a confusing and emotionally charged debate. Given the reality of the bad death, this in itself is of no small importance.

A second advantage of focusing on death management is that we are able to see clearly that it is a form of treatment directed at achieving the wellness of the patient. As such, the same rules of prescription and treatment protocol apply to death management as to any other form of medical care. For instance, no treatment is justified unless it is reasonably believed that it will produce more benefit than harm to the patient. The same is true of death management. Secondly, any treatment is subject to the consent of the patient (or a valid proxy). Death management, as we will see, is governed by the same restriction.

The third attractive feature of death management, is that its practice helps to maintain the therapeutic relationship between the physician and the patient. This allows for continuity of care. In the context of death management, the doctor does not abandon the patient once nothing more can be done to preserve life. The doctor continues to treat the patient even when the focus of the treatment switches from trying to avoid death to trying to avoid the bad death. Accepting that death management is permissible, indeed an instance of morally responsible conduct, is not to accept that doctors should become killers. It is merely to accept that a doctor's duty is to provide appropriate care for a patient, whether that patient is living or dying.

CHAPTER 1:

GOOD DEATH, BAD DEATH

The problem is one of the bad death. Before, however, the problem can be addressed directly, what exactly a bad death is and how it comes about must be explained. This explanation is best achieved through a discussion of death in terms of its descriptive and circumstantial components, both of which have changed over time. In other words, death, or rather the way we die, is different now than before the rise of modern medicine. An analysis of this change will provide valuable insights into how we might challenge the modern bad death. Being able to cite the causes and/or the circumstances of the bad death will be crucial in determining a solution to the problem.

It will be my contention that the current prevalent mode of death is what is denoted by the "bad death". It is also my claim that modern medical technology and the attitudes developed around this technology are the leading contributing causes of the bad death. This is not to say that a death process which involves technology is necessarily a bad death. Rather, my point will be that the current use of technology is one of the causes of the bad death. Since the use of technology is within our power to change, it is my suggestion that we modify our use of technology during the death process so as to avoid the bad death and instead promote the good death.

THE EVOLUTION OF THE BAD DEATH

The pre-modern death has been termed the "tame death" by Callahan.[1] He claims that the tame death was characterized by three features. First, the tame death was ritualized and unchanged over centuries. In saying that the tame death was unchanged, Callahan is referring to the notion that the mode of death was not transformed by any significant medical or social change. Second, the tame death was familiar since life spans were short and death was an event common to every one in society regardless of age. In other words, death was a "steady and routine part of life."[2] Third and finally, the tame death was public, which is to say that there was a sense of community; one died with family

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[1] Daniel Callahan, The Troubled Dream of Life: Living With Mortality, (New York: Simon & Schuster, 1993) [Hereafter referred to as TDL] Callahan takes the term from the author Philippe Aries.

[2] Callahan, TDL, p. 26

and friends around.[3] To this description of the tame death, Callahan offers this caveat:

> Death is not, and should not become, a glorious event to be sought and embraced. It is an evil. It ruptures the solidarity of the human community. It forces the dying person out of the lives of those around her, a loss both to her and to others. The source of the evil is the "savagery of nature,"[4] a nature to be accepted but not romanticized. "Familiarity with death is a form of acceptance of the order of nature."[5,6]

Notice the emphasis on nature in the warning not to romanticize the tame death of the past. It is critical to the understanding of death that we consider the evolution of human control over nature.[7] Before the advent of various medicines and much of our present day medical and biological knowledge, we were at the mercy of nature. If we became sick or infected there was not much

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[3] Callahan, TDL, p. 27-28

[4] Philippe Aries, <u>The Hour of Our Death</u>, trans., Helen weaver (New York: Alfred A Knopf, 1981) p. 5-28, Daniel Callahan, <u>The Troubled Dream of Life: Living With Mortality</u>, (New York: Simon & Schuster, 1993) p. 29

[5] Philippe Aries, <u>Western Attitudes Toward Death</u>, trans., Patricia M. Ranum (Baltimore: Johns Hopkins University Press, 1974) p. 64, Daniel Callahan, <u>The Troubled Dream of Life: Living With Mortality</u>, (New York: Simon & Schuster, 1993) p. 29

[6] Callahan, TDL, p. 29

[7] In using the word "nature" I do not mean to enter into the debate over definition. It is not my cause at the moment to sort out exactly what constitutes nature and what does not. For the purpose of this section by nature I mean the absence of human agency.

we could do for ourselves. We could maybe undergo a little creative blood-letting, or have a few holes bored into our skull, but chances were that if we were going to recover, we would do so without the assistance of a doctor or any other kind of intervention by human agency. If we died as the result of the illness, then we died because of the course of nature, not because of human intervention or lack thereof. Since death was not under human control, that is, not manipulable by human agency, death was considered natural. As natural, death was accepted — not because it was a good thing — but because there was no choice. To color in the picture of the natural, tame death, consider what Callahan says:

> For the most part..., people in earlier times typically died of infectious disease of rapid onset and quick crisis; they did in fact die over a relatively short period of time. ...This meant that someone could be awake and alert, even if suffering, until the last moments. Death was more a discrete than a drawn-out, indefinite process.[8]

The pre-modern death then, was a death without human agency (natural), it was usually quick, and the dying person was usually conscious, and the death carried with it a meaning that was public, familiar, simple, and ritualized. Elisabeth Kubler-Ross tells the story of a pre-modern death:

> I remember as a child the death of a farmer. He fell from a tree and was not expected to live. He asked simply to die at home, a wish that was granted without question. He called his daughters into the bedroom and spoke with each one of them alone for a few moments. He arranged

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[8] **Callahan, TDL, p, 28-29**

> his affairs quietly, though he was in great pain, and distributed his belongings and his land, none of which was to be split up until his wife shoula follow him in death. He also asked each of his children to share in the work, duties, and tasks that he had carried on until the time of the accident. He asked his friends to visit him once more, to bid goodbye to them. Although I was a small child at the time, he did not exclude me or my siblings. We were allowed to share in the preparations of the family just as we were permitted to grieve with them until he died. When he did die, he was left at home, in his own beloved home which he had built, and among his friends and neighbors who went to take a last look at him where he lay in the midst of flowers in the place he had lived in and loved so much. In that country today there is still no make-believe slumber room, no embalming, no false makeup to pretend sleep. Only the signs of very disfiguring illnesses are covered up with bandages and only infectious cases are removed from the home prior to the burial.[9]

Though we cannot tell just from this story whether the cause of the farmer's death was internal bleeding, or an infection picked up as a result of the fall, it is clear that this farmer died in a way consistent with the description of the tame death. Though it seems that the farmer died within a relatively short period of time following the fall, he wanted to be at home, with his family and friends, to say good-bye and set things in order before his death. Notice how children were not shielded from death, but involved in the preparations and the grieving. Nowhere in the story is there mention of attempting to stave off the inevitable, nor is there any mention of doctor's visits. In other words, the death of the farmer was natural in the sense that

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[9] Elisabeth Kubler-Ross, On Death and Dying, (New York: Macmillian Publishing Company, 1969) p. 5-6

it came and went without human (medical) intervention or manipulation.[10]

The modern death is quite different, though it too has a number of predictable features. Some of us will die a quick death as the result of an accident or as the victim of a violent crime. Most of us however, have a much longer dying process awaiting us. Chronic conditions are the cause of 87% of all deaths.[11] At least 50% of the population dies of an illness diagnosed at least 29 months earlier.[12] As well, most of us will die this slow death in a hospital or other medical institution. In 1983, it was estimated that 80% of deaths occurred in this setting.[13] Add to this the fact that because our deaths are slow, and because we are likely to require hospitalization, our deaths are almost necessarily characterized by decline, disability, and incapacity.

Clearly, this modern death suggests a dying process radically different from the dying process of the tame pre-modern death. Where the former dying process is long, the latter is short. The modern version is an institutionalized death,

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[10] I thought it important to mention that the story Kubler-Ross tells of the farmer happened not so much at a great temporal distance, but rather in a country of slow technological advancement. So in the case of the farmer, it is not time, but technology that marks a difference in the designation "pre-modern" or "modern" death.

[11] Robert M. Veatch, Death, Dying and the Biological Revolution, (New Haven: Yale University Press, 1989) p. 3 [Hereafter referred to as DDBR]

[12] Veatch, DDBR, p. 3

[13] Veatch, DDBR, p. 3

while the pre-modern death is not. While the modern dying process is a process that fights nature, i.e., brings to bear all the armament of technology and all we have learned in harnessing nature, the pre-modern dying process eschews attempts to thwart death. None of this is to say that the pre-modern death was necessarily less painful, or more noble, than the modern death. Indeed, I do not wish to make the mistake of romanticizing the past. However, it remains the case that the modern death is different, and this difference is for the worse. I hasten to add that it is possible for a person dying in this day and age to die a tame death. It is just not particularly likely. The modern and pre-modern deaths do not designate necessary descriptions of a death, rather they serve as illustrations to the prevailing characterization of death in different circumstances. While the modern dying process may be, in fact, less painful (due, e.g., to pain killing drugs), and further from consciousness (due to the same drugs), whatever the conditions of the dying process, they typically will be endured longer. The length of the dying process might not be an issue if it were not for the fact that slow killers, like heart disease and cancer, do not leave one feeling fully healthy until a few days or weeks before death. Both heart disease and cancer are more likely to bring on decline, disability, and long bouts of sickness. This in turn means that illness is more likely to be of a chronic, lingering type, rather than an acute, rapid type.

Another way by which we can discriminate between the modern and the pre-modern death is to talk about each in terms of the fear of death. More specifically, we have good reason to fear the modern death, and less reason to fear a pre-modern death. Allow me to explain. Consider the modern death. It is not a pretty picture. Anticipation of this kind of death must be frightening. Indeed sociological and psychological studies on death support this suggestion:

> Weisman and Hackett (1967) indicate that for many the dread of impairment is greater than the fear of death. Extinction is feared less than progressive dissolution. From another study of 168 elderly individuals in Kansas City, Williams and Wirths (1965) [found it striking] that again and again respondents volunteered that they dreaded crippling accidents or chronic disease. Immobilization of the action system rather than death was the great source of anxiety among the aging. Fear of the method of dying was greater than the fear of death per se. Weisman and Hackett (1967) indicate further than most aged patients do not eagerly anticipate death; neither are they afraid of death. It is not unusual, they say, to find aged patients openly expressing envy of another patient who had died quietly and without complaint during sleep. [14]

It seems then, from these observations, that we more closely associate fear with the *mode* of death, rather than with the *fact* of death. The dying process is what is at issue. What makes a death particularly feared or not is the anticipation of the dying and not of the death itself. If this is the case, then the modern death would be more feared than the pre-modern death. Given that the death processes are so different, and that the modern death is so clearly the longer and more debilitating

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[14] Glenn M. Vernon, Sociology of Death: An Analysis of Death Related Behavior, (New York: The Ronald Press Company, 1970) p. 181

of the two, the modern death is obviously the more feared death.

Given the above, it seems reasonable to claim that the modern mode of death is a bad death. The modern mode of death is understandably dreaded and it seems an appropriate inference to say that the modern mode of death would, and probably should, be avoided if possible by most, if not all, rational individuals. The point is that if given a choice between a pre-modern mode of death and a modern mode of death, it seems reasonable to assume that the choice would be, in most, if not all, cases, for the former rather than the latter.

To make the point another way, suppose an individual had sufficient control over the mode of her death to decide between a long, disabling, declining, and incapacitating dying process, and a dying process that minimized or eliminated such characteristics. It is my contention that most rational individuals would choose the latter type of dying process over the former. I say "most" rational individuals since I want to leave open the possibility that an individual might, for various reasons, prefer the bad death. For example an extremely religious person might see suffering as a path to heaven. In this case it could be rational for this individual *not* to make an effort to avoid a bad death. The rationality of a patient is an issue for any decision that patient makes regarding his or her care. Choices about mode of death would be subject to the same parameters as any other medical care decision. Be this as it may, I maintain that barring some special circumstance, a patient would choose a good death over a bad death. In other words, if a patient could avoid the lengthy debilitating incapacitating dying process, that patient would do so.

TECHNOLOGY AND THE BAD DEATH

What is central to the modern bad death — what has changed the way we die, for instance, from quick to slow — is technology.[15] Science and technology have largely done away with the infectious diseases of the pre-modern era that kill quickly, and have lengthened the life expectancy of those with chronic illnesses like cancer and heart disease.[16] Moreover, technology has afforded us the opportunity to extend life significantly by artificial and mechanical means. This is not to say that technology has insinuated itself into our lives uninvited. Certainly there are a great many people who benefit from organ transplants, new surgical procedures, short term life support and the like, and go on to live relatively healthy and productive

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[15] By technology I mean primarily medical technology and science. Certainly the technological advances in other areas are influential, and as such are subsumed under the term "technology".

[16] This is not to suggest that the only issue here is the length of the death process. Certainly there are pre-modern type diseases and illnesses that would not yield a death process any better than the modern death. What is at issue, however, is that slow death processes are usually accompanied by a decline of the faculties and abilities. It is this slow dissolution of our bodies that people fear more than death itself.

lives. The point is, however, that technology is a double-edged sword. While it helps provide full recovery for some, it can also extend life beyond all hope for even marginal recovery for others.

None of this is to say that the entire evolution of the modern bad death is the fault of technology. Technology is merely what has made possible the modern death. There is, of course, no guarantee that without technology the pre-modern death would still be the norm. However, since technology is a key factor, it is worth the effort to explore exactly how technology makes the modern bad death possible.

Technology has given rise to three intertwined changes in the way we think about, and deal with, death. First, as Callahan observes that technology has made possible the insertion of morality into our concept of death. Second, and as a consequence of the first, technology has helped to create the illusion that human agency has the ultimate control over life and death. Third and finally, technology has led to the technological imperative that what can be done shall be done.

Previously, I discussed the connection between the pre-modern death and its moral status. The pre-modern death was an evil, but an accepted evil. Callahan makes a similar point:

> Death was initially understood by human beings as a natural event, as much an inevitability in their lives as the death of every other organic creature. At the same time, death was widely experienced as an evil, as a threat to our

> desire to live and to our social lives. But it was interpreted as a religious, metaphysical, or psychological evil, not a moral evil. Why was it not, save for murder, a moral evil? Because it was beyond human control, something visited upon us, not caused by us. Historically, there is good evidence that not until the eighteenth century was it even considered part of the duty of physicians to save life. ...It is a modern notion, and necessarily so: it was not conceivable until doctors could actually preserve life.[17]

Not only did medical advances make effective treatment and cure possible, the advent of this possibility inserted a moral component into the concept of death. Death is no longer something merely visited upon us. With the possibility of defying death in certain circumstances comes the evaluation of the attempt to do so. Callahan expands on this notion of the morality of death:

> As it became increasingly possible to manipulate the conditions of dying, fatalism was rejected and a moral dimension added. That dimension soon took the form of a simple principle: since death is an evil in human life, we have a moral obligation to use medical means to combat it. What can be done to struggle against death ought to be done. That gradually became the working moral premise of modern scientific medicine, fully supported by religious and secular authority.[18]

What all of this means is that the notion that death is out of our control, and in that sense natural, gave way to the idea that death was controllable, beatable, and this could be accomplished through human agency. If this is the case — that death

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[17] Callahan, TDL, p. 59

[18] Callahan, TDL, p. 60

is under our control — then naturally, we would have a duty to combat it. In short, while the evil of death was out of our hands, there was nothing we could do to fight it. However, when something could be done, and since death was and is not counted as a good thing, but rather as an evil, we ought to do that something. In the case of avoidable evil, "can" implies "ought". Since we can do something about death, we ought to do something about death.[19] Incredible advances in medical science gave us the tools of antibiotics, vaccines, and so forth that made previously deadly diseases and infection curable or avoidable. Certainly medicine looks powerful from this perspective. Every death has a cause and every cause has a cure, therefore, in theory, death is curable[20]. Exciting as curing every potentially fatal disease might be, it gives rise to what Callahan calls the moral logic of medical progress:

> The scientific imperative of progress [medicine can consonantly advance the frontier of human health], part of the idea of medical science, is broadened to include a moral imperative: if we do not pursue the conquest of disease, we are open to moral blame. People will die who

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[19] This is not to say, of course, that doctors practicing before the rise of modern medicine did nothing in an attempt to stave off death. Certainly treatments were tried, but since they were rarely effective, the notion of death as not subject to human agency prevailed.

[20] It may seem odd to talk in the manner of death as *curable*, rather than saying that death is avoidable, etc. Callahan does in fact talk about death as curable, but curable in theory only. The strange terminology is used to make a point, which is that a mistake in reasoning has lead to an unproductive goal: the *cure* of death.

> need not die. If we do not use our newly available technologies to save lives, we can be held accountable for the loss of those lives. The hidden, but hardly arcane, premise here is that we have a duty to relieve suffering and to save life. If medical progress makes that possible, then we are *obliged* to pursue it.[21]

The notion of medical science as unlimited in potential only gives more credence to the idea that medicine can "cure" death. Moreover, if we do not think this way about medicine, we will essentially be letting people die needlessly, and will thus be morally blameworthy. Clearly this sets up death and medicine as adversaries, as opponents in a moral battle over human life.

We are consequently stuck in a bit of a quandary concerning what we think about death. If we view death as a natural thing — that it is out of our control — then we will view medical science as limited. Viewing medical science as limited will be counter-productive, since doubting the power and efficacy of science may create barriers to the discovery of new treatments, procedures, and cures. At other extreme, when we view death as fully under human control, or at least see the control of death as the fully realized goal of medicine, we are faced with the prospect of increasing the occurrence of the bad death. Of course, we cannot seriously and consistently hold that the whole goal of medicine is to gain control of death since that would mean overcoming mortality which seems more like science-fiction than medical science.

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[21] Callahan, TDL, p. 61

Now the moral logic of medical progress and the consequent illusion of the possibility of control over death has led to what has been called the technological imperative. The technological imperative dictates that what can be done shall be done. In other words, all technology and knowledge must be brought to bear on the process of death. When the technological imperative is taken to the extreme we get what Callahan calls "technological brinkmanship":

> By [technological brinkmanship] I mean there has been a powerful clinical drive to push technology as far as possible to save life while, at the same time, preserving a decent quality of life. It is well recognized by now that, if medical technology is pushed too far, a person can be harmed, that there is a line that should not be crossed. I define "brinkmanship" as the gambling effort to go *as close to that line as possible* before the cessation or abatement of treatment.[22]

The practice of technological brinkmanship is a manifestation of the way in which technology has changed our thinking about death and dying. Clearly in emergency situations, brinkmanship might be quite reasonable. However, as a general protocol for health care it is problematic in that it is the final necessary element in giving rise to the bad death, the modern death.

THE PROBLEM OF THE BAD DEATH

The bad death then, has arisen out of the evolution of medicine, changes in our thinking about death and changes in our thinking about the

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[22] Callahan, TDL, p. 41

objectives of medicine. We are now in a situation where death is viewed as a moral evil, and people must be made to, or helped to, live as long as technologically possible, or that moral evil surfaces. As a result, the dying process is prolonged and marked almost inevitably by disability, fear, and dissolution. Part of the problem of the bad death is that it seems unavoidable. The invisible hand seems to have designed things such that the price we pay for a longer life is a longer, more debilitating, more stressful dying process. Unfortunately this longer death bears little or no resemblance to the pre-modern death.

It is important to stress again that not all deaths, even those which are technologically extended, are bad deaths.[23] There is little double that at least some deaths occurring in the modern era are of a pre-modern type. While this may be factually true, it does nothing to solve the problem of the all too typical bad death. The bad death is more prevalent and as such requires attention.

USING TECHNOLOGY FOR THE GOOD DEATH

Among proposed solutions to the bad death, certainly the most

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[23] I do not wish to confuse the point but I feel it necessary to say that it is not impossible for a bad death to be the "natural" result of an illness. Even without any application of life-extending or enhancing technology, a death can still be a bad death. It is possible that the technological answer for the bad death that I am suggesting would be an equally viable solution for the "natural" bad death. I do wish to emphasize that my main argument here refers to the techno-induced bad death and I maintain that it is technology that is one of the leading causes of the bad death.

controversial is euthanasia. Broadly defined, euthanasia is the term used for all killing of a person for whom death is thought to be a preferable alternative to life on humanitarian (e.g., pain and suffering) grounds. Obviously such a broad use of the term is problematic. Such a definition encompasses all sorts of categories such as: active and passive, voluntary and involuntary, and assisted and unassisted. No matter what the combination of these categories however, the idea is the same. Euthanasia is an attempt to end or avoid the bad death. If technology, especially life extending technology, is partly to blame for the bad death, then it stands to reason that eliminating the technology (at least the kind that extends the death process) should improve the conditions of death. The right to refuse treatment or have treatment withdrawn, even if doing so hastens death, arises from this desire to avoid the bad death by eliminating the technology which helps bring the bad death about.

The problem of the bad death has, as its leading contributing causes, technology and the technological imperative. When this imperative is viewed as an absolute it leads to technological brinkmanship. But if technology is such a problem, what ought we to do about the role of technology in health care, and more specifically, in our deaths? We have two basic options: 1) using less technology, and 2) using more technology.[24] The first is that we could put aside

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[24] It could be argued that using technology differently might comprise a third option. For now I want to include using technology differently under the second

much or all of our technology and turn the absolutism of the technological imperative into an absolutism of technology avoidance. Perhaps this course of action would lead to more quick deaths, but it would also mean the deaths of people for whom cure (or an extended valuable life) is possible. Clearly it is not reasonable to suggest that total abstinence from technology is going to yield more favorable results, on balance, than we have now.

We could weaken the technology-avoidance option in an attempt to render it more promising to suggest that instead of eschewing all use of technology, we must refrain from using only that technology and those treatments which prolong the death process in an unacceptable way. The problem, of course, is to delineate precisely *when* the use of technology *would* be acceptable. It may be difficult to establish clear guidelines upon which we could all agree and which would not be subject to an unacceptable degree of misapplication or abuse. For example, in one set of circumstances, a respirator or cardio-pulmonary resuscitation might seem to constitute an acceptable life saving intervention. In another set of circumstances employing such measures could contribute to a lengthy and unacceptable dying process. But how to characterize these circumstances properly is a difficult question admitting of no easy solution.

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option of using technology as a different use of technology would mean more rather than less exposure to technology. For example if one technology can be used in several ways, then we are more likely to be exposed to, or come into contact with, that technology.

Callahan makes a similar point when he talks about the techno-imperative and the attempt to limit the application of technology:

> ...aggressively work to prolong life until it becomes futile, or harmful, to continue doing so; then just as boldly, halt life-extending treatment. But this seemingly obvious strategy assumes an ability to manage technology and its consequences with a delicacy and precision that medicine simply does not possess and may never possess. The effort to go as close to the line as possible is itself the problem...[25]

Of course, when to use technology and how far to go with it are questions faced in almost every clinical encounter. Certainly decisions about the appropriate use of technology will be present in any case except extreme abstinence of all technology. My point here is a little different. If the goal of the use of technology is to extend the life of a patient, then any and all technology that has a reasonable chance of doing so will be used until its use becomes futile. This still leaves the patient with (potentially) a bad death. In fact this is one of the ways in which the use of technology causes bad deaths — sometimes the use of technology can over-extend a life such that once the technology is withdrawn or becomes ineffective, the patient is in a worse condition than if the technology had not been applied in the first place. Clearly the strong version — total abstinence from technology — is not workable. Neither is this weaker version. To attempt to limit technology, even if choices about when to use technology are made in good

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[25] Callahan, TDL, p. 41

faith with the patient's best interest at heart, will only create more bad deaths and do very little to avoid bad deaths. It turns out this way because by using technology solely on the basis of maintaining life, we miss the point that this may not be the only tenable end for the use of technology, especially considering that the price of a longer life is often a longer dying process.

If our first option, in either its strong or weak form of limiting the use of technology holds little promise of helping to achieve the good death, then perhaps the answer lies in *expanding* rather than *shrinking* the role of technology. That is to say if technology has the power to change our lives, and it most definitely does, then should it not also have the power to change our deaths? This notion of expanding the role of technology in its application to the death process is the second option. Technology has already changed our deaths in one direction, by promoting the circumstances that give rise to the bad death. Isn't it possible that the very same technology might be used to *promote* a good death? In other words, might not the promotion of a good death, in addition to the promotion of a good life, be a legitimate end of technology?

To make the point another way, simply using technology to the point of futility or harm, and then withdrawing the technology completely is not enough to assure a good death. The mere absence of technology may not be enough to overcome the damage of the already over-extended life. So if restricting technology will not, by itself, promote the good death, then perhaps technology could be applied, used, and brought to bear to *promote* the good death. Once all hope for continuing life is abandoned and death is imminent, perhaps technology could change, or improve, the process of our death. Life-ending treatment could be as beneficial an application of technology as life-extending treatment, *but only once extending life has raised the specter of the bad death.* For example, we have drugs to induce a death no more physically traumatic than falling asleep. We have adjustable dosages for medication that can at one dose ease discomfort, and at another hasten death.

The problem now is that technology does not apply itself; drugs do not prescribe themselves, and dose recommendations on charts do not change on their own. Someone applies technology, writes prescriptions, and cares for the dying patient. Because of the immense power of the science and technology of medicine, we as a society have mandated that only those trained in its use are licenced to wield its power. Health care providers, doctors in particular, by virtue of their specialized education and training, undertake the burden of caring for the rest of us. This background makes the health care professional an obvious candidate for applying technology to avoid a bad death and promote a good death.

OBJECTIONS TO THE USE OF TECHNOLOGY TO PROMOTE THE GOOD DEATH[26]

It could be argued that allowing health care professionals to promote a good death is incompatible with the aims of medicine. The viability of this objection, however, is contingent upon a certain interpretation of the aims of medicine. If death is the enemy of medicine, then allowing, never mind promoting death is not compatible with the aims of medicine. There is good reason to believe that the widespread view is that a principal goal of medicine is to vanquish death. Veatch claims that our fixation on technology

> make[s] it appear that we are engaged in a struggle against death itself, that, as never before, we look upon it as an evil. We are mobilizing technology in an all-out war against it, and we are assuming that, if not death itself, at least certain types of deaths are conquerable. ...As humans first learned to control infectious diseases, then social diseases, and now chronic illness, they seem now to close in on death itself, leading some to treat it as an immoral power to be driven from the community like the Salem witch.[27]

Callahan, in the same vein, thinks that we desperately want to believe that

> medicine can, in its conquest of disease, remove the unpleasant, distressing *causes* of death, thus transmuting

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[26] **It is not my intention to provide conclusive exhaustive arguments in this section. My goal is to establish that using technology to promote a good death is a plausible option worth exploring. Further arguments in support of this option will be taken up in more detail later in the thesis.**

[27] Veatch, DDBR, p. 3, 4.

> it from a condition to be feared to one that can be managed and tolerated. If death can be socially hidden, and medicine can remove its sting, then it can cease to be of consequence in the lives of individuals or society.[28]

If we as a society think that death itself is an evil, and that medicine is our only weapon against its immoral power, then we are unlikely to find promoting a good death compatible with the death-avoiding goals of medicine.

However, both Callahan and Veatch go on to say that while this might be the way we think about death and medicine, ultimately we are wrong. Both authors point out that death is not an "evil" or an immoral power; rather it is a biological fact. It is inevitable. Once we conquer one cause of death another develops to take its place. What is really incompatible with medicine is the expectation that it can change (physical) mortality to (physical) immortality. Since this change is physically impossible as things now stand, it is hardly necessary to maintain that the *elimination* of death altogether is one of the aims of medicine. Instead, the aim of medicine is the *avoidance* of death where this is possible and desirable, meaning that we accept that death cannot be entirely overcome.

Once we have taken the step of accepting death itself as inevitable, we can shift the focus back to the mode of death. Here we can accord the medical profession some power and remain consistent with a more realistic

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[28] Callahan, TDL, p. 32.

rendering of the aims of medicine. The revised aims of medicine, given the acceptance of the fact of death, should contain some provision for the care of the dying. In other words, once promoting good health is not possible, and further technological extension of life is futile or harmful, then a bad death should be discouraged and a good death promoted. Rejecting this idea is tantamount to suggesting that we abandon a patient once we can no longer extend her or his life. This goes no distance in promoting a good death. Having established that caring for the dying is compatible with the general goals of medicine, and that the avoidance of a bad death is of concern to the patient, the permissibility of promoting a good death seems obvious.[29]

A second worry about including the promotion of a good death under the health care mandate is that if doctors and other HCPs[30] accept the reality of death, and life ending treatments for the promotion of a good death are available, moral concerns about what is perceived as professional killing will arise. Certainly if what I am suggesting translates into the "Grim Reaper" specialization producing HCPs who make a clinical practice out of administering life ending treatments, then

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[29] Please note that while there is a distinction between promoting a good death that occurs earlier than it would otherwise and promoting an early death which is good, such a distinction serves no purpose at the moment. It is true that the promotion of a good death may, in some cases, lead to an earlier death, but it is not the timing of the death that is at issue. Rather it is the nature of the dying process that is designated by the term "good death".

[30] HCP refers to Health Care Professional

the concern is justified. However, if located within the context of caring for a patient in life, promoting a good death may be viewed as the end stage in doing what can be done for a patient. A bad death is not a new category of illness requiring the services of a specialist. A bad death is the result of the attempts to promote health, and when this can no longer be done, the imminence of death is not the result of a new illness; it is the signal to shift our focus from preventing death to preventing a bad death.

While the worry over the consequences of allowing HCPs to promote a good death is understandable, the concern regarding the consequences of *not* allowing HCPs to promote a good death and forcing them to leave their patients to a bad death is just as understandable and serious. If a patient cannot turn to a HCP to help promote a good death, the patient has limited resources from which to create her own good death. Perhaps one could arrange to die from carbon-monoxide poisoning in her or his own garage. Or maybe one could find the strength to pull the intravenous tubes from his or her own arm. These deaths however, would hardly qualify as good deaths. A more accurate characterization would describe them as desperate and tragic. These deaths are all the more tragic when you consider the alternatives that could be provided by the person's own doctor. With a doctor or HCP helping the patient to avoid a bad death, the doctor removes the desperation and much of the tragedy.

CONCLUSION

The problem of the bad death is that such a death involves a dying process of a highly unattractive nature. Certainly the prospect of death is bad enough without having to add to the mix a long and tortured means to that ultimate end. Given the technological imperative and our current conceptualization and valuation of death as a humanly controllable moral evil, a bad death seems almost unavoidable. But if we can begin to understand how the bad death comes about; that it is caused in part by our own conceptual misunderstanding of death as itself somehow under human control; and there seems to be a considerable lag between social and technological advancements; we leave some room in which to try to turn the tide away from the inevitability of bad deaths.

As I have mentioned, one controversial solution to the bad death is often claimed to be euthanasia. Of course, this term can mean a number of things and we must be careful not to allow confusion about its meaning to cloud our reasoning about death and the death process. What I have suggested is that we should, under appropriate circumstances, actively use the very technology that has been causally implicated in the bad death to promote the good death. This is a form of euthanasia. But it is important to stress that it is also *active* in the sense that there is active participation on the part of a HCP, *voluntary* in that the patient experiencing the bad death makes a request for a good, or at least better, death (which means that the promotion of a good death is not morally impermissible on the grounds of consent). And finally, it is *assisted* since the doctor is providing the technology and its application for the good death. As a solution to the bad death then, I am proposing a certain version of active, voluntary, assisted euthanasia. In so far as a good death means utilizing medical technology under the control of HCPs, it follows that it will inevitably require the involvement of an HCP, usually a doctor. My argument will be, then, that it is sometimes the doctor's responsibility, under certain conditions, to participate in the active promotion of the good death.

CHAPTER 2:

RESPONSIBILITY

In order to determine the moral permissibility of a doctor actively promoting a good death, i.e, participating in death management, certain moral language will have to be invoked. In other words, there must be some terms with which to describe what it means for conduct to be morally permissible, impermissible, or morally neutral. I have elected to use the language of 'responsibility' for several reasons. First, in most of the cases with which I am concerned, the outcome of the case is one of the paramount moral elements under consideration. Since the bad death is a harm[1] and the good death ostensibly not a harm, it seems fitting to use, in most cases, ends-oriented language — which allows us to talk of *outcomes* of harm and/or benefit — in the description of the cases. The language of responsibility lends itself nicely to

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[1] By 'harm' I mean a serious setback of an interest where an interest is a stable state and not a passing whim.

outcome oriented moral assessment. Thus we can talk about a doctor being responsible (in a number of idioms) for a patient, that patient's health and the nature of that patient's death. Second, and perhaps more importantly, the language of responsibility is useful in framing clearly our moral concerns regarding the participation of a HCP in death management. Given the obscurity of much of the discussion about assisting patients to die well, we should strive for as much clarity of expression — and thought — as we can.

Let me begin with an example. A patient is dying. She has reason to believe that her death will be a bad death. She wants to change that and design a good death. In order to do this, she needs the help of her physician, as her physician has access to the technologies and knowledge that is necessary to the type of death she wishes to design. (The physician, if following the technological imperative, can be instrumental in creating a bad death, and if following a directive of the patient's request for death management can be instrumental in creating a good death). Now if the moral question arising in this situation lies not in the dying patient wanting a good death rather than a bad death (and whatever it will mean to pursue the good death — like active, direct, or intentional activities), it must be in the response of the doctor.[2] What should the response of the doctor

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[2] The reason that the arising moral question does not lie with wanting a good death over a bad death is that — following from inferences made in the last chapter — I maintain that barring extreme circumstances, the rational individual would choose a good death over a bad death. If this choice is at least prima facie

be? How will we evaluate her response? It is her response to the situation, not the situation itself, that will be judged as right or wrong. The doctor is the party responding, so it is the doctor who will be judged.

The questions concerning the moral permissibility of death management now are: How should the doctor behave when a patient requests death management? What are the doctor's responsibilities regarding that patient? What are the doctor's responsibilities regarding his or her profession? If the doctor participates in the death management, is the doctor responsible (as in culpable) for the death of that patient? If the doctor does not participate in death management, is the doctor responsible for the continued forced existence of the patient and the ensuing bad death?

Part of my strategy in answering these questions is to establish a presumption in favor of a reconceptualization of the role of doctor. I want to show that there are good reasons for thinking that the good death of a patient is as much the responsibility of a doctor as is any other kind of medical treatment undergone by that patient. In reforming the role of doctor I want to undermine the often implicit notion that when a doctor is in any way involved in the death of the patient, then that doctor is culpable for that death. I want to show that it is possible

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reasonable, and if there are no other issues such as coercion or such, then preferring a good death to a bad death is not the moral question with which we need be concerned.

for a doctor to be involved with the death of a patient where this involvement is a fulfilment of responsibility to the patient rather than a violation of responsibility to the patient.

The first task is to sort out the appropriate uses of the term "responsibility". There are a number of different senses of the term in use. All of these senses are meaningful, but the meanings are different. What is needed then, is to make precise our usage of the term 'responsibility'. What we shall find in the sorting out of the various meanings of the various expressions of responsibility is that a doctor has certain responsibilities to his or her patients which revolve around a patient's wellness, and that to participate in death management is to properly avoid liability for a bad death. While it is important to tease apart all the senses of responsibility, the two most important for this discussion will be "role-responsibility" and "liability-responsibility."

THE LANGUAGE OF RESPONSIBILITY

H. L. A. Hart has four heads of classification for the term 'responsibility': a) Role-Responsibility, b) Causal-Responsibility, c) Liability-Responsibility, and d) Capacity-Responsibility. The first of these, role-responsibility, is an explanation of an agent's relationship to an action or event by virtue of the professional position of the agent. Certain positions, professions, or other socially constructed designations are defined by the agent holding the position which means that he or she stands in a certain normative relationship to others. For example, a man in the role of Captain of a ship, stands in a certain relationship to others. This certain relationship usually consists of the agent's having duties to others. To be the Captain of a ship is to take on certain duties to his passengers and crew. Hart explains:

> ...whenever a person occupies a distinctive place or office in a social organization, to which specific duties are attached to provide for the welfare of others or to advance in some specific way the aims or purposes of the organization, he is properly said to be responsible for the performance of these duties, or for doing what is necessary to fulfil them. Such duties are a person's responsibilities.[3]

Now a person in a position in a social organization may have any number of duties, not all of which would count as responsibilities. For example, a doctor may have a duty to be on time for appointments, and also to oversee a particular patient's treatment. Hart offers the following for the determination of which duties are responsibilities:

> I think, though I confess to not being sure, that what distinguishes those duties of a role which are singled out as responsibilities is that they are duties of a relatively complex or extensive kind, defining a 'sphere of responsibility' requiring care and attention over a protracted period of time, while short-lived duties of a very simple kind, to do or not do some specific act on a particular occasion, are not termed responsibilities. [4]

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[3] H. L. A. Hart, "Responsibility," in Philosophy of Law, eds., Joel Feinberg and Hyman Gross (Belmont, California: Wadsworth Publishing Company, 1986) p. 474 [hereafter referred to as RES]

[4] Hart, RES, p. 475

I take it that what Hart is trying to suggest is that those duties which are essential to the definition of a role are responsibilities. So a doctor can still be a doctor even if she is late for an appointment. She may have a *duty* to be on time, like any of us, but it is not within the sphere of *responsibility* she is committed to *as a doctor.* Overseeing a patient's treatment, on the other hand, is an essential component of the role of doctor and therefore at the very core of the sphere of responsibility. Without taking on the duty of overseeing treatment as a responsibility of the role of doctor, one is not a doctor.

Role-responsibility may appear as a bit of a truism; as a classification that does not tell us much. Role-responsibility however, does help to make sense of certain usages of the term 'responsible'. Citing a person as a responsible person, or claiming that one acted responsibly are two examples. So a parent who carefully inspects the child's Halloween candy is behaving responsibly. The teacher who recognizes students with special needs and fulfils those needs, is behaving responsibly. Hart would agree:

> A 'responsible person', 'behaving responsibly' (not 'irresponsibly'), require for their elucidation a reference to role-responsibility. A responsible person is one who is disposed to take his duties seriously; to think about them, and to make serious effort to fulfil them. To behave responsibly is to behave as a man would who took his duties in this serious way. [5]

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[5] Hart, RES, p. 475

Causal responsibility is rather tricky. For one, it is usually possible to substitute 'caused' for 'was responsible for' but the substitution does not work the other way around. Hart explains with an example:

> 'The long drought was responsible for the famine in India.' In many contexts, as in this one, it is possible to substitute for the expression 'was responsible for' the words 'caused' or 'produced' or some other causal expression in referring to consequences, results, or outcomes. The converse, however, is not always true. [6]

Now the point of the substitution example is to highlight that often when we use the term 'responsibility' it functions to merely cite a *cause* of some action or event. We are hardly *judging* the long drought; we are merely pointing out the cause of the famine. Causal responsibility is limited to this sort of cite-of-cause usage. Should some sort of moral or legal judgement piggy-back on this cite-of-cause, another sort of responsibility is being used.

> The past tense of the verb used in this causal sense of the expression 'responsible for' should be noticed. If it is said of a living person, who has in fact caused some disaster, that he *is* responsible for it, this is not, or not merely, an example of causal responsibility, but of what I term 'liability-responsibility'; it asserts his liability on account of the disaster, even though it is also true that he is responsible in that sense because he caused the disaster, and that he caused the disaster may be expressed by saying that he was responsible for it. On the other hand, if it is said of a person no longer living that he was responsible for some disaster, this may be either a simple causal statement or a

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[6] Hart, RES, p. 475

statement of liability-responsibility or both. [7]

Liability-responsibility then, differs from *causal-responsibility* in that it is a statement asserting blame, that compensation is required, or that the person in question is liable. There are two types of liability-responsibility; there is *legal* liability-responsibility and *moral* liability-responsibility.[8] It is Hart's contention that the legal version has a wider extension. He says:

> But in the case of the present topic of liability-responsibility, separate treatment [of legal and moral versions] seems advisable. For responsibility seems to have a wider extension in relation to the law than it does in relation to morals, and it is a question whether this is due merely to the general differences between law and morality, or to some differences in the sense of responsibility involved. [9]

At a later point in his article Hart concludes that any differences between the legal and moral sense of liability-responsibility are due to exactly what he suspects; the general differences between law and morality. In the law it is common for individuals to be held responsible (liability-responsibility), not only for what they themselves do (strict liability) but also for what their servants or employees do; this is a reference to law on "vicarious liability". Vicarious liability in morality is much less common, if it exists at all. It would require certain extenuating circumstances for

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[7] Hart, RES, p. 475

[8] There may be other types of liability-responsibility, but these are the two with which I am most directly concerned.

[9] Hart, RES, p. 476

a person to be morally responsible (liability-responsibility) for actions or events over which he or she had no control but which were under the control of his or her servants or employees.

Aside from liability-responsibility being an issue for both law and morality, there is another problem with the notion. At least in the legal context, the terms 'liability' and 'responsible' do not mean the same thing. To be held *liable* means being held susceptible to punishment, or to being required to make compensation. *Responsibility*, on the other hand, in the legal context, normally refers to the conditions, usually psychological, under which an action takes place. One has to be *responsible* for one's actions (that is, have a connection to the action in such a way as) to be *liable* for those actions. Thus one cannot be held liable for that for which she is not responsible. In order to be held *liable*, two conditions must be met. First, the person whose liability is in question must be responsible for her actions. This means that she must fulfil the general sort of *mens rea* requirement; the mental or psychological conditions that are required to conclude that a person has reasonable control over his or her actions.[10] In other words, we would not say that an insane person had reasonable control over his or her actions and we would not, therefore, hold such a person liable for his actions.

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[10] I do not wish to enter into the debate over exactly what constitutes an action: whether it is a series of muscular movements, or a state of mind. I take it as sufficient here to say that in order for a person to be responsible for her actions, she must have some mental control over which actions she will attempt.

Another component of being responsible for one's actions is knowledge or intent. A person is responsible for those actions undertaken with knowledge and/or intent. It should be noted that where knowledge or intent is lacking, one may still be held legally liable, though not responsible for the action. So the first condition for being held liable is that a person must be responsible for her actions in that she must meet the *mens rea* type requirements, and she must have knowledge/intent.

With regard to the second condition of liability Hart says:

> Questions of legal liability-responsibility are not limited in their scope to psychological conditions of either of the two sorts distinguished above [psychological and knowledge/intent]. Such questions are also...concerned with the issue whether some form of connection between a person's act and some harmful outcome is sufficient according to law to make him liable; so if a person is accused of murder the question of whether he was or was not legally responsible for the death may be intended to raise the issue whether the death was too remote a consequence of his acts for them to count as its cause.[11]

Clearly one must have some causal relationship to the harm caused to be held liable for that harm. There are however, several kinds of causal connections to an action, event, or outcome. In order to be held liable, the cause must be direct. The more remote the causal connection, the weaker the case for liability. In very simple language then, if one directly causes some harm and one is responsible for

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[11] Hart, RES, p. 478

one's actions, then one can be *held liable for the harm.*

In contrast to this complex notion of legal liability-responsibility, the moral version is quite straight forward.

> To say that a person is morally responsible for something he has done or for some harmful outcome of his own or others' conduct, is to say that he is morally blameworthy, or morally obliged to make amends for the harm, so far as this depends on certain conditions. These conditions relate to the character or extent of a man's control over his own conduct, or to the causal or other connection between his action and harmful occurrences, or to his relationship with the person who actually did the harm. [12]

It is the nature of the connection(s) to harm that is particularly interesting for moral liability-responsibility. It is to this issue of connection to harm that I will return when I discuss moral responsibility in more detail below.

The final sense of responsibility discussed by Hart is that of capacity-responsibility. This sense of being responsible for one's actions has already been partly addressed as one of the conditions of moral (and legal) liability-responsibility. In order to be responsible for one's actions, one must have certain capacities. These capacities, according to Hart, include:

> understanding, reasoning, and control of conduct: the ability to understand what conduct legal rules or morality require, to deliberate and reach decisions concerning these requirement, and to conform to decisions when

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[12] Hart, RES, p. 480

made.[13]

In other words, a person must be competent to be considered responsible (capacity-responsibility) for his or her actions.

With Hart's classifications then, we have a better understanding of responsibility and the various senses in which the term can be employed. One can be responsible in the sense that one caused the occurrence. One can be responsible in the sense that it is a duty of that person's position in a social structure to perform a certain action. One can be responsible in the sense that he or she is competent. And finally, one can be responsible for harm in the sense that the person is liable to moral censure or legal punishment.

When we talk about whether or not the doctor is responsible for the death of the patient, we are usually talking of liability-responsibility. What we want to know is if the doctor is to blame for the death. When we talk about whether the doctor ought to participate in death management, typically we are asking whether the doctor has this sort of duty to a patient in the role-responsibility sense. We then have two questions, each dealing with a different sense of responsibility. This however is not to say that these senses are not connected. How we decide the responsibility issue for one question can affect the decision regarding responsibility for the other question. So, for example, if we determine that it is the doctor's

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[13] Hart, RES, p. 481

responsibility (role-responsibility) to participate in death management, then chances are we would not then blame the doctor for the death of that patient, since the doctor was fulfilling her responsibility to the patient. On the other hand, if we decide that to participate in death management is to violate a doctor's responsibility to the patient, then we might take a different view of the death of that patient.

ROLE-RESPONSIBILITY

Since one must start somewhere, I will begin with the role-responsibility question. What are the role-responsibilities of a doctor? In the standard case, the doctor's duties include any and all appropriate diagnostic measures, cure of the disease, amelioration of symptoms, and prevention of disease where possible. So when a patient shows up at a doctor's office, these are the expectations the patient has. The patient expects to have the ailment or the reason that brings her or him to the doctor's office diagnosed, treated, and cured. Where cure is not possible as with some chronic conditions, the expectation would be at least some amelioration of symptoms, and the ongoing management of the condition. In either case, the goal of the interaction between physician and patient is essentially the "wellness" of the patient.

WELLNESS AS THE ROLE-RESPONSIBILITY OF A DOCTOR

I do not want to engage in a detailed debate over the definition of "health". I do, however, think that barring radical definitions, it is sufficient to say that health can be generically defined as wellness. The concept of wellness, better than most definitions of health, incorporates both the subjective affect of the patient, i.e., what the patient perceives to count as health, and the biological condition of the patient, which is a common component to any definition of health.

For most intents and purposes, I follow Arthur Caplan's thinking in regard to the definition of health/disease. Caplan says that

> one common definition of disease often found in medical literature is that disease represents any deviation from the existing norms that prevail for human functioning.[14]

He resists this definition of disease (and by default, of health) because it would mean that people for whom a particular dysfunction causes no problem would be labeled as diseased anyway. So for example, if a woman was infertile, but had already decided not to have children, she would still be labeled as diseased even though this fortunate dysfunction of her reproductive system hardly qualifies as a disease in this case. It seems more like a lucky coincidence of circumstance and desire. Caplan wants to supplement this sort of technical-medical definition including its strong biologic component, with a psycho-social component. He claims that

> Perhaps the most satisfying way to handle the problem of defining disease is to attempt a definition that captures

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[14] Arthur L. Caplan, "The Ethics of In Vitro Fertilization," in Ethical Issues in the New Reproductive Technologies, ed. R. Hull (Wadsworth Publishing Company, 1990) p.104 [hereafter referred to as EVF]

> both physiologic and patient perspectives. Disease would appear to refer to those dysfunctional states that a person recognizes or, if left untreated, will eventually come to recognize as dysfunctional either due to impairments in abilities or capacities or as a result of noxious symptoms.[15]

It is this combination of medical abnormality and the patient's perspective on the abnormality that I am trying to capture in using wellness in defining health.

Wellness then, is feeling as good as possible (patient's subjective affect)[16] and functioning (biologic component) at as high a degree as possible given the circumstances. The happily infertile woman then, is already in a state of wellness, at least with respect to her reproductive organs. To take another example, if a patient has a chronic condition, say back-pain, wellness would probably mean something like absence of pain. For a person suffering from the common cold, wellness simply means absence of sneezing, coughing, and congestion. Now wellness for a paraplegic might be thought to include access ramps to buildings since this would go a long way in raising the degree of both positive affect and functioning. However, if we are going to say that the wellness of the patient is the doctor's responsibility, this would mean that access ramps were

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[15] Caplan, EVF, p.105

[16] I do not mean to imply that positive affect is in any way a fundamentally hedonistic concept. I am using affect to capture that component of wellness that is measured by the patient's perceptions of their condition. Without the inclusion of affect or some corollary notion, the definition of wellness is reduced to normal biological functioning or some other such unsatisfactory definition.

under the responsibility of the doctor. This goes too far. The doctor's responsibility has to be limited to the role the doctor plays. The doctor is not a civic engineer, and so cannot contribute to wellness in this way. But the doctor is an engineer of another kind, and in the medical sense the doctor can be responsible for the medical aspects of the wellness of the paraplegic patient. In other words, in terms of the doctor's responsibility, the paraplegic's wellness would be defined as feeling as good as possible, and having as many functioning systems as possible under those particular circumstances of paraplegia. Therefore, when we refer to "wellness" it should be understood that we mean the medical aspects (which include patient affect) of wellness.

On my account, then, wellness is the highest degree of abilities, capacities, and positive affect that can reasonably be expected given the circumstances. Certainly for the paraplegic, the highest degree of wellness would include the ability to walk. However, the circumstances of paraplegia make this impossible. The degree of wellness attainable is relative to and contingent upon the medical problem — the type and severity of the medical abnormality. In the standard case then, the doctor's role-responsibilities are largely comprised of the duty to assist the patient in achieving the highest degree of wellness possible given the circumstances.

In dealing with death management, however, we are not dealing with the standard case. In the cases with which we are concerned the patient is already dying.[17] Presumably, the doctor has been engaged in fulfilling the role-responsibilities thus far — he or she has been diagnosing and treating the patient for a particular disease or condition, or set of diseases or conditions. The goal, prior to the dying process, has been the wellness of the patient. Usually, wellness would include avoidance of death and the dying process. When a person is already dying and there is no hope for recovery, it makes no sense to include this goal under wellness. What then could wellness mean for the dying patient? If wellness in general means feeling as good, and having as many systems functioning as possible under the circumstances, then I would say that wellness for the dying patient would mean the avoidance of a bad death and the attainment of a good death. Since death is inevitable given that the patient is dying, and the bad death is a significant harm, then wellness must mean the attainment of a good death.

The bad death, as I have already discussed, is the death resulting from

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[17] An extensive discussion of the concept of dying follows this chapter. For the present discussion it suffices to say that dying is a stage functioning as a prelude to death and contrasts sharply with the stage called living. I use the concept of dying, as it is cashed out later, to distinguish between cases of death management and cases of suicide. Again, for the present discussion it suffices to confine the examples to those who are, in the foreseeable future, about to die.

a dying process marked by prolongation, disability, fear, and dissolution. Part of what has given rise to the bad death is our technological fight to prevent death, which manifests itself in our blind devotion to the technological imperative. While we have little quarrel with this objective of the avoidance of death under normal circumstances, it is no longer appropriate when a person is dying and requests death management. When a person is dying, trying to prevent the ensuing death only serves to make that death a bad one through prolongation of the process, increased disability and so on. This in no way contributes to the patient's wellness. Instead, when a person is dying and requests death management, the doctor's goal should be a good death. This in turn means that when a person is dying, and requests a good death, the technological imperative must be abandoned. Once abandoned, it is no longer a duty of the physician to keep the patient alive. What is left then, are all the other duties normally undertaken by the physician which include diagnosis and treatment of symptoms. In other words, the doctor is still responsible for the wellness of the patient, it is just that the context in which wellness can be pursued has changed. In the context of someone who is dying and requests death management, wellness means feeling the best one can, and being as enabled as one can be while dying. This in turn means that a good death rather than a bad death must be the aim of one whose role-responsibility is to pursue the wellness of the patient.

If a doctor's role-responsibility is, generally speaking, the wellness of his or her patients, then when a patient is dying and requests death management, the pursuit of a good death and the avoidance of a bad death are the responsibility of the physician. The doctor is responsible for helping the patient to achieve the highest possible degree of wellness given the circumstances of that patient. For the dying patient, this means creating the good death. Therefore, it is part of the doctor's role-responsibility to participate in a patient's death management.

I would like to note that I am working under the assumption that all rights extending from autonomy will remain standing. Thus, should a patient not request death management, then it is not an issue.[18] It is only when a patient wants and makes a request of the doctor for death management that issues of the doctor's responsibilities come into play. Should a patient refuse death management, then like all other refusals of treatment, it must be honored.[19] I am not trying to suggest

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[18] It could be the case that someone other than the patient requests death management. A family member or some other sanctioned proxy decision maker might, on the dying patient's behalf, make a request for death management. This request would have to be dealt with like any other decision or request made by proxy. Justifying the legitimacy of proxy decision making requires its own set of arguments which are outside the scope of my present purpose.

[19] It could be the case that the patient not only refuses death management, but also requests that everything be done to extend the dying process (i.e., to extend existence). The primary issue in this situation is no longer death management. What has to be considered is if the patient's request is for futile treatment — that is, treatment which would not benefit the patient in any way. At present, however, I am concerned with requests and refusals of death management.

that death management should be implemented against a patient's wishes. I am, however, concerned with the response to those patients who do wish for death management and have been refused on the grounds that such a course of action would be morally impermissible. Death management is like any other course of treatment. Its goal is the wellness of the patient, and as such it falls under the responsibility of the doctor to utilize it when appropriate. Determining the appropriateness of death management would consist of the same process as used in determining any other kind of treatment or intervention, and consent would be required.

Having determined that participation in death management is indeed part of the doctor's role-responsibility for a dying patient, it remains to be seen how this determination will affect the moral assessment of the doctor's actual activity in death management. If my arguments this far are sound, then for a doctor to refuse to participate in death management would be to shirk his or her responsibility. This is not the question, however, with which we need to deal. We still want to be able to discriminate between morally acceptable participation in death management and morally unacceptable participation in death management. In other words, it is not enough to say that doctors must participate. We also need to know the permissible *ways* in which they may participate.

What I think marks the correct distinction between acceptable and unacceptable participation in death management is the notion of liability-responsibility that was discussed earlier. What I hope to show is that acceptable involvement in the death of a patient would not be such that the doctor would be liable for the death. Consequently, if the doctor's behavior was such that he or she could be held liable for the death, then the behavior in question would be unacceptable.

WHEN TO INVOKE LIABILITY-RESPONSIBILITY AND DETERMINATIONS OF FAULT

Hart has informed us that to be held morally liable is one sense in which we can use the notion of responsibility. Thus we can say she is responsible for the damage and mean that we hold her morally liable for the damage. Also from Hart, we get the information that in order to be liable one must be responsible in the sense of capacity-responsibility, and also have some significant connection to the harm. These two conditions of liability are designed to distinguish liability-responsibility from other types of responsibility, and are not meant as hard and fast rules by which we can determine someone's liability. In other words, when we want to deem someone responsible, Hart's classifications are very helpful in determining exactly what sort of responsibility would be appropriate. However, the question remains as to how to designate someone as responsible — in whatever sense — in the first place.

For example, let us say that I drive my car into a neighbor's fence. I do considerable damage to the property. It is a simple matter to conclude that I am causally responsible for the damage to the fence. How do we decide whether or not I am *liable* in the moral sense for the damage to the fence? I propose that the answer lies in an examination of 'fault'.

'Fault', like 'responsibility', has many uses in common language. By way of introduction to 'fault', Feinberg says:

> The word "fault" occurs in three distinct idioms. We can say of a man that he *has a fault*, or that he is (or was) *at fault*, or that he is "to blame" for a given harm, which is to say that the harm is (or was) *his fault*. [20]

Having a fault is rather simple to explain. For one to have a fault, some characteristic of that person fails to meet some norm or standard. For example having a temper is a fault. The reason that having a temper is a fault is that to become angry at inappropriate times, or to routinely become angry over things reasonably considered trivial by others, is to behave in a substandard way. To consistently and predictably exhibit anger inappropriately (by some social standard) is to have the fault of a temper.

Fault, like responsibility, has a causal component. For example, let us say that it is Miss X who has the temper. While dining at an exclusive restaurant, she finds she has been served the wrong order. In a fit of temper she shouts at the

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[20] Joel Feinberg, "Sua Culpa" in Philosophy of Law, eds., Joel Feinberg and Hyman Gross (Belmont, California: Wadsworth Publishing Company, 1986) p. 512-513 [hereafter referred to as SC]

waiter until he cries. She caused the harm, i.e., the waiter's emotional breakdown, because of her fault. Feinberg puts this more eloquently:

> To cite a man's character flaw as a cause of harm, in short, is to *ascribe* the cause to an act or omission and then to *classify* that act or omission in a certain way — as characteristic of the actor. It is also, finally, to *judge* the manifested characteristic as substandard and thereby derogate it. [21]

Clearly Miss X caused the harm. But notice that what is judged is the character flaw and not the liability for the harm. Just like with responsibility, we can cite a cause without necessarily also implying a judgement. It requires more than a character flaw to be held liable.

The second type of fault is being 'at fault'. To be *at fault* is similar to having a fault, except the faulty behavior is not characteristic of the actor. A person may display inappropriate anger on an occasion but not have the persistent character flaw of a temper. Again, we can make statements of cause in connection with being *at fault*. Feinberg says of being at fault:

> [w]hen these uncharacteristic failures cause harm, it is correct to say that a *faulty aspect* of some act or omission did the causing but incorrect to ascribe the cause to some faulty characteristic of the actor...[22]

So to be at fault is to have caused some harm, but this harm is linked to the faulty

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[21] Feinberg, SC, p. 513

[22] Feinberg, SC, p.514

aspect of the action and not necessarily some personality trait of the person. It is tempting when a person is *at fault*, also to hold this person *liable* for the harm, but it must be remembered that the faulty aspect of the action must be the cause of the harm. For instance, consider a woman driving without a driver's license. She drives in an appropriate manner; however, the noise of the car scares a horse which throws its rider, causing injury to the rider. The driver was at fault for driving without a license, but the rider's injuries are not the driver's fault. The faulty aspect of the driver's actions were not the cause of the rider's injuries.

There are three basic ways that one can be *at fault*. One can act or omit in a rule-breaking or substandard manner where harm results by intentional wrongdoing, recklessness, or negligence. Intentional wrongdoing is relatively straightforward. Feinberg says:

> The traditional test of intentional wrongdoing has been a disjunctive one: There is intentional wrong doing if either one acts with a wrongful conscious objective or one knowingly produces a forbidden result even incidentally as a kind of side-effect of his effort to achieve his objective. [23]

So if I intend to push a stranger out in front of an oncoming bus, then I am acting with a wrongful conscious objective, and I am knowingly producing (or setting out to produce) the forbidden result of the death of the stranger.

Recklessness is a little more complicated. The essential component to

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[23] Feinberg, SC, p. 514

recklessness is risk. If one knows that a side-effect of her action is a high risk harm and proceeds with the action despite this, she acts recklessly. The risk of harm associated with the action must be unreasonable for the action to be labeled as reckless. Feinberg explains recklessness and its association with intentional wrongdoing:

> When the occurrence of the forbidden or undesirable side-effect is not certain, but nevertheless there is a known substantial likelihood of its coming about as an incidental byproduct of one's action, its subsequent production cannot be called "intentional" or "knowing" but verges into *recklessness*. What is known in recklessness is the existence of a *risk*. When the actor knowingly runs the risk, when he is willing to gamble with his own interests or the interests of others, then providing the risk itself is unreasonable, his act is reckless. [24]

If I seriously suspect that unless I change my course, I will bump a stranger into the path of a bus, and I do not change my course, I act recklessly. I do not *know* that the stranger will remain in my path, or that the collision will be enough to force the stranger into traffic, but if I know that these are *unreasonable risks*, and I take those risks, then I am acting recklessly.

Negligence differs from recklessness in that there is no intention or knowing of any kind. Here, again, the element of risk figures prominently. The difference in its function is that if one is negligent, one unknowingly creates an

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[24] Feinberg, SC, p. 514

unreasonably dangerous risk by his or her faulty action. Feinberg distinguishes between recklessness and negligence in this way:

> When one knowingly creates an unreasonable risk to self or others, one is reckless; when one unknowingly but faultily creates such a risk, one is negligent. [25]

To use the stranger-bus example one more time; if I am walking down the street with my attention on a book, I unknowingly create the risk of bumping into someone and propelling her into traffic. I am concentrating on the book I am reading and I have no intention of knocking anyone into danger. I do not know, because I am not paying attention, that I am coming up to a bus stop crowded with people. I am unknowingly creating the risk of harming one of these people. Walking down the street reading is an act of negligence. Should I accidentally drive someone onto the street, then I am at fault for the harm through negligence.

To summarize then, there are three ways for one to be *at fault*. One can be at fault through intentional wrongdong, through recklessness, or through negligence. If the harm caused was intentional or was within the scope of the risk created through either negligence or recklessness, then this person is at fault in causing the harm. If one is at fault, then we have established one of three causal connections to the harm. However, establishing a mere cause in not necessarily enough to establish *liability*. When we want to communicate that a person is *liable*

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[25] Feinberg, SC, p. 515

for the harm, we usually, according to Feinberg, use the locution 'his or her fault'.

It is this third type of fault that is the most relevant in our discussion of death management. When we say that a particular event is 'his/her fault' we are insinuating more than just the simple causal connection. We not only explain the event in terms of cause, but we also judge the person 'at fault' so as to place blame on that person. Feinberg suggests the Triconditional Analysis for determining that an event is a *person's fault* and that that person is therefore morally responsible (liable). The three conditions of something being a person's fault are: 1) The Fault Condition: This condition is met when he or she was 'at fault' in acting or omitting. 2) The Causal Condition: This condition is met when his or her faulty action or omission caused the harm.[26] 3) The Causal Relevance Condition: This condition is met when the aspect of the act or omission that was faulty was also one of the aspects in virtue of which the act was a cause of the harm. Simply put, the person, to be blameworthy, must be 'at fault' in a manner directly pertaining to the harm caused.

Basically for something to be *my fault*, I had to be *at fault* in acting (or

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[26] It may be suggested that the Causal Condition is redundant given what it means to be at fault. However, according to Feinberg, it is possible for me to be at fault in acting, but not in such as way as to have caused harm. In other words, I could be at fault and just be lucky enough not to directly cause any harm. For something to me my fault, I would have to have been at fault in acting, cause harm, and the harm caused must be in direct relation to the faulty nature of my action. For Feinberg's entire analysis of his Triconditional Analysis, see Feinberg, SC, p. 515-522.

omitting) in such a way as to have by my faulty action caused harm. For example, I drive into my neighbor's fence, creating extensive damage. Now in order for this damage to be *my fault*, I had to be *at fault* in acting or omitting. I was trying to make a corner at an unsafe speed when I crashed into the fence. Driving at an unsafe speed is an act of recklessness. I was knowingly creating an unreasonable risk by driving too fast. Because the car was moving at a high speed, I lost control of it on the corner and hit the fence. I was at fault (through recklessness) and it was this same faulty behavior that caused the damage to the fence. Thus the damage to the fence is *my fault*.

Now consider what happens to fault determinations when the story is changed. In the changed story we must apply some of the other components of the Triconditional Analysis. Consider that instead of my crashing into the fence, a second car smashes the fence. I was driving at an unsafe speed, trying to make a corner. The driver in the car following me was so impressed with my racing skill that he failed to notice he was coming up to the same corner. Because of his misplaced attention, he misses the corner and smacks into the fence. Certainly I am at fault in driving too fast just like I was in the previous story. As well, chances are that if I had been driving normally, the other driver would not have been distracted and might not have damaged the fence. But, the faulty aspect of my action (driving too fast) is not the same aspect of my action that resulted in the damage to the fence. It is possible to claim that I was also at fault in distracting the other driver. However, it must be considered that allowing one's attention to wander when driving is negligent, if not reckless, and therefore the driver of the other car was also at fault. It was by virtue of the *other* driver's *at fault behavior* that the fence was damaged. Thus the damage caused to the fence is *his fault*. I am *at fault*, but the damage to the fence is *not my fault*.

It is important to note that the most important component of the Triconditional Analysis is the 'at fault' condition. The other two conditions serve mainly as qualifiers to loopholes that would allow a person to be at fault and yet not blameworthy, or erroneously blameworthy, as the case may be. The other two conditions help us make sense of the two damaged-fence stories by sorting out which fault caused what. If one were to fail to meet the 'at fault' condition, the other two would be largely irrelevant. My point is that when assessing fault, it seems more logical to start by seeing if the individual was at fault (acting with intention to do wrong, recklessly, or negligently) and if he or she was, to then check to make sure the harm caused meets the other two conditions. The corollary point then, is that if one is not at fault, if one does not act with intention to do wrong, with recklessness, or with negligence, then any damage or harm cannot be that person's fault.

I began this discussion of fault with an eye to determining how we might go about identifying those who could be held liable-responsible. In order to be held liable, one must be reasonable in terms of capacity-responsibility, and one must have a causal connection to the harm. I will continue working under the assumption that the doctors we are talking about in cases of death management are fully responsible in the sense of capacity-responsibility. The second condition, the causal connection, is a bit more controversial. It is my contention that in order to be held responsible — that is, in order to be liable — the harm must be *one's fault*. So providing the doctor is sane, if the death of a patient is *that doctor's fault*, then that doctor is responsible — liable — for the death. By the same token, if the death is *not* the doctor's fault, then that doctor *cannot* be held responsible (liable) for the death.

Now in order for the death of a patient to be *the doctor's fault*, the doctor must be *at fault* in acting or omitting. The doctor must have acted with intention to do harm, or with recklessness, or with negligence. If none of these is the case, then there is no point in continuing with the Triconditional Analysis since the other two conditions are contingent upon the 'at fault' condition. If the doctor is not at fault in acting, then there is no chance that the result of events would be that doctor's fault. If the death is not that doctor's fault, then that doctor cannot be held responsible — liable — for the death. What this means is that it is much easier to determine who *is not* responsible than who *is* responsible. It is sort of like a blood test to determine paternity. The blood test can effectively rule out a candidate as the father, but it cannot make a 100% confirmation of a candidate as the father. The 'at fault' condition is much the same. If the doctor fails to meet the 'at fault' condition, that doctor cannot be responsible. If the doctor meets the 'at fault' condition then additional tests are required to confirm the doctor's liability, such as the rest of the Triconditional Analysis.

PHYSICIAN RESPONSIBILITY: FITTING TOGETHER THE PIECES

It is the responsibility of the physician to pursue the wellness of her patient. This in itself is not a revolutionary conception of the role of a doctor. Nor is it particularly problematic to build into the role the idea that wellness encompasses not only biological malfunction, but also the patient's perspective on the malfunction. This dual featured definition of wellness allows the patient to decide what will count as harm (a setback of wellness) and as a benefit (a promotion of wellness). For example, recall the case of the infertile woman. In her case, the malfunction counted as a benefit. For a woman desperate to have a child the malfunction would most likely be counted as a harm. The point is that in determining what constitutes wellness one must pay some attention to the context.

What might be new to the conception of a physician's role is my suggestion that in the context of dying, wellness means the avoidance of a bad death and the promotion of a good death. Typically we do not want our conception of the doctor's role to include the promotion of any kind of death. Indeed, in all contexts but that of the dying patient, it is justifiably assumed that wellness, in its most minimal instantiation, will include the avoidance of death. This is because in all contexts but that of the dying patient, continued existence will be counted as a benefit.[27] Because a patient is already dying, and because the bad death is a harm, it may be the case that in this context, continued existence is not a benefit, but a harm.

In the case of a dying patient, the physician's responsibility remains what it always was — to pursue the wellness of the patient. Since wellness in this context means the pursuit of a good death and the avoidance of a bad death, then the physician has a responsibility to promote the good death. In other words, the wellness of the dying patient is still the responsibility of the doctor, even if fulfilling that responsibility means promoting death, albeit death of a particular sort.

This conception of a doctor's role-responsibility might sound alarming if one thinks that the goal of medicine is preserving life at all cost. What I am claiming is that the proper goal of medicine is the pursuit of wellness. This conception of a doctor's role might also sound dangerous if one thinks that it somehow gives doctors the authority to kill patients. In fact this conception does give doctors the power to end a life, but only on the grounds of the achievement

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[27] Of course, cases of suicide are excluded here. I deal with suicide and death management in the next chapter.

of wellness and not on malicious grounds. It is here that liability-responsibility is vital. It is a physician's responsibility to pursue wellness for a patient, even if that means the death of the patient, but the doctor is always constrained by liability. The physician must never act so as to willfully or purposefully harm the patient, or to harm the patient through recklessness or negligence. Since the dying patient who has requested death management will typically equate a certain kind of continued existence with harm, and a designed dying process with benefit, the physician, in promoting the good death, would not be harming, but rather benefitting, the patient. Should, in this context, the physician instead continue to pursue continued existence for her patient, she would be morally liable for the harm suffered by that patient.

I explore further the issue of liability and death management in the following section. It should be noted that I do not deal with the case in which a doctor objects to, or refuses to participate in, death management on grounds of personal moral conscience. It is possible that an individual doctor might have serious objections, say on religious grounds, to the practice of death management. Such cases would have to be dealt with under the rubric of exceptions to the rule. For the time being, I am merely trying to make a case for what the rule ought to be — that physicians have a responsibility to participate in the death management of a dying patient.

PHYSICIAN LIABILITY-RESPONSIBILITY AND DEATH MANAGEMENT

If a doctor participates in a case of death management, is she responsible/liable for the death of that patient? My answer to this question depends on whether the doctor was at fault — whether the doctor acted with intention to do wrong, recklessness, or negligence. This will be my first test in determining the liability-responsibility of the doctor.

It will be easier to demonstrate if we look at a case. Take, for example, the standard "high dose of morphine" case. A patient is dying, she is suffering a tremendous amount of pain which requires an ever increasing dosage of morphine to ameliorate. The patient asks her doctor to give her enough morphine to hasten her death. The patient is asking for death management. The question, then, is whether or not the doctor should give a fatal dose of morphine. Now the doctor, in order to fulfil her role-responsibility, must aid the patient in achieving wellness, and in this context that means she must help the patient achieve the best possible death. Suppose that the large morphine dose would bring about the best possible death for this dying patient. On this basis the doctor decides to administer the morphine, as per the patient's request. Now, is the doctor responsible/liable for the death of this patient? I think the first step in answering this question is to answer another question: Is the doctor at fault in administering the lethal dose?

In order for the doctor to be at fault in administering the dose he or she would have had to have acted with intention to do wrong, recklessness, or negligence. I think the latter two are easily dealt with. In order to have acted with recklessness or negligence, the doctor would have had to have created an unreasonable risk. In this situation, an unreasonable risk would include creating a worse, instead of a better, death. This is highly unlikely since even if the large dose of morphine were not fatal, it would certainly render the patient unconscious, perhaps comatose. Another dose of some medication would be in order. The patient, however, would not, presumably, experience this lengthened process. The giving of morphine does not, typically, create an unreasonable risk of a bad death.

Assessing whether or not the doctor was at fault in acting in terms of purposefully harming is a bit more complicated. In order to act so as to purposefully harm the patient, the doctor would have had to identify a harm and then act (or omit) so as to bring it about. So, for example, a doctor who decided to perform a non-therapeutic experiment on the dying patient, without getting consent from that patient, would be participating in purposefully harming that patient. Now it could be argued that participating in death management is tantamount to participating in purposeful harming simply because the goal or end here is the death of the patient. Embedded here is the notion that death *always* counts as a harm.

I would like to point out several things in response to the suggestion that the death of the patient in this case of death management constitutes a harm. In the first place, when a person is already dying, that person has a choice between a good death and a bad death. This is not the same as a choice between life and death. The point is that once a person is dying, what counts as a *harm*, and what counts as a *benefit* change from what may have so counted when the person was not dying. For a dying person, forced continued existence, the prolongation of a miserable death process, might be a harm. If a person is not dying, then continued existence is more likely to be counted as a benefit.[28] Similarly, death for a person not dying would most likely be a harm, but for the dying person, death may count as a benefit.

So does the doctor purposefully harm the patient by giving the fatal dose of morphine on the patient's request? No, the doctor's purpose is to benefit the patient who is dying by providing the best possible death and not leaving the patient to a bad death. In giving the fatal dose of morphine on the request of a dying patient, the doctor does not (prima facie) act so as to be at fault. In other words, the doctor does not purposefully harm, nor does she create an unreasonable risk of harm through recklessness or negligence. Given the mechanics of how being at fault is necessary to being held liable, if the doctor is not at fault then the doctor cannot be held liable. Thus there are no barriers, at

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[28] This is of course, excluding cases of severe suicidal depression. These cases however, are taken up in Chapter Three.

least in terms of fault and liability, to giving the lethal dose of morphine. However, talking about the presence or absence of barriers — constraints on action or omission — is much different from talk of directives derivable from the notions of fault et al. Having talked extensively about what the doctor *may* do, it is now time to talk about what the doctor *ought* to do — at least in terms of fault, liability, and responsibility.

RESPONSIBILITY AND DIRECTIVES FOR ACTION IN DEATH MANAGEMENT

When the doctor receives a request for death management — a request for the best possible death and the avoidance of a bad death — the doctor has a choice between several courses of action.[29] The doctor could abandon the patient by doing nothing, by changing nothing. Since the course of treatment to this point has probably been to extend the life of the patient, as dictated by the technological imperative, doing nothing, that is, not changing the course of treatment, will most likely lead to the classic bad death. Another option for the doctor is to change the course of treatment such that all possible passive, indirect, options are implemented to attempt to avoid a bad death. This might include withdrawal of some treatments or some interventions, or selectively refusing

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[29] My goal here is not to delineate every possible course of action, but rather to identify the general categories of likely possible courses of action.

to initiate certain forms of treatment or intervention. This *may* bring about an easier death for the patient, but as we observed in the preceding chapter, it could also mean that, contrary to the wishes of the patient, the death is not the best possible death but rather, a bad death. A third alternative for the doctor is to design, in conjunction with the patient, a good death, and then employ whatever means are necessary to carry out the plan.

In choosing among these three general options, the physician must keep in mind her responsibility to the patient. Her responsibility is to the wellness of her patient. Assuming that the context in which wellness is being evaluated is that of the dying patient, what counts as a harm is the bad death and what counts as benefit is the good death.[30] In order to fulfill her responsibility to the patient the physician must help that patient to achieve whatever measure of wellness is possible. If harm should result from failing in this responsibility, the doctor, if at fault in bringing about that harm, is liable for the harm suffered by that patient. These, I believe, are the stakes riding on the doctor's choice of course of action. The doctor then, ought to choose the course of action that has the best chance of promoting wellness, and the doctor must pursue this option in such as way as to

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[30] Of course, there may be exceptions to this evaluation of harm and benefit. There may be a reason a person wants to count death as a harm even when the death is a good one. My goal here is not to argue for the evaluation of harm and benefit, but to show that if harm and benefit are calculated in the above manner, certain responsibilities for the physician follow.

avoid being at fault in doing so.

In light of the above discussion on responsibility and fault, let us evaluate the doctor's options for course of action. The first option, the do-nothing option, is a poor choice on two counts. First, doing nothing goes no distance to promote wellness for the dying patient. Certainly, prior to the onset of the death process, many measures would have likely been undertaken in an effort to prolong the patient's life. However, once the patient is dying, prolonging life may count as a harm rather than a benefit. Failure to acknowledge this shift in what counts as harm can lead to the bad death. Doing nothing different for a dying patient than what was done for her prior to the onset of the dying process is tantamount to pursuing the bad death. Clearly this is, in this context, the antithesis to wellness. Thus in choosing this option, the physician fails in her role-responsibility to promote the wellness of her patient.

The do-nothing option is a poor choice in a second respect. The doctor not only fails in her responsibility to promote the wellness of her patient, she is at fault for the harm of the bad death suffered by the patient. In order for the doctor to be at fault, she had to either knowingly bring about the harm, or she had to create an unreasonable risk of harm through recklessness or negligence. It could be argued that persisting in extending life for a dying patient beyond that patient's wishes, where this prolongation of the dying process is known to lead to a bad death is knowingly bringing about harm. If this is the case then the doctor is at fault for the harm. Even if the doctor was not sure as to the outcome of attempts to extend life, once a patient is irrevocably dying, these attempts create an unreasonable risk of the bad death. The doctor is then at fault through recklessness (where she knew the risk of the bad death, but took the chance on life prolongation any way) or negligence (where she should have known the risk of the bad death was present, but did not).

The second option is, at least at first glance, a little more promising. In following the second option, the doctor would use all possible passive, indirect, options in an attempt to avoid the bad death. The good death is not itself pursued with this option, rather the goal is to minimize the harm of the bad death. This option seems more promising because the doctor choosing this option is recognizing the harm of the bad death, and trying to do something about it which translates into an attempt to meet the responsibility (in terms of wellness) to that patient.

The physician choosing this option, however, still runs the risk of being at fault for the harm suffered by the patient should the attempts to minimize or avoid the bad death fall short. As mentioned, the goal of this second option is not the good death; the goal is not benefit, but merely a reduction of harm. While the minimization of harm is a good place to start, the remainder of the harm suffered cannot be ignored. In all likelihood, the patient still dies a bad death, and the best we can say is that the death could have been even worse, but thankfully it was not. So the patient still suffered a harm, just not the worse harm possible under those circumstances. I want to suggest that the doctor is liable for this harm. If one can be at fault by knowingly or unknowingly creating an unreasonable risk of harm, then I suggest that the physician choosing the second option is creating, or rather, leaving behind, an unreasonable risk of a bad death.

It is only in choosing the third option, the outright promotion of the good death, that the doctor can be assured that she is both meeting her responsibility to promote the wellness of her patient and doing so in such a way as to remain clear of fault and liability. The physician's goal is to benefit the patient thus helping the patient to achieve wellness. In the context of the dying patient, a good death counts as benefit. Even if the death of the patient should fall short of the good death, the doctor cannot be held at fault. The doctor clearly did not knowingly bring about the harm (the harm of the less-than-good death). In fact the whole point of the course of action was to avoid the harm altogether. Similarly, no unreasonable risk of the bad death can be assumed from the promotion of its opposite. There may be an element of risk in the pursuit of the good death — but this risk is not unreasonable. If a doctor faithfully pursues the good death, taking care to eliminate as much of the risk of a bad death as possible, then that doctor cannot be held responsible (liable) for a fluke that brings to fruition what little irremovable risk remains. Certainly it is *possible* for a doctor, through one sort of incompetence or another, to create an unreasonable risk of the bad death even in pursuit of the good death. In this case we would, of course, amend the observation to hold the doctor at fault. However, my point is only that in the general course of events, when one makes a thorough attempt to eliminate risk, what risk remains is not grounds for claiming one is at fault.

It looks then, as if of the three options — (1) do nothing, (2) attempt to minimize harm of the bad death, (3) promote the good death — the third is the most acceptable. Not only does the doctor steer clear of fault with the third option, but more importantly, the doctor has in clear focus the wellness of her patient. If we are going to take seriously the responsibility of the physician, and if we grant that this responsibility is to promote the wellness of the patient whether she is living or dying, then it is the responsibility of the physician to participate in death management upon the request of a dying patient.

CONCLUSION

This chapter has been an effort to build a prima facie case that participation in death management — i.e., the active promotion of a good death and the avoidance of a bad death — falls under the responsibility a doctor assumes as a doctor. In order to do this, I have suggested that we reconstruct our concept of the role of the doctor to include providing appropriate care for the dying. By specifying 'appropriate' care I intend to underline the notion that care for the dying may be dramatically different than what constitutes care for the living. The reason for the difference, I have suggested, is that what counts as benefit and what counts as harm will be different for the living than it is for the dying. Continued existence is usually assumed to count as a benefit. However, when one is already dying, prolonging the experience may in fact count as a harm. Similarly, for the living, death is usually the ultimate harm, whereas for the dying death may be tragically the ultimate benefit. The underlying issue here is that when a person is dying, instead of a choice between life and death, she is making a choice between a good death or a bad death. So it is not that death itself is a great benefit to a dying person, but when one's choices are limited to a good death or a bad death, the good death comes to be counted as a benefit and the bad death as a harm.

In an attempt to capture this contextual nature of appropriate care, I conceived of the role of the doctor in terms of the doctor's responsibility to pursue a patient's wellness. Wellness was defined as achieving the highest level of positive patient affect and the highest level of functioning under the circumstances. This definition is contextually sensitive enough to account for what wellness might mean to the dying patient. If the good death is a benefit and the bad death is a harm, then wellness most likely means the pursuit of a good death and the avoidance of a bad death. To claim that a doctor's role-responsibility is to promote the wellness of her patients is not, in itself, a particularly controversial claim. However, to consider that meeting this responsibility might mean promoting the death, albeit the good death, of a dying patient is somewhat controversial.

Through the use of the concepts of fault and liability I attempted to show that this view of a doctor's responsibility is legitimate. Squarely meeting the challenge of promoting a good death for a dying patient who requests death management is ostensibly the only way to ensure that a physician's responsibility is met and that the physician does not end up being liable for the harm of a patient's bad death. Certainly there will be individual doctors who, for reasons of their own, have moral objections to perceiving their role in this way. Be that as it may, I have not been concerned with these individuals directly. I have been focused on building a case for a general perception of the role of the physician and while I grant there may be cases argued for excepting certain individuals, those arguments would have to be taken up elsewhere.

The position for which I have made a prima facie case will meet with resistence on a number of fronts. These include those who will insist that active measures to bring about death are wrong, that it is wrong to intentionally aim at death, even if it is a good death, and finally those who will doubt that there can be a meaningful distinction drawn between those who are dying and those who are not. In order to strengthen my prima facie case I will address each of these objections with the hope that overcoming them will lead to further support for death management.

CHAPTER 3:

THE CONCEPTUAL DISTINCTION BETWEEN SUICIDE AND DEATH MANAGEMENT

In setting out to establish the thesis that it is morally permissible for a doctor to participate in the active promotion of the good death, one is immediately confronted with a serious objection. It might be argued that any steps taken to hasten or bring about one's own death — even a good death — is tantamount to suicide. Suicide, it may be further argued, is not only irrational, but more importantly, morally wrong for its victim and anyone who might be willing to assist in bringing the death about.

There are at least two avenues we could take in meeting this objection. First we might address the objection head-on and establish the moral permissibility of suicide and assisting a person to commit suicide. I shall not here pursue that option. Instead, I shall argue that the promotion of a good death is not always equivalent with suicide or assisted suicide. Death management is conceptually and morally distinct from suicide and assisted suicide; and even if the latter is morally impermissible, the former — that is, death management so as to bring about a good death — is not.

Death management is the active promotion of a good death. "Promoting" a good death rightly suggests active behavior directed towards death. What then is the difference between contemplating the management of my death and contemplating suicide? Certainly suicide and death management share one important component; in both cases death is the salient factor. Moreover, having one's own death as a goal or end is a central element in the the very definition of suicide.

So it is tempting to claim that death management is merely a form of suicide. There can be, of course, many forms of suicide depending on the circumstances surrounding, or the reasons for, the suicide. We can say that to accept the mission is suicide. To refuse help is suicide. Jane is so depressed she is suicidal. Bob chose suicide over being a burden. Perhaps 'death management' is just one more contextualized description of suicide. If we think that situations of extremely high risk and extremely low probable success (to accept the mission is suicide) are just special cases of suicide, then perhaps situations involving decisions to end one's life are too, just special cases of suicide. Perhaps 'death management' then is just a fancy term for suicide under certain circumstances.

While categorizing death management as a type of suicide is tempting, it is ultimately mistaken and confuses the relevant issues. I want to claim that death management is not a type of suicide. Death management, I shall argue, is a category all of its own. This is not to say that death management and suicide do not have some similarities, or do not raise some parallel issues. It is only to suggest that there is a fundamental difference between suicide and death management. This difference, I shall argue, is that the person in the case of death management is *already dying*, whereas a person in the case of suicide is not. By so distinguishing death management from suicide we can accomplish several things. First our intuitions about the differences between certain cases can be explained. Second, the moral questions pertaining to death management can be dealt with separately from the related but very different moral questions that arise in the case of suicide.

In order to see the crucial difference between death management and suicide, consider the following examples from Battin:

> Case 1: [Elsie Somerset]...an 80-year-old woman who had for two years been living in a nursing home. She suffered from glaucoma, which had almost completely blinded her, and from cancer of the colon, for which she was receiving chemotherapy. Her husband was recently dead. To relieve her chronic pain, and perhaps to mitigate the side effects of chemotherapy, she was being given hydromorphone, a morphine-like drug. In order to save up a week's supply of hydromorphone tablets she suffered through 168 hours of uninterrupted pain. Then she

> swallowed her hoard and went into a coma. She was rushed to a hospital emergency room and subjected to a variety of procedures to save her life, including the intravenous injection of naloxone, a powerful morphine antagonist. The naloxone worked and she was returned to the nursing home — still suffering from glaucoma and from cancer.
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> Case 2: In St. Paul, some years ago, a fifteen-year-old boy jumped to his death from a bridge, saying that he was doing so because his favorite television program, "Battlestar Galactica," had been canceled.[1]

It is my contention that Elsie's case is one of death management, and the boy's case is one of suicide and it is this difference that largely explains our differing reactions to them. Elsie's case is a case of death management because Elsie is *already dying*. The boy's case is one of suicide because he is *not already dying*.

An obvious objection to my separation of suicide and death management is that it relies on a questionable distinction between those who are and those who are not "dying". In actual fact, the objection continues, the Battlestar Galactica boy is dying. Since, from the moment of our birth our death is unavoidable and inevitable, we are all, always moving toward death, that is, *dying*. The only relevant difference between Elsie and the BG boy is the length of time by

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[1] Both cases taken from: M.P. Battin, The Least Worst Death, (New York: Oxford University Press, 1994) p. 227 Please note that Battin does not use the cases cited for the same purpose that I do. She is interested in a slightly different question concerning the legal power of the right to refuse treatment.

which their dying processes were shortened — and possibly the quality of the two lives which would have been lived had those processes not been shortened. Since dying encompasses all stages of existence between birth and death, the concept cannot be used to discriminate between Elsie and the BG boy, and between death management and suicide. In order to answer this objection, it is incumbent upon me to show that "dying" is a stage in a person's life which is conceptually distinct from those stages of life when that person is said to be "living" but not (yet) dying. If such a distinction can be drawn, then it can be used to mark a further distinction between suicide and death management; and to show, ultimately, that the two forms of intervention are morally different in crucial ways.

In some sense of the term, we can all be said to be dying the instant we are born. But there is a narrower sense of the term which applies only to some stages of our lives. It is this narrower sense that will allow us to distinguish between Elsie and the BG boy. Since dying is a *physical process* which we undergo it seems reasonable to postulate that dying requires physical changes of some fundamental kind. And since such changes require time, it seems that dying involves a span of time. So we have two defining components of dying: a process of change, or what I will call the mechanistic component, and duration, or what I will call the temporal component.

What marks the change from living to dying? In a normal process of living, the mechanism[2] we call a body is in a constant cycle of decay and renewal. Our cells die off and are replaced by new ones.[3] Our skin sheds, wounds heal, and our nerve system regenerates (in a limited fashion) while we sleep. In order to keep the machine working we have to eat, sleep, and perform certain acts of maintenance. This complex machine is built of various systems, such as the gastro-intestinal, the cardio-pulmonary, the central nervous, and so on, all working interdependently and in concert. There may be minor fluctuations in these systems, due to accident or illness, but recovery is typically possible because of the renewal half of the decay-renewal cycle. We break a bone, it mends. We get a cold or flu, our immune system fights a winning battle. These are mere fluctuations in the system, not full breakdowns. So one is not dying when one breaks a leg, or has a cold.

At some point the cycle of decay and renewal alters such that renewal takes longer and finally stops altogether. There may be any number of reasons for this — AIDS cripples the immune system such that a cold can be fatal, cancer[4] can

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[2] I am using the term "mechanism" in an illustrative metaphorical sense and I am not trying to make any ontological or metaphysical statements.

[3] The exception to this rule: brain cells.

[4] Cancer is a somewhat paradoxical example since cancer is usually unrestrained multiplication of cells. However, this multiplication can only take place because some cells have been damaged in such a way that their "stop growth" systems no longer work. Cancer nonetheless represents decay rather than renewal.

cause the rupture of various major organs, making their functioning impossible thereby destroying those systems dependant on those organs. Old age can demonstrate the weakening of certain systems that simply give out. Whatever the reason, at some point decay overcomes renewal, and acts as the predominant force of change in the body. Instead of a cycle (graphed it would look like a wave) we now have a trajectory (graphed it would be a curve toward one axis). The process of dying is a process of decay, unmitigated by significant renewal, that results in a system('s) breakdown.

Now a systems' breakdown, or the decay, that marks dying occurs over time. In other words, dying represents a span of time between living and death. Dying also represents a temporal perspective change from a distanced view of death to a foreshortened view of death. When we are living, the fact of our mortality, our death, is temporally unspecified. Even though we know that one day we will, in fact, die, we do not know precisely when that day is, and furthermore, we presume that it is sometime in the distant (as opposed to the foreseeable) future. When we are dying, the fact of our death now becomes temporally specified. Once we are dying, we have some temporal parameters within which we can predict the time of our death. This is not to say that we can pinpoint the moment of our death, rather, the point is that when living our death was a far off eventuality, and now that we are dying it is an imminent event. It is this shift from eventuality to imminence that I wish to capture in the notion of foreshortening.

While living, a person makes plans, goes about her business, and generally conducts herself with a temporally unconstrained future in mind. This is the perspective she has on her life while living. Certain things then will count as goods: a job, money, freedom, and so on. This perspective changes when one enters the dying process. When dying, a person may have a different set of plans, and may count different things as goods because the future she is planning for is now viewed as being temporally constrained. I am using the phrase 'foreshortened life span' in an attempt to capture this change in perspective in life span.

Along with decay unmitigated by significant renewal such that the result is a system(s) breakdown we use the foreshortening of a life span to mark off the dying process. In other words, we know a person is dying if she is suffering from decay unmitigated by renewal such that the result is a system(s) breakdown which foreshortens her life span.

Now it is important to note that the elements of decay-system breakdown and foreshortening are only constitutive of the dying process when combined. Used in isolation we get some strange, and erroneous, cases of dying. For example if the decay-system breakdown were used alone to indicate the dying process, a woman in menopause, a person paralyzed in an accident, or a man with male-pattern baldness would all be classified as dying. Clearly these people are not dying in spite of the breakdown or destruction of a system or two. None of these breakdowns necessarily foreshorten life span expectancy.

Similarly if we employ the foreshortening element alone we again get strange results. A man scheduled for execution in the morning, and a woman pushed from the roof of a building could both be said to be dying. While it is true that they *will* die, they are not *now*, waiting in the cell and standing on the roof, dying. But for the execution and the push both would live as neither has any decay unmitigated by significant renewal such that a system(s) breakdown would result. The foreshortened life span in both cases is not due to dying, but due to the agency of another. Foreshortening by itself cannot mark the dying process.

Now the task is to determine whether or not having thus defined dying we are able to draw a conceptual distinction between death management and suicide. The cases of Elsie and the BG boy are easily categorized. Elsie is clearly suffering from a decay unmitigated by renewal that ends in a systems breakdown. This systems breakdown is such that it foreshortens her life. Her decision to take an overdose, reflects her choice to manage her dying process in the ostensibly only way she could find. This is a form of death management. Whether Elsie was justified in this decision, should have been helped, or should not have been saved by intervention are all moral questions that need to be addressed. For the moment I am only interested in the conceptual distinction between death management and suicide.

The BG boy is clearly a case of suicide. He is not suffering from a decay unmitigated by renewal such that it brings about a systems breakdown that foreshortens the life span. One might object to this classification and suggest that the BG boy was suffering from a mental illness such that a decay of affect (mood) brought on a systems breakdown (depression — serotonin deficiency). To answer this I would point out that depression does not, but for the decision to end life, foreshorten the perspective of a life span. It is possible to live a "normal" life span in terms of years, even if those years are marked by psychological misery.[5] So, whether or not the BG boy's actions ought to have been sanctioned, assisted, or prevented, the fact remains that those actions did amount to suicide because he is not suffering from a decay unmitigated by renewal such that it brings about a systems breakdown that foreshortened his life span.

To be sure, there are cases of rational suicide and rational death management, as well as cases of irrational suicide and irrational death management. Similarly, there may well be suicides that we want to allow and those we do not; as well as death management cases that we want to allow and those we wish to forbid. The point here is that while there are many moral questions

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[5] I would point out that most cases of depression, even severe depression, are treatable. I will come back to the rare case where the depression is not treatable and is severe.

to be considered in relation to both suicide and death management, those questions are different because suicide and death management are different. They are different because the one set applies to persons who are already dying while the other does not.

So far we have isolated two crucial components in the dying process: decay unmitigated by renewal bringing about the breakdown of vital systems; and the foreshortening of life expectancy. It might be suggested that a third crucial component is irreversibility. Perhaps it is not simply decay and foreshortening that mark dying, but an *irreversible* decline that marks death. Perhaps we need to add a third condition, that the decline marked by the dying process is irreversible. But it is easy enough to see that this third criterion is inapplicable. It is not true that the dying process is necessarily unidirectional; that it is always irreversible.

To illustrate, consider a situation in which I am shot in the stomach. Now it typically takes a relatively long time to die of a gun shot wound to the stomach. To say that I am not now dying would be wrong. I am dying. However, were I to get to a hospital and undergo surgery, I could survive. If I do survive, then obviously I will no longer be dying. I was dying (past tense), but now I'm not dying (present tense). This indicates that the dying process can be reversible. One might object by saying that until it is determined that I will not survive, even with the surgery, it cannot be said that I am dying. This however is wrong. Certainly it is possible that

I might die with or without the surgery. My status as living or dying cannot be held in limbo. Either I am living or I am dying. According to what I have argued, I am dying if I am experiencing decay unmitigated by significant renewal such that systems breakdown occurs in such a way as to foreshorten my life span. Once I am shot, I am dying. I continue to be in the process of dying until some sort of intervention interrupts and reverses the dying process or I am dead. I am not suggesting that all cases of dying are reversible. I am only interested in pointing out that it is incorrect to suppose that dying is necessarily irreversible.

To suggest that the dying process can be manipulated or even reversed is not to make a mountain out of the proverbial mole-hill. That the dying process is malleable is a crucial observation. If the death process were unalterable, we would be unable to choose between good and bad deaths. The bad death is the result of a dying process that has been extended beyond reason through intervention and the use of medical technology. The promotion of a good death is the attempt to change the dying process in another direction. It is essential that the dying process be malleable if we are to understand and do something about the bad death.

THE RELEVANCE OF THE DISTINCTION

Now that we have some sense of what dying is, and that it is necessarily present in cases of death management but not suicide our key question emerges.

What is the relevance of dying? As I have argued a patient's conception of wellness will be altered once she begins the dying process. When one is making decisions about death while one is already dying, the issue is what to do about or with that dying process. When one is living, i.e., not dying, then decisions are about whether to proceed with that process. When one is living and decides to willingly bring about a death process, we call the situation a case of suicide.

We have a number of concerns regarding cases of suicide. We wonder if suicide is a rational act, and if a person ought to be allowed to make such a decision, whether it is rational or not. We also wonder about the moral position of others who are in a position either to prevent the act or to provide assistance in carrying it out.

Along with these questions and concerns about suicide, we also have some general tendencies in answering these questions about suicide — especially those questions concerning third party intervention.[6] We tend to assume that a person who wants to kill herself is not rational, or that the deliberation process in arriving at this decision to kill herself is somehow impaired. Now this is not to claim that suicide is always irrational; it is only to point out that the burden of proof is on

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[6] In what follows I am only concerned with describing common practice. I am not arguing for these presumptions concerning rationality and intervention, but I am merely pointing them out and showing how they might work to our advantage once we have accepted the conceptual difference between suicide and death management.

those who would claim otherwise. For example, the soldier who throws himself on the grenade which has landed in the school yard full of children might be an exception to the assumption of suicide as irrational. There may be very good reasons for holding that the soldier himself was rational, as was his decision to kill himself. The point however, is that the rationality of suicide is generally not debated; we presume that it is irrational in some way, granting that there can be exceptions to this presumption. I am suggesting that unless or until shown otherwise, it is common for us to presume that suicide (either the person or the decision) is irrational. Linked to this presumption is another. Where a person is rational, so goes this second presumption, intervention (to prevent) is prohibited. Where a person is irrational, intervention (to prevent) is recommended. In other words, we generally follow the assumption that rational persons ought to go about their business unfettered. Irrational persons on the other hand, may be subject to varying doses of well-meant paternalism. So in general, though these are but descriptive observations and not normative arguments, in the case of suicide, we presume both irrationality (of some kind) and the appropriateness of intervention to prevent the suicide.

In cases of death management, we also have questions, and tendencies in our answers. Certainly, we want assurance that the person is rational/competent and that the decision itself is rational. And perhaps even more importantly, we are interested in the moral position of others vis a vis the dying person and her attempts to manipulate the dying process.

Just like with suicide, we have certain assumptions about what is going on in a case of death management. Unlike our assumptions about the case of suicide, when a person is already dying and makes decisions about this process, even when the time of death is hastened, we do not presume that the patient is irrational. We tend to accept patients making decisions about their care as an expression of autonomy. This is not to say that there are no exceptions. Certainly a case could be made for one patient or another being incompetent to make decisions on his or her own behalf. However, the point is that the burden of proof is on those who would make such a case. In other words, we assume a patient to be rational, and we assume that the decisions made by this person are rational, unless or until shown otherwise. Again, we make assumptions about the connection between rationality and intervention. When a person is rational, intervention to prevent her from doing what she wants to do (in a case of death management, what she might want to do is die) is unwarranted and might be considered unjustified paternalism — while intervention to assist might, in fact, be warranted. Where a person is irrational (incompetent) and wants to participate in death management, because of the person's incompetency we would not automatically presume that intervention to assist is warranted.

The point is that conceptually separating suicide and death management assists us in sorting out our common tendencies regarding presumptions of rationality and of the appropriateness of intervention. In a case of suicide, we presume irrationality unless or until shown otherwise. Because we suspect irrationality, we feel justified in prohibiting intervention to assist the suicide, and allowing intervention to prevent the suicide. In the case of death management, we presume the presence of rationality unless or until shown otherwise. Because of this presumption, we have fewer qualms about allowing intervention to assist in death management, and feel there might be a violation of autonomy if we do not prohibit intervention to prevent death management.

I want to be very clear about the purpose of these presumptions. My goal is merely to illustrate that in our common practice, these are our tendencies with respect to rationality and intervention. I am not arguing that our tendencies are correct, or that they ought to be the same as, or different from, what they are. What I do want to suggest is that sorting out these tendencies helps to illustrate the difference between suicide and death management. Furthermore, this illustration will help us in deciding which questions pose real concerns for death management and in determining that these questions are different from those posing real concerns for cases of suicide.

Let us look a bit more closely then at the questions concerning rationality and death management and suicide. The first question concerns the determination of choice making as rational or irrational. It is this question with which the bulk of the literature on suicide grapples. Whether or not a suicide is rational tends to bear significant weight in determining whether that suicide is to be condemned or condoned. Certainly this link between an action's rationality and its moral permissibility arises in the case of death management as well. It is not customary in medicine to allow incompetent people to make decisions for themselves about their care, especially decisions affecting whether someone continues to live or dies.

Even considering the parallel concerns about rationality in both suicide and death management, the rationality issue is significantly different in the case of death management than in the case of suicide. In the case of suicide, the debate revolves around the *possibility* of suicide *ever* being rational. Can choosing death over life ever make sense? In other words, the assumption tends to be that suicide is generally irrational, even though there may be some exceptions to this rule. At the very least, a heavy burden of proof is on those who would want to say that a particular case of suicide is indeed rational. Such is not the case in death management. In death management, the patient who requests death is typically assumed to be rational, and the decisions made are respected as rational, unless it can be shown that the patient is incompetent. Wanting to make decisions about one's own health care, including decisions which shorten one's own dying process, is not thought to be prima facie irrational the way that suicide is thought to be prima facie irrational. When one is already dying, it is not thought to be irrational to want to make decisions about the process one is going through. So a person in a case of suicide is presumed irrational until proven otherwise; a person in a case of death management is presumed rational unless proven otherwise.

The issue of intervention is perhaps the most important. Not surprisingly, the issue of intervention is greatly influenced by whether the case in question is one of suicide or one of death management. In general, intervention to save or prevent death is considered appropriate in a case of suicide. Perhaps this has to do with the presumption of irrationality together with either the upholding of the sanctity of life principle or the prevention of harm. Whatever the case, generally speaking, prevention of suicide is considered appropriate and assistance in bringing about a suicide is strictly forbidden. For example, were a bystander to grab the BG boy before he plunged to his death, the bystander would be hailed a hero (even if not by the BG boy). Now if the bystander were to give the BG boy, in a moment of hesitation, a push, the bystander would come under the sharpest of censure. Even if the BG boy had been declared rational, and even if we really did think that the cancellation of a television show was a good reason to choose death over life, the pushing bystander would still be considered to have acted inappropriately. It seems that while it is one thing for a person to be allowed to make certain decisions and take certain actions resulting in his own death, it is another thing altogether for another party to help promote the end of those decisions and actions. The Jones Town massacre is a good example of this. Jones did not force everyone (though he did force some at gunpoint) to take the poison drink. He did assist in their suicide however, by promoting the decisions and actions that led to the mass suicide. In that Jones contributed to those people taking their own lives by suicide, he is morally responsible (liable) for the deaths of those people. Note that Jones is not the only factor involved. Those people (those who were not forced) still raised the cup to their own lips. However one does not have to be the sole factor in order to receive his share of the blame.

Just like we assume that suicide is irrational until proven otherwise, we assume intervention to prevent is appropriate (and intervention to assist inappropriate) until or unless proven otherwise. Now with death management we typically have a different set of presumptions. We presume that death management is rational until proven otherwise. Along these same lines, I want to suggest that we assume that intervention to prevent death in such cases is inappropriate unless proven otherwise. I also want to suggest that intervention to assist should be presumed to be appropriate until or unless proven otherwise. Take, for example Elsie's case. Elsie was attempting to manage her own death. The only means she had available to her was to hoard her pain medication and then attempt an overdose.[7] The third party intervention came into play when Elsie was rushed to the hospital and "saved." Here the intervention to prevent (or to save) is inappropriate. In fact, forcing Elsie to live when what she wants is to manage her death is tantamount to torture. To undergo invasive procedures to which one has not consented, and which are not wanted, is to be harmed. Torture might be a tad too strong a charge, but harm is not. To force the prolongation of a dying process, to force one to experience a bad death, cannot, I wish to argue, ever be thought to be appropriate intervention.

Now consider another scenario. Elsie is dying from her cancer and undergoing chemotherapy. She requests that the therapy be stopped and that she only be palliated, with the full understanding that her death will be hastened by this course of action. Or consider the common case of the removal of a respirator from a dying patient. In both of these cases, the intervention to assist in managing the death is (for the most part) uncontroversial. None of this is to suggest that any and all interventions to promote a good death are necessarily always sanctioned.

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[7] I want to point out here that this is what comes of not allowing assistance. We end up with people attempting their own death management and not being able to create the good death. Because the average patient or person does not have the means available to them to create a good death, what happens is typically a bad death. The bad death of their own creation simply occurs sooner than it otherwise would have. This argument has been made elsewhere in this thesis, and will be made again in more detail, at a more appropriate place.

My point is merely that the presumption concerning intervention is different for death management than it is for suicide. In a case of death management the presumption is that intervention to save is generally *not* appropriate, while intervention to assist *is* generally thought to be appropriate. To claim that intervention to assist is generally acceptable is not to say that there are not disputes concerning the appropriate kinds of assistance. Typically, controversy around intervening to assist in a case of death management takes the form of trying to decide whether or not the intervention ought to be of a certain nature, e.g., either active or passive, and the moral, causal, and legal implications of either. This debate will be discussed in full in the next chapter.

This issue of intervention has a particular poignancy for my discussion of death management, the promotion of a good death. I have claimed that a physician's participation in death management is required in order to meet role responsibilities and to avoid liability for a patient's bad death. I contend that our customary thinking about the appropriateness of intervention in the case of a person who is already dying, is consistent with my conception of a physician's responsibility to her dying patient. In other words, in our customary thinking about the situation of the dying person, we already assume the person is rational, and we assume that intervention to assist in dying is appropriate. We already commonly treat cases of suicide as different from cases in which the person is already dying.

Drawing a conceptual distinction between suicide and death management contributes to understanding why this is so. Our reactions to the stories of Elsie and the BG boy are so different because one case is a suicide and the other is a case of death management.

SOME HARD CASES

I want to take a look at some hard cases to test my proposed distinction between suicide and death management and the different presumptions concerning intervention. For each of the following cases I would like to deal with two questions: 1) Is it a case of suicide or of death management?; and 2) What is the moral status of the intervention to prevent (save) and the moral status of the intervention to assist in each case?

> Case 1: Jake decides to take his own life. He did poorly on an exam and feels the best solution is to take his own life. Jake shoots himself in the stomach. He is discovered before he is dead and rushed to the hospital. Jake pleads with the doctors not to intervene to prevent his death. He claims that he is dying and as such he wants to manage his own death.
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> Case 2: A man, Rajib, is waiting in the airport for the arrival of his family on Air India flight 321. Rajib is informed that the plane carrying his family has crashed, and that there are no survivors. Without his family Rajib has nothing, no reason to go on living. He would like his death to be quick and painless and so attempts to get a prescription from his doctor to produce this sort of death. The doctor refuses. Years pass, and Rajib is still insistent that he be given a prescription to end his life. He feels no better now than the day of the crash, and is not predicted to recover at all

> from the loss of his family.
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> Case 3: Sara is diagnosed with very early-stage breast cancer. If Sara receives treatment quickly there is every likelihood that she will be fully cured of the cancer. If Sara does not receive treatment there is a strong probability that the cancer will spread, become untreatable, and be a direct cause of her death. Shortly after the diagnosis is reported to Sara, she makes a treatment decision. She claims that she is dying, and wants to manage her death so as to ensure a good death. She does not want treatment, except for that which will hasten or immediately produce her death. In short, since Sara thinks she is dying, she does not want to attempt a cure, she wants to manage her death.
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> Case 4: Elinor is in much the same position as Elsie. Elinor, at age 87, lives in a nursing home and is suffering through the last stages of a debilitating terminal illness. She is on very strong medication for pain. One day after she has been hoarding her medication to attempt an overdose, she learns that her only daughter has passed away in a swimming accident. Upon hearing the news and while understandably distraught she consumes her hoard of pills. When attempts are made to treat her for the overdose, Elinor demands that they stop all such attempts and requests that they let her die.

The problem in determining whether or not Case 1 is a case of suicide is the that the scenario changes status mid-way. Case 1 certainly looks like a suicide at the beginning. At the time Jake picks up the gun, he is not already dying. He is dying, however, once he reaches the hospital and makes a claim to death management. In spite of this, I take this to be a case of suicide.

There are several good reasons for supposing that Case 1 is a case of suicide. First of all, at the time of the initial decision-making process, Jake was not dying. This establishes his act as one of suicide. Just because he did not die fast enough to avoid intervention to save him does not change the status of his action. It is still a suicide. Recall the case of the BG boy. Let us say that the BG boy jumps from the bridge, hits the water and begins to drown. He is, when in the water, drowning, his lungs are filling with water and effecting a respiratory system breakdown. I am passing by in a row boat, and against his objections I fish him out of the water and save his life. I have now reversed the dying process (decay of, via damage to, the respiratory system) thereby preventing his suicide. It is important to note that while at some time during the course of a suicide a person will be involved in a dying process, the presence of a dying process alone does not make every death a case of death management. The point is rather that if a decision is made about death *when* one is already dying, it is a case of death management. If a decision about death is reached while one is not dying then this is a case of suicide. To reiterate then, a case of death management is marked by the person being said to be *already dying* when the hastening of death occurs. This is not true in the case of suicide. It is certainly true that both suicide and death management have death as a goal. It is also true that in order to get from life to death, some sort of dying process is usually required (though the processes are not identical).[8] In

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[8] **There is always some process of dying, but in some cases dying can be so quick as to render the marking off of a temporally relevant process practically**

these ways suicide and death management are very similar. Where they differ is at *the point* at which death becomes the goal, the aim, the end sought. When death becomes the end sought but one is *already* dying, say for instance he has given up his fight against advanced cancer, then this is a case of death management. When death becomes the end sought but one is *not* already dying, then this is a case of suicide.

My conclusion in Jake's case is that it is a suicide and susceptible to the presumption to intervene to save. Whether or not that intervention is ultimately justified would require knowing much more about the case than we do. Suffice it to say that there is at least the *presumption* that intervention to prevent (to save) is acceptable.

Case 2 is perplexing. The problem is not identifying the case as one of suicide or not, since it is clearly a suicide. The problem is determining the status of the intervention. Certainly the presumption is to intervene to save Rajib. But if this fails, and Rajib persists in choosing death as an end, even though he is not already dying (at least not in the physical sense) should we continue to maintain the

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impossible. For a person dying this quick a death, it is difficult to say whether the death is good or bad. It is the nature of the dying process that makes a death good or bad, and in the (for all intents and purposes) absence of a dying process, the determination on the nature of the death would have to be made on other grounds. (Perhaps if the death was the result of violence it would be a bad death; or if the death were a very quick painless stroke in an extremely elderly person, perhaps this would be a good death.)

presumption that intervention to assist is prohibited? I think this is a hard case for exactly this reason. There is the sense that if we force this man to live by refusing to assist in the death of his choice[9], we are torturing (or at least harming) him. Though he is not dying, his situation seems parallel with Elsie's. While Rajib is not, strictly speaking, being made to experience a bad death, he is being forced to experience a bad life. His own perception may be that he is, in fact, dying, though this type of dying does not fit my definition of the term, except possibly in an expanded, metaphorical sense.

I think that in this particular case, in these particular circumstances of the longevity of the desire and the unchanging nature of his predicament, we may have reason to override the presumption that intervention to assist is impermissible. This is not to say that the presumption to save is not still in effect. It is only to suggest that there may be justifiable exceptions to the presumption.

Case 3 is complicated in that there is a significant time delay between the decision to manage death and the onset of the dying process.[10] When the

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[9] Let us say, for the sake of discussion, that Rajib cannot bring himself to end his life in any other way by, e.g., a gun shot or leaping from a bridge. The only means he can bring himself to use is medication — prescription medication designed to create a painless quick death.

[10] A diagnosis, in Sara's case of cancer, does not mean the same thing as an actual system breakdown unmitigated by renewal such that the life span is foreshortened. In other words, having cancer and dying from cancer are two different states. A person can have cancer and not yet be experiencing dying as defined above.

decision to make death the goal takes place, Sara is not already dying and therefore it is a case of suicide. On the other hand, however, she believes that a process of dying will begin very shortly. It is in anticipation of the onset of the dying process that she makes death the goal. Stating the case this way makes it look much like — though the resemblance is deceiving — a case of death management.

I think it is extremely relevant to point out that a diagnosis even when there is no available cure, does not alone determine that the dying process has begun. Knowing that the dying process *may* begin from a particular cause is not the same thing as the actual onset of the dying process. One is not dying until such time as there is decay unmitigated by significant renewal such that there is a systems breakdown which foreshortens the life span. Now it is not the diagnosis of cancer and the expectation of the dying process that mean Sara is in fact dying. Furthermore, the onset of the dying process is avoidable. Sara's decision is not really about how to manage her death since she is not already dying, and can well expect not to begin the dying process in the foreseeable future. Her decision is about making death her goal, perhaps because of the shock of finding herself with an illness of this magnitude, when she is not already dying. The fact that the onset of the death process is avoidable, makes her choice even more clearly one of suicide.[11]

I claim, then, that Sara's case is a case of suicide and not a case of death management. There is no dying process to manipulate to promote a good death over a bad death. In fact, the dying process itself may be avoidable. Had the diagnosis been that she was suffering from *advanced* cancer (systems breakdown and foreshortened life span) that was untreatable, the case would be one of death management, since she could be said to be already dying. Because the dying process has not yet begun and is avoidable, this case is one of suicide.

The question of the status of intervention is very complicated in this case. Because it is a case of suicide, we have the presumption to intervene to save Sara. This, however, would mean treating her against her will. She has a well established right to refuse treatment, even if it means the onset of a dying process. What we have then, is another outside factor to figure into the calculations of whether or not intervention to save is justifiable.

Since this is a case of suicide, we presume irrationality or incompetence

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[11] It could also be that the onset of the death process could be put off for a while or delayed. Whatever the case, the point is that if the decision about death is made prior to the onset of the dying process then the decision is not made while dying, and it is a case of suicide. This is not to say, however, that anticipation of the dying process might not be justification for overriding the presumptions concerning the intervention in a case of suicide. Additional arguments for such an exception would have to be made.

until or unless shown otherwise. On the other hand, we generally accept that patients making decisions about care are rational unless or until shown otherwise. In this case, since we seem, given the circumstances, to have both presumptions in operation, it might be prudent to look at competency as its own issue. If she is competent then there is nothing we can do but hope that she will change her mind about treatment before it is too late. If she is incompetent, then perhaps we can override her right to refuse treatment in order to save her.

Case 4 is very interesting. Elinor, by most people's standards, committed, or attempted to commit suicide. But I have defined suicide as a decision to die when one is not already dying. Since Elinor is already dying, by my own definition, this case should be classified as one of death management. Clearly the problem is that this case seems to be simultaneously one of suicide and one of death management.

Allow me to restate the problem. While engaged in death management — the hoarding of pills to manage her death — Elinor attempted to commit suicide. Elinor made a decision about the nature of her death process when she was already dying. This observation supports the conclusion that the case is one of death management. However, Elinor made a second decision which was to take the pill hoard at a particular time for reasons having nothing to do with avoiding a bad death. This seems to support the conclusion that the case is one of suicide.

Up to this point I have been claiming that it is the timing of the decision to make death a goal that helps to categorize cases. In all the other cases and examples it was a simple matter to assume that the reason behind the desire for death management was the avoidance of a bad death. What Elinor's case brings to light is that there may be other reasons when one is already dying for wanting to end the death process (i.e. to die) other than the most common reason which is to avoid the bad death. What part then, do these other reasons play? Do these other reasons for wanting to hasten death while already dying impact on the distinction between suicide and death management? The reason that Elinor wants to die is because of her despondency over the death of her daughter. Looking at the reason behind Elinor's desire to die makes the case look like one of suicide. Yet it cannot be ignored that she is already dying and as such our presumptions about her desire to die are different from what they would be in an uncomplicated example of suicide.

Perhaps in a case such as this, when the case seems to be simultaneously one of suicide and one of death management we need another tool to aid in categorization. But for the death of her daughter, Elinor's consumption of her pill hoard would be considered death management. We would assume that what Elinor was doing, the reason behind her course of action, was to manage her death. When we enter the fact of her daughter's death, our assumptions change. Now we assume that Elinor took a course of action out of emotional despair — with no intention to mange her own death, but to escape the pain of the death of a love one. Now with the former assumption about the Elinor's reasons, we conclude that this is a case of death management. The latter analysis of Elinor's reasons make her course of action appear to conform to the classic case of suicide.

If looking at the timing of the decision (whether when made the person was already dying or not) does not settle the question of categorization, then I suggest we look to the reason behind any additional decisions. Clearly, in this particular case, Elinor's attempt to end her life was not motivated by a desire to manage her dying process in order to avoid a bad death. In this case Elinor was motivated by the attempt to avoid living on after her daughter. I conclude then that Elinor's case is one of (attempted) suicide.

What analysis of Elinor's case suggests is that the motivation for death management is, along with the timing of the decision to manage death, crucial to the identification of true death management cases. Death management, as distinguished from suicide, is then characterized by the person already dying and desiring to hasten death out of a motivation to avoid the bad death. In most cases of death management we are not called upon to consider directly the motivation. For example, in Elsie's case where we have the absence of any reason to think otherwise, we assume that her desire to die arises out of her desire to avoid a bad death. Where, however, we do have a reason to question motivation, we ought to do so to keep clear on which cases are those of suicide (motivation other than to avoid the bad death) and which are truly cases of death management (motivation to avoid the bad death).

Looking to motivation is consistent with everything else I have said regarding the distinction between suicide and death management. For example, certainly one of the reasons we want to prevent the BG boy from killing himself is because we do not think his reason for wanting to die is sufficient to justify wanting death. Generally speaking, I have claimed that the avoidance of a bad death is sufficient reason for wanting to die. If it is necessary to have a fall-back classification tool, and it is necessary given Elinor's case, then I suggest the (careful) use of the motivation behind the decision should the timing (before or after the onset of the dying process) of the decision not settle the question.

In Elinor's case, the issue of intervention is almost as complicated as was the categorization of the case. Since I have concluded that Elinor's case is one of suicide, we have the presumption to intervene to save Elinor. However, in this case, saving Elinor would be to continue her existence so that she could manage her own death. Since she is already dying, and but for the death of her daughter, her case would have been an uncomplicated case of death management, it seems perverse to save her life in order to allow her to take it later should her motivation change. Keep in mind that even though this case was eventually classified as a suicide, there were good reasons not to dismiss it as having elements of death management. Since she is already dying, and in spite of the fact that this may be technically suicide, I think we have reason to override the presumption to save Elinor. The reason is that we would not be benefitting Elinor in the same way that we might benefit, say, the BG boy by preventing her death.

In has been my intention in the analysis of these four cases to demonstrate how the "already dying" distinction and the presumptions concerning intervention can be used to sort through messy cases and help arrive at ostensibly acceptable conclusions. By showing that the distinction between suicide and death management can withstand the challenge of several hard cases, I hope to strengthen my case for drawing the distinction. Drawing this distinction is important to my larger argument in that this distinction helps to validate my claim that fleshing out what wellness might mean to a particular patient is contingent on whether or not that patient is dying.

CONCLUSION

I began this chapter by discussing the concern that death management would turn out to be just a highly contextualized case of suicide. This notion was troublesome, not just because it meant that death management would then be susceptible to all of the ongoing debates concerning the legitimacy of suicide, but because death management really did seem to be different from suicide. Claiming that suicide and death management were essentially the same thing did not explain our tendency to view cases like those of Elsie and the BG boy so differently.

The conceptual separation of death management and suicide rests on the 'already dying' distinction in conjunction with the motivation factor. If a dying person takes action with death as the goal, aim, or end, and that person does so because of the desire to avoid the bad death, we have a case of death management. If, on the other hand, the person is not already dying and takes these same actions, we have a case of suicide. Of course, to make this distinction work, it was necessary to investigate the concept of dying. The dying process, we found, is marked by a combination of two factors. There must be a physical decay unmitigated by significant renewal that results in a systems breakdown. This systems breakdown must be of a kind that foreshortens the person's life span.

Distinguishing between suicide and death management is significant because the distinction aids in dealing with questions most often associated with making death our aim, goal, or end. These are questions concerning the rationality of the decision and/or the person making the decision to end his or her life, the moral permissibility of acting on such decisions, and most interestingly, the status of third parties and possible interventions aimed at assisting in or preventing the occurrence of the person's death.

I attempted to make a case for the presumption to intervene to prevent in a case of suicide, and the presumption to intervene to assist (or at least not interfere) in the case of death management. These presumptions are not absolute and can be overridden in the face of other, more weighty, factors.

If I am correct about the difference between suicide and death management, and the presumption to intervene to assist (or to not interfere) in the case of death management, then this has powerful implications for the promotion of the good death. As discussed in the previous chapter, doctors are faced with both role-responsibilities and moral (liability) responsibilities. For the doctor to effectively fulfil her role-responsibility, which is to promote the wellness of the patient, she must recognize that wellness will be different for a dying patient. Once a person is dying, the good death and the avoidance of a bad death typically constitute wellness. Thus the doctor has a responsibility (role) to promote the good death.

To burden the physician/HCP with the presumption to assist in death management — to imply that the appropriate option is the promotion option — can be to suggest that active euthanasia (defined broadly) is sometimes acceptable, even required. At present, active physician participation in a death, even to promote a good death and avoid a bad one, is legally forbidden and morally condemned by many individuals. *Passive* participation, on the other hand, is generally legally allowable and morally sanctioned by virtually everyone.

While providing assistance in death management is thought to be acceptable — in a way in which it is not in suicide — the *nature* of acceptable forms of assistance (passive is acceptable, active is not) is hotly debated. If this is so, then new tasks emerge. Having established that assistance in death management is the doctor's responsibility, I now have to explore more fully the implications of actively promoting the good death. Since passive forms of assistance are often insufficient to facilitate a good death, it may be necessary to invoke more active measures if this end is to be achieved. Since such measures are generally condemned, both morally and legally, it will be necessary to explore the difference between active and passive measures and whether they bear the moral significance many people suppose.

CHAPTER 4:

ACTIVE VERSUS PASSIVE EUTHANASIA

So far, we have been considering a patient in a terminal condition who wants to avoid a bad death. This patient wants instead to make certain decisions about the management of his or her death process so that said process will be as close as possible to a good death. The manipulation of the dying process is inextricably tied to the use of, or abstinence from, technology. Medical technology is almost exclusively under the control of the HCP, and more specifically, the attending physician. It is the doctor, then, at the request of the patient who is principally responsible for the designing of the death. It is the doctor who knows the ramifications of accepting or refusing certain treatments and can modify the prognosis accordingly. The patient may set the parameters of death management, and may instigate the process by a request, but it is the doctor who architects the design of the death.[1]

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[1] I want to be explicitly clear here. I am talking about a switch in focus from saving the patient's life to saving the patient from a bad death. It is a matter of

We know that the doctor is responsible for pursuing the good death since the good death for such a patient means wellness, and the promotion of wellness is the (role) responsibility of the doctor. However, as we have seen, this pursuit of the good death can involve appropriate or inappropriate conduct on the part of the doctor. In other words, there may be certain ways to pursue the good death that are morally permissible and other ways which are not. In the chapter on responsibility, we discussed the three options a doctor has in promoting a good death. The do-nothing option led, at the very least, to an unreasonable risk of the bad death. This left only two options: pursuing the good death passively (passive option) — which is generally morally and legally sanctioned, or pursuing the good death actively (promotion option) — which is generally morally and legally prohibited. I further suggested that the passive option also created an unreasonable risk of the bad death. This constitutes either negligence or recklessness and therefore probably means that the doctor is liable for the patient's bad death. Before condemning the passive option I would like to describe and discuss its most promising instantiation.

INFORMED REFUSAL

What I have been calling death management might look suspiciously

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focus: all attempts to prevent death should be made, but when these become futile or harmful, the focus should then become the prevention of a bad death.

like what Margaret Pabst Battin calls informed refusal.[2] There are, however, several important differences despite the similarities. One of the most important differences is that Battin is looking at the issue of the bad death from a legal point of view. That is to say, her main concern is how to achieve a better death under the current legal constraints on doctors and patients. I have been concerned with the moral issue rather than the legal one, but nevertheless, what Battin has to say about informed refusal is similar to at least the logic behind death management.

Battin implicitly recognizes the problem of the bad death. The solution to the bad death, contends Battin, is the safe-guarding of a "natural death." A so-called "natural" death, it seems, is one that is similar to Callahan's tame death — a death that is quick and merciful. In fact, the "natural" death is the goal of the right-to-die movement. This movement has lobbied for some sort of legal protection and there is, in fact, one such protection for the "natural" death, namely, the right to refuse medical treatment.[3] Battin says:

> In the face of irreversible, terminal illness, a patient may wish to die sooner but "naturally," without artificial prolongation of any kind. By doing so, the patient may believe he or she is choosing a death that is, as a contributor to the *New England Journal of Medicine* has put it, "comfortable, decent, and peaceful;" "natural death," the patient may assume, means a death that is

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[2] **Margaret Pabst Battin, Least Worst Death, (New York: Oxford University Press, 1994) p. 33-39 [hereafter referred to as LWD]**

[3] **Battin, LWD, p. 33**

> easier than a medically prolonged one.[4]

The problem here is the assumption of what constitutes a "natural death." It seems from the description in the above quotation that a "natural death" would be a death something like the pre-modern death. In other words, a "natural death" would seem to indicate a death without the influence of technology or human agency attempting to prolong life. While this might suffice for a working definition of "natural" it does not seem quite to fit the spirit of the kind of death the patient wants. The point is that "natural" or "without human or technological attempts to prolong life" does not always mean painless, quick, comfortable, or peaceful. To assume that a natural death is necessarily a peaceful death is to mistake what is required to achieve a peaceful death. Battin addresses this equivocation over the term "natural," with the main point of the discussion being that what patients want is a peaceful death. Patients are simply calling what they want by the wrong name. In essence, patients tend to think that a natural death will mean a peaceful death. Battin gives an example to illustrate how assuming that natural and peaceful deaths are the same thing can, in fact lead to a bad death:

> Even less likely to match the patient's conception of natural death are those cases in which the patient is still conscious and competent, but meets a death that is quite different than the one bargained for. Consider the bowel cancer patient with widespread metastasises and a very poor prognosis who — partly out of consideration for the

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[4] Battin, LWD, p. 33

> emotional and financial resources of the family — refuses surgery to reduce or bypass the tumor. How, exactly, will he or she die? This patient is clearly within his or her legal rights in refusing surgery, but the physician knows what the outcome is very likely to be: obstruction of the intestinal tract will occur, the bowel wall will perforate, the abdomen will become distended, there will be intractable vomiting (perhaps with a fecal character to the emesis), and the tumor will erode into adjacent areas, causing increased pain, hemorrhage, and sepsis. Narcotic sedation and companion drugs may be partially effective in controlling pain, nausea, and vomiting, but this patient will *not* get the kind of death he or she bargained for. Yet, the patient was willing to shorten life, to use the single legally protected mechanism — the refusal of treatment — to achieve that "natural" death.[5]

Quite simply, the right to refuse treatment falls short of providing the good death in many instances. In fact, it seems the right to refuse treatment may make the bad death even worse. Why? Well, part of the issue is the fact that some medical treatment will be instigated before it is known that the condition is terminal, or before the condition becomes terminal. This means that to achieve a natural death, treatment and technology will have to be withdrawn. As noted in Chapter One above, the withdrawal of treatment can sometimes mean that the patient is abandoned and will eventually face a bad death. However, once death is imminent, refusing technology and treatment at that point will not change the dying process from bad to good. We fight the disease until there is no point in continuing to do so. However, what to do *then* is the real question. Just giving up

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[5] Battin, LWD, p. 33-34

the fight is clearly not the answer. Perhaps instead we should fight a different battle. Instead of fighting the disease, we ought to fight the bad death.

Battin's solution is to use the right to refuse treatment selectively. In other words, the patient and the physician aim at a good death, and use the means of accepting some treatment (usually the minimum to make the patient comfortable) and rejecting other treatments (usually any aggressive measures designed to extend life — or in this case, dying). While this kind of effort may fall short of the good death, the doctor and the patient, by means of selective refusal, settle for the least worst death.

Of course a patient will likely not have the knowledge and specialized skills by which to make the selection above, so in the refusal of treatment the patient must be fully informed by the physician. This idea is neither new nor controversial. We are used to dealing with information in terms of consent to treatment. People need to be informed of the risks, dangers, benefits, and so on, of any proposed treatment. This information is provided so that a patient may make an appropriate decision for herself. This same concept is at play in the notion of informed refusal when patients are dying. The patient needs to know what rejecting a treatment will mean for the dying process. The patient will need to make decisions, based on the information provided by the doctor, as to which treatments to accept and which to reject. Notice one important difference between informed consent and informed refusal: in the former case the emphasis is usually on promoting health, and in the latter the focus is on promoting death — albeit a death of a certain kind.[6]

Now it could be argued that promoting death of *any* kind is not part of the physicians' mandate. However as I have already argued[7], promoting life during the dying process is often only harmful to the patient.[8] The most a physician can do in promoting wellness is to promote a good death over a bad death. In addition, as Battin has pointed out, the right to refuse treatment is a legally protected instantiation of patient autonomy. Clearly the patient has a right to refuse any treatment, and if she should choose to do so on a selective basis intending a good death, then the physician is still under an obligation to provide the information necessary to make selective refusal informed refusal. In short, it is clearly sometimes permissible to promote death if only because selective refusal is permissible even when the aim is to promote death, albeit a good one.

Now informed refusal might be thought to be identical with death management. In both cases, the goal, regardless of the means, is a better than

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[6] It is possible to have informed refusal in cases where the patient is not (at least at that time) dying. These are just not the cases of paramount interest at present.

[7] See chapter one.

[8] This is especially true when the patient has requested death management.

bad death. But the two are crucially different. While informed refusal attempts to seek out the least worst death within the established legal constraints, death management, as I have defined it, is concerned with bringing about the best death all things considered. In other words, Battin is attempting to solve the problem of the bad death within the options available under current legislation. I am attempting to solve the problem of the bad death from the moral point of view. And from this point of view, the conclusion might be that some of the currently illegal options ought, morally, to be available.

Even though Battin's agenda may differ slightly, she does, however, make some points worthy of our consideration. As she makes abundantly clear, the bad death is something that many people wish to avoid even at the cost of dying earlier. Embedded in the wish to die earlier, is often the wish to die more easily. The goal of a person facing a bad death is often this earlier and easier death. Terms like "earlier," and "easier" are relative terms. Certainly a good many unsavory deaths would count as earlier and easier than the anticipated bad death. As well as being relative terms, they are median terms, as in "easy, easier, easiest." I realize that when faced with legal constraints, "easier" is often the best we can do. But if an easier death is not enough for a good death, then we must look very closely at the barriers to seeking the easiest death. One such barrier is that implied by the distinction between active and passive euthanasia. Aiming for the easiest death often means that we must intervene actively to promote this goal. And such intervention is generally believed to be morally, as well as legally, impermissible.

ACTIVE VERSUS PASSIVE DEATH

The right to refuse treatment is a negative right. The patient holds a right such that the doctor must refrain from some specified action. This, in part, is why informed refusal is often limited to an easier death. In order actually to *do* something to promote a good death, it appears we cross the line from passive to active. Traditionally in medical ethics, it is thought that allowing someone to die (passive) is less morally abhorrent than killing someone (active). On this view, it is allowable to get out of a patient's way when he or she is ready to die, but it is not acceptable to do anything to help her or him along.

James Rachels challenges this notion that passive death is more acceptable than active death by arguing for what he calls the Equivalence Thesis.

> The Equivalence Thesis, as I will call it, says that there is no morally important difference between killing and letting die; if one is permissible (or objectionable), then so is the other, and to the same degree. More precisely, it is a claim about what does, or does not, count as a morally good reason in support of a value judgement: the bare fact that one act is an act of killing, while another act is an act of 'merely' letting die, is not a morally good reason in support of the judgement that the former is worse than the latter.[9]

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[9] **James Rachels, The End of Life, (New York: Oxford University Press, 1986) p. 111 [hereafter referred to as EOL]**

Rachels goes on to say that there may be other reasons to distinguish between killing and letting die, but such a reason will not be based on the difference between act and omission.

In Rachels classic example used to illustrate the equivalence thesis, we are to imagine two men, Smith and Jones, both of whom stand to gain a great deal if a young cousin dies. Smith, eager for his inheritance, waits until the boy is taking a bath, steals into the room and drowns the child. Jones, with exactly the same motivation in mind, sneaks into the bathroom where his cousin is bathing. Jones is fully prepared to drown the child, but before he gets the chance, the boy slips, hits his head and falls under the water. Jones sees this and waits with the intention of holding the boy under if necessary, but it is not and the boy dies.

Rachels point is that we find the behavior of both Smith and Jones to be abhorrent. It is not the case that we think Jones is less of a fiend simply because he merely let his cousin die.[10] The Smith case and the Jones case are identical in that each wanted his cousin dead, and each was under the same motivation of the inheritance. The only difference between the two cases is that Smith achieved his goal through active means and Jones through passive means. This difference is not difference enough to be reflected in the moral judgement of either case. Both Smith and Jones are equally morally blameworthy for the death of their

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[10] Rachels calls this kind of argument the bare difference argument: the only difference between the two stories is that one is of an act and one is of an omission.

respective cousins.

Notice that because the motivation and the end are the same for both Smith and Jones, it would be easy to jump to the conclusion that Rachels is making a case for the end justifying the means. Put another way, it would be an easy criticism of Rachels to assume that his bare difference argument is tantamount to suggesting that so long as the end is justified, the means are largely irrelevant. I do not think this is an accurate portrayal of Rachels. He is not claiming anything about the nature of the means other than they are morally equivalent. He does not claim that one kind or category of means is justified and one is not. His argument seems to be more in the direction of claiming that if one is connected to an event, whether this connection is through active or passive behavior, it is the connection that counts and not the means by which such a connection is established. This is not the same as claiming that any means will suffice so long as the end is justified.

The implications of the bare difference argument and the equivalence thesis for the case of death management are clear. Actively promoting a good death is no worse (nor any better), all else being equal, than passively allowing a good death. Informed refusal would be like passively attempting to create a good death. Death management would be actively pursuing a good death. According to Rachels, if the passive form is allowed, and it most certainly is, then so too should the active form be allowed. So even though death management might mean actively doing something to ensure a good death, this is not prohibited given the equivalence thesis.

In fact, following Rachels' logic, actively promoting a good death is preferable to passive means of attempting to achieve a good death. Remember that Rachels claimed that the mere difference between act and omission was not enough to justify a difference in moral judgement. There might, however, be other factors that could be used to discriminate between the two cases. Consider what Rachels says of the case of a man in the last stages of terminal throat cancer who is in tremendous pain:

> Remember that the justification for allowing the patient to die, rather than prolonging his life for a few more hopeless days, is that he is in horrible pain. One problem is that, if we simply withhold treatment, it will take him *longer* to die, and so he will suffer *more*, than if we administered a lethal injection. Why, if we have already decided to shorten his life because of the pain, should we prefer the option that involves more suffering? This seems, on the face of it, contrary to the humanitarian impulse that prompts the decision not to prolong his life in the first place.[11]

In essence, using passive means to promote a good death is often far less effective and humane than using active means. In other words, given the goal, active means are often more likely to facilitate achievement of that goal than are passive means.

Notice that Rachels deals only with those cases where we can assume

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[11] Rachels, EOL, p. 108-109

the patient is already dying. When one is already dying, the equivalence thesis brings down the barrier to the good death presented by the moral difference thesis. Notice as well, that Rachels' thesis is not licence to kill just anyone for any reason. For example, a suicidal patient would not, given what Rachels has argued, be any more entitled to assistance than he or she would under the moral difference thesis. Essentially then, the debate over the morality of active measures versus passive measures is generally restricted to cases in which the patient is already dying. In other words, the active versus passive measures issue only comes up once we have narrowed our focus to cases of death management, that is, when the primary issue for wellness is a good death.

The set of objections to Rachels' arguments that I will now deal with, I take from Callahan, who, among other things, faults Rachels for conflating cause and culpability. Callahan maintains that in collapsing the distinction between active and passive euthanasia, Rachels also collapses the vital distinction between the cause of a death and responsibility for that death.

CALLAHAN'S OBJECTIONS TO RACHELS

Callahan, in direct rebuttal to Rachels' bare difference argument and the equivalence thesis, claims that Rachels makes three mistakes. The first of these is as follows:

> The first [moral consideration of the significance of the difference between killing and letting die] is that, as a

> reality of nature, killing and letting die are causally different. "Letting die" is only physically possible if there is some underlying disease that will serve as the cause of death. Put me on a respirator now, when I am in good health, and nothing whatever will happen if it is turned off. I cannot be "allowed to die" by having the respirator turned off if I have healthy lungs. It is wholly different, however, if a doctor gives me a muscle-relaxing injection that will paralyze my lungs. Healthy or not, those lungs will cease to function and I will die. That is what it means to "kill" someone as distinguished from "letting" someone die. Put more formally, there must be an underlying fatal pathology if allowing to die is even possible. Killing, by contrast, provides its own fatal pathology. Nothing but the action of the doctor giving the lethal injection is necessary to bring about death.[12]

The point here is that the cause of death is important. The obvious implication of Callahan's position is that if the cause of the death is nature, i.e., we let nature take its course in causing the patient's death, then there is no meaningful question concerning culpability. The death was not caused by some human agent or act necessitating agency, and so no one can be blamed for the death. If, however, it is the case that *but for* the act or omission on the part of an agent, the person would have continued to live, then the death was caused by that agent and as such that agent is responsible for the death. Since in this instance it was an agent who was the cause of death and not nature, that agent must be accountable for the death. As Callahan says, "There is and will always remain a fundamental

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[12] Daniel Callahan, The Troubled Dream of Life: Living With Mortality, (New York: Simon & Schuster, 1993) p. 77 [hereafter referred to as TDL]

difference between what nature does to us and what we do to one another."[13] Thus the difference between killing and letting die is of vital importance since the difference is a causal one, and this difference explains why it is proper to assign moral culpability in the one case, but not the other.

Callahan's second problem with Rachels concerns, in a narrow sense, the doctor's intention.

> Though the result of killing and allowing to die may be the same in one way — a patient is dead in either case — that hardly means that the causal difference between the two incidents is morally irrelevant. Here is Rachels' second mistake: to assume that the intention in letting die is ordinarily the same as in killing, that is, to make a person dead. It is certainly the case that we *might* intend someone's death and turn off a machine to bring that death about. But it is equally the case, and far more common in ordinary medical practice, that patients are allowed to die because of a judgement that it no longer makes sense, medically or morally or both, to continue life-extending treatment. Doctors have long stopped treating patients when their skills and art run out. There is no reason to think that, as a rule, it is because their intentional goal is to make people die.[14]

Doctors halt treatment when the treatment becomes futile, or when no further treatment is available. So, it would seem that doctors allow patients to die because they have no choice in the matter. Put another way, if the doctor has exhausted all of her professional resources (both knowledge and technology) it is not as though

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[13] Callahan, TDL, p. 76

[14] Callahan, TDL, p. 77

she could do otherwise than let the patient die. Callahan implies that the intention of the doctor coincides with the traditional "do no harm" and "provide benefit for the patient" principles of ethical medical practice. The doctor may know that the patient will die, but that is not because of a choice that the doctor made, but because the patient has a condition beyond medical intervention. The decision to discontinue or withhold treatment is a function of the treatment's ability to harm or benefit the patient. If a treatment is harmful, or provides no benefit, then such intervention is not warranted. Should the patient die, it is because of the underlying condition and not because of the agency or intention of the doctor.

Callahan's third and final criticism of Rachels is as follows:

> Rachels' third mistake is to think that the method by which a physician brings about a patient's death is "not in itself important." Yet it is, and for an obvious reason. With "letting die," it is the disease that causes the patient's death, not the doctor; and the doctor's traditional stance of refusing to kill patients has not been challenged. In the case of killing, doctors become the cause of death. That shift erases the long-established moral rule against killing by doctors, and also introduces a new justification for killing, that of relieving suffering. Even if one agrees with such a change, can it really be characterized as "not in itself important"? Nothing less than the meaning and goals of medicine is at stake.[15]

Here Callahan seems to be charging Rachels with the destruction of one of the most salient principles of professional ethical medical conduct which is: under no

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[15] Callahan, TDL, p. 79

circumstances is killing allowed. Doctors should not go about intending to cause the death of their patients, even where death brings the only available relief from pain and suffering. If we follow Rachels and claim that killing is no worse than letting die, we give license to doctors to violate the fundamental idea that doctors should not kill. This furthers the erroneous idea that doctors always have control over nature, and thus over death. If doctors are mandated to kill in order to relieve pain and suffering, then they *do* in fact have the ultimate control over nature: doctors can legitimately kill. Not only does this violate our very notion of physician as healer, but it violates a deeper ideal that human life is somehow more sacred than killing someone because he or she is in pain would indicate.

RESPONSE TO CALLAHAN'S OBJECTIONS TO RACHELS

In response to Callahan, I think we must begin by noting that he has missed part of the main point of Rachels' arguments. Though Callahan makes some interesting points of his own, they are not necessarily as directed at Rachels as Callahan seems to intend. The first challenge by Callahan is about the difference in causality between killing and letting die. Callahan claims that in letting die, it is the disease that is the cause of death while in the case of killing, the cause of death is an agent's action or omission. This causal difference, however, only makes sense when applied to cases that differ in terms of prognosis. To illustrate using Callahan's own example, if I am put on a respirator while in good health, removing me from the respirator will not kill me, nor will it allow me to die. In order for me to die, I would have to be killed. Clearly here the cause of death is relevant, since I would not have died without some sort of active intervention with my death as a goal. But if I have a terminal condition and the respirator is necessary to extend my life, were I to have it removed I would die. Even if I do not have the respirator removed, I will still eventually die from the same underlying condition. Now the difference in the cause of death for a terminal patient and a non-terminal patient would be of grave concern. But as Callahan himself points out, a causal designation like "letting die" is only relevant when there is an underlying condition that makes death inevitable. The causal designation "killing" under these same circumstances — namely, a terminal condition — now does not so markedly differ from "letting die". To deny this is to make some strong claims about being able to identify what it is exactly that brings about death.

Allow me to make the point another way. Say I am in the last stages of terminal cancer. What would it mean for me to die of cancer? I could, while in hospital, develop pneumonia, and if untreated I could die from such a secondary illness. It could be decided that because of the state of my cancer, treating me for pneumonia is futile. When I die, it is at least as legitimate to cite my cause of death as pneumonia, as it is to claim I died from cancer. The cancer is what made the treatment of pneumonia futile, but nonetheless, I would not have died when I did but for that case of pneumonia. Now consider the case in which I do not develop pneumonia or any other secondary fatal complication. I talk my physician into giving me an injection not only to control the pain but also to hasten my death. Now my cause of death is the injection, or rather the action of the physician. Certainly, but for my dying of cancer, I would not have received the injection. In neither case — the die-from-disease case, nor the die-from-human agency case — do I die from my underlying condition of terminal cancer. Callahan may want to point out that pneumonia is a natural precipitate of cancer, and thus dying from pneumonia is still dying from natural causes, whereas the injection is not natural. I would respond to this by saying that in both cases, it is the cancer that precipitates the action or omission. First the cancer is the reason why the pneumonia goes untreated. Second the cancer is the reason why my pain is treated in such a way as to hasten my death. My point is that there is a sense in which the cancer is the cause of death, regardless of what the patient actually succumbs to in the final moment. Notice that the specific cause of my death is not as important a factor in my death as is my prognosis. Were I expected to recover from cancer, then treating the pneumonia would have been deemed worthwhile. Regardless of the specific cause of death, the point is that my death was part of my prognosis. Once a death is unavoidable — once the patient is *already dying* — the actual cause of the death, whether it be a doctor or nature, is not the crucial factor in a moral judgement of culpability. It makes sense to suggest a difference between killing and letting die if the avoidance of death is in question, i.e., if death is not the certain prognosis. Once death is the prognosis, i.e., the person is already dying, the specific cause of that death is largely irrelevant. This is not to say, I hasten to add, that there may not be other grounds on which to judge the treatment of a terminal patient. We even have moral guidelines, culturally specific though they may be, about the treatment of a corpse, so it is not the case that a dying person cannot be mistreated just because she is going to die anyway. For example, it is still the case that a doctor cannot experiment without consent on a dying patient.

Another problem with Callahan's remarks on causality is that in both cases where I have cancer, there is some agency on the part of the doctor. It is not the case that when I die from pneumonia, my death is in no way in the control of the physician. Certainly the fact of my death is outside the scope of the physician's powers, but the type of dying process I go through is, at least to a degree, manipulable by the doctor. *There is agency present whether the agent commits or omits an act.* I think this is closer to what Rachels is getting at when he asserts that the bare difference between act and omission is not enough on which to base a moral judgement. Since there is an agent acting or omitting whether I die from lethal injection or a decision to terminate treatment, the action or omission by itself, is not as important as other factors such as the motivation behind or the reason for the action or omission.

Callahan's second criticism is based on what he believes to be the mistaken assumption that the intention behind killing and letting die are the same, that the patient die. He argues that the intention in allowing to die is something akin to refusing to harm the patient with futile or outright harmful treatments. The intention is to do no harm. That the patient dies of the underlying condition is unfortunate, but unavoidable. Even were treatment continued and the patient subjected to futile or harmful interventions, the patient would still die of the underlying condition. Now a lethal injection, says Callahan, requires the direct intention on the part of the doctor to have the patient die. This issue of intention is highly controversial. It can be argued that if one foresees an outcome of an action or omission, it is automatically intended. Others counter this contention by claiming that one does not necessarily intend all possible outcomes of a given action or omission; one can intend a certain outcome independently of the manifest outcome.[16] In an attempt not to skirt the issue, but to clarify it, I want to suggest that what is really important here is *motivation* rather than *intention*. I want to claim that it is not *what* you want to happen, but *why* you want it to happen that is at issue in determining if there is any real difference between killing and letting

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[16] I will discuss all of this in more detail when I address the doctrine of double effect.

die.

It makes less sense to talk about *what* you want to happen when talking about the ultimate outcome concerning a terminal patient, than it does to talk about *why* you might want that outcome to manifest itself at a certain time or under certain conditions. In the case of a terminal patient, it could be the case that the doctor *intends* the death of the patient when she orders treatment withheld or withdrawn. This does not tell us much by way of providing morally relevant reasons for laying blame. I could *intend* the death of the man with the axe chasing me down the street, and I would not be culpable for that death, whether I kill him myself in self defense, or he gets hit by a bus. What does tell us something about the doctor's moral blameworthiness, or lack thereof, is *why* she wants (intends) the patient's death. If the patient has willed the doctor a valuable estate, then this sheds some light on the moral conduct of the doctor. If the doctor wants the patient's death because the alternatives are a good death now or a bad death later, I think this too sheds light on the moral conduct of the doctor.

One serious problem, of course, is that motivation is often more difficult to ascertain then intention. We can often ascribe a particular intention by observing a certain action or omission. Motivation does not usually have this close link to conduct. We cannot usually infer a person's motivation merely by watching what they do. While motivation may be more important than intention, at least for this one of Callahan's points, it is much harder to get at, prove, or show. This however, is beside the point. That motivation is difficult to establish is no reason to suggest that it is less important, morally speaking, than intention, which is after all, only slightly less difficult to establish in many cases. In other words, the point that motivation is more relevant than intention cannot be ignored just because motivation might be harder to pin down.

I think that Callahan misses the mark when he claims that Rachels mistakenly assumes that the intention in both killing and letting die are the same. What Rachels thinks is the same in both killing and letting die is the motivation. Rachels assumes a humanitarian motivation in the case of the terminal patient, and a malevolent motivation in the Smith-Jones example. Rachels makes clear that he is talking about motivation and not intention when he discusses an example of babies with Down's Syndrome. Sometimes a baby with Down's Syndrome is born with an intestinal blockage. The intestinal blockage is not part of Down's, but does sometimes accompany the disorder. The blockage is easily fixed with a little surgery, but the surgery is not always recommended, nor is consent to perform it always given.

> To bring out the irrationality of this situation, we may first ask *why*the babies with blocked intestines are allowed to die. Clearly, it is not because they have blocked intestines. The parents do not despair, and opt for death, over this condition which often could be easily corrected. The reason surgery is not performed is, obviously, that the child

> is mongoloid and the parents and doctors judge that because of *that* it is better for the child not to survive. ...What makes this situation possible, of course, is the idea that there is a big moral difference between letting die and killing: when there is an intestinal obstruction, we can 'let the baby die', but when there is no such defect there is no choice to be made, for we must not 'kill' it. The fact that this idea leads to such results as deciding life or death on irrelevant grounds is one reason, among others, why it should be rejected.[17]

It is obvious in this statement that Rachels finds the motivation (*why* the baby's death is wanted), and not the intention (*that* the baby's death is wanted) behind the death, to be the morally relevant element. Moreover, maintaining the distinction between killing and letting die (that the latter is acceptable and the former is not) only affords the opportunity to make life and death decisions, with dubious motivation, under the guise of acceptable intent, i.e., letting die.

The third mistake that Callahan believes is made by Rachels concerns the method by which the physician brings about a patient's death. Rachels claims that, all else being equal, it matters not whether the method of bringing about death is active or passive. Callahan disagrees in a strenuous fashion. This criticism is not entirely independent of the other two. The reason Callahan disagrees is because he claims that if death is passively brought about, then the death is caused by the terminal condition. If the death is actively brought about, claims Callahan, then the death is caused by the physician. This point has already been

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[17] Rachels, EOL, p. 110-111

addressed.

Callahan, however, adds another dimension to his third criticism by claiming that collapsing the distinction between killing and letting die will mean a major, and ethically troublesome, shift in the practice of medicine. No longer will the doctor be the model of the healer, the benefactor, the warrior against illness and disease. If the doctor is thought to be justified in killing on the grounds that killing will relieve suffering, he shifts from being a healer to being a killer and we have further eroded our commitment to prohibit the killing of another human being.

How, exactly, having a justification for a patient's death is connected to the "meaning and goals of medicine"[18] is a bit of a mystery. Presumably, Callahan is concerned that without the distinction between killing and letting die, we will come to find doctors responsible for anything that happens, good or bad. Callahan buttresses this interpretation of his point when he says:

> I do not want to deny that physicians can wrongly allow patients to die, and thus be culpable for that death. That is why it is understandable to speak colloquially of a doctor's "killing" a patient if treatment is wrongfully stopped. This linguistic convention allows us to place the doctor in the same moral category as those who directly kill others; thus we express the strongest possible moral condemnation. But it is not *literally* the case that the doctor kills. Only the underlying disease can accomplish the necessary condition for death to occur when treatment

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[18] Callahan, TDL, p. 79

is stopped. [19]

So Callahan is worried that if Rachels' arguments succeed, and the distinction between killing and allowing to die is collapsed, doctors will no longer be the champions of wellness, but also the accomplices of death. In other words, our view of medicine will contain a conflation of the concepts of cause and culpability such that we expect too much of medicine. More that this, however, without the distinction, we will never be able to separate nature from moral judgement, and this in Callahan's eyes is simply a mistake.

While I sympathize with Callahan's desire to separate cause and culpability, nature from human agency, I think it is unlikely that we will find the sort of hard and fast line of separation Callahan wants. Consider a woman with heart disease, who is admitted to the hospital with a myocardial infarction. Without treatment she will die, but if she receives treatment, she can expect to recover, at least temporarily until her condition deteriorates further due to the already present heart disease. If this woman (who has consented to treatment) is not treated, then I am assuming that this would be a case of wrongful withholding of treatment. Callahan admits that the doctor would be culpable for the woman's death. He claims that it is because of a linguistic convention that we put the doctor in the category of murderer, but maintains that the doctor did not *literally* kill her. It

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[19] Callahan, TDL, p. 79-80

seems to me that the doctor did kill her, and is culpable because she brought about harm; the doctor is at fault for the woman's death. The doctor is liable for the death resulting from the omission to treat because the doctor is at fault in not treating. If the doctor is at fault, and it was the faulty aspect of the conduct that caused the harm, then the doctor is liable for that harm, i.e., the death of the patient she refused (out of intentional wrongdoing, recklessness or negligence) to treat.

It is not because of a linguistic convention that we can say that the doctor killed, it is because but for the conduct (action or omission) of the doctor, that woman would have lived. Just because the weapon of choice was a (un)luckily timed heart attack, does not excuse the doctor from culpability. Yes, the heart attack killed her, but only because the doctor allowed it to. To deny that there is agency and liability-responsibility here is to underestimate how much of nature is manipulable by agency. It is not necessary that agency dominate, or eradicate, or completely control, nature. It is sufficient to recognize that agency and nature interact, and much nature not under complete human control, is still influenced by agency. The point is that there are areas of nature that we can control or influence. In this grey area, not even linguistic convention will save Callahan's black and white categories of human control and nature.

THE CRUX OF THE RACHELS-CALLAHAN DEBATE

To summarize the Rachels-Callahan debate, Rachels put forth the bare difference argument and the equivalence thesis. The bare difference argument, illustrated by the Smith-Jones example, concludes that the bare difference between act and omission makes no difference in allocating moral responsibility. An omission can be just as acceptable or unacceptable as a commission, and vice versa. If there is no moral difference between act and omission, then in a situation where some end can be brought about either actively or passively, the courses of action are, all else being equal, morally equivalent to each other. Put another way, the equivalence thesis states that, all else being equal, there is no moral difference between active and passive euthanasia; there is no difference between killing and letting die.

Callahan objects to the collapse of the active-passive distinction on the basis that without the distinction cause and culpability will become conflated. He further objects that on Rachels' view, the intention behind killing and letting die are the same. Callahan maintains that they are not. Lastly, Callahan worries that without discriminating between killing and letting die, we will suffer from further confusion concerning our power over nature, meaning that we will be unable to determine what ought to be under human control and what simply cannot be under human control.

Callahan's objections, while refutable, are an understandable reaction to what Rachels is proposing. Rachels is looking at the facts of the matter, and using carefully thought out arguments, showing that it makes no sense to allow one type of conduct bringing about death (passive) and not another (active). However, it is the ramifications of accepting such arguments that has Callahan objecting. The parting of the ways seems to be located at the point of practice. While Rachels is claiming that the practice will change, but the morality of the situation will not, Callahan seems to be contending that one cannot change the practice without changing the morality of the situation. In other words, Callahan seems to think that if we change what we *do*, we change who we *are* such that if we allow anything that has the stigma or connotation of what we traditionally think of as "killing" we will become, in essence and in the worst possible connotation of the term, "killers". If we let nature be the killer then we can rest assured that we have crossed no lines. He is trying to separate human agency from death. Unfortunately, this cannot be done, and for some of the very same reasons pointed out by Rachels. We already manipulate, influence, or control a number of our medical encounters with nature. Changing our practice, by, say, accepting that there is no moral difference between commission and omission, does not necessarily doom us to becoming killers. For all of Callahan's talk about making the distinction between nature and agency, he fails to see that agency is present in conjunction with death no matter what the final cause of death. Agency can be manifested either actively or passively, and letting a "natural" condition be the cause of death will not alter the fact that agency was involved in stopping treatment, or otherwise allowing[20] to die.

THE BARE DIFFERENCE ARGUMENT TESTED

Assuming that Callahan's objections have been dealt with there may yet be reason to question Rachels' bare difference argument. I have been defending Rachels against Callahan on the assumption that there is no difference between act and omission, and consequently that the equivalence thesis holds. Winston Nesbitt explores the problem of active versus passive euthanasia by addressing this assumption explicitly. He says by way of introduction:

> A view frequently debated in discussions of euthanasia is that there is a moral difference between 'active' and 'passive' euthanasia, between, that is, euthanasia which takes the form of deliberately acting to end someone's life and euthanasia which takes the form of merely refraining from acting to prolong her life. For brevity's sake, I will refer to this view as the 'moral difference' thesis. Specifically, the moral difference thesis asserts that it is more difficult to justify active euthanasia than passive euthanasia.[21]

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[20] Using the term "allowing" is a bit misleading. Callahan points out that we do not allow someone to die in the sense that we otherwise could cure her. But we do allow people to die in the sense that we do not force them to continue living. It is in this sense that I use the term "allowing to die."

[21] Winston Nesbitt, "Euthanasia and the Distinction Between Acts and Omissions," in Journal of Applied Philosophy, vol. 10, no. 2, 1993, p. 253

Nesbitt thinks that the reason it is thought to be more difficult to justify active euthanasia is because we think that there is a morally relevant distinction between acts and omissions. This is understandable since we tend to associate active and act, on the one hand, and passive and omission, on the other. Nesbitt sees this as being an application of a broader doctrine that it is worse to harm someone outright than it is merely to allow harm to come to her. He calls this broader thesis on acts and omission the "acts and omissions doctrine."[22] Nesbitt's next move provides an insight into this doctrine:

> What we must now note is that the acts and omissions doctrine refers only to a subclass of acts and omissions, namely those which harm someone; there are also acts and omissions which are beneficial to someone, and those which neither harm nor benefit anyone. Given this, it can be seen that it is a mistake to think that the doctrine that it is worse to kill than to let die establishes or supports the moral difference thesis. For the former is an application of the more general doctrine that it is worse to actively harm another than to allow harm to come to him, and is thus understood to be referring to cases of killing and of letting die which are harmful.[23]

Nesbitt's point is that in the case of euthanasia, death is not considered a harm, but rather a benefit. Those who assert the moral difference thesis, however, are assuming that death is a harm, and it is on this basis that they invoke the doctrine

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[hereafter referred to as EDAO]

[22] Nesbitt, EDAO, p. 253

[23] Nesbitt, EDAO, p. 254

in claiming that it is worse to harm a person outright than to let harm befall a person. But if the death has already been established as a benefit, the moral difference thesis simply does not apply. Instead of arguing for or against the contention that acts (of harm) are somehow worse than omissions (failure to prevent harm), Nesbitt skirts the whole issue by suggesting that none of this applies in the euthanasia debate.

An obvious objection to Nesbitt's claim is that those who maintain the acts and omissions doctrine in relation to euthanasia see letting die as a benefit but killing as a harm. The idea is not just that killing or actively bringing about the death is more of a harm, it is that it is a harm period. Similarly, while allowing someone to die is tragic, it is not a harm at all to the person who dies but a bitter sort of benefit. Therefore, the objection continues, the moral difference thesis is saved on the premise that it is acceptable to benefit someone, but unacceptable to harm them outright.

This objection is unfounded. As Nesbitt points out, death in the case of either active or passive is a benefit rather than a harm. Take Rachels' example of the man with throat cancer. As Rachels points out, the man's death is a benefit, it would be cruel to fail to provide him with that benefit because of some misguided beliefs based on the moral difference thesis.[24] As I have already argued

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[24] Obviously, Rachels is trying to establish the supremacy of active means over passive. But establishing this is not done on the grounds of any difference

above, what counts as wellness — and thus a benefit — for a person already dying is different from what would count as wellness — and thus a benefit — for a person not dying. Once the focus of treatment has switched from trying to prevent death to trying to prevent a bad death, it is the bad death and not death itself that counts as a harm. The *avoidance* of such a death is, correspondingly, a benefit, *not* a harm.

Nesbitt's arguments have now left us with a rather curious possibility. Perhaps there is indeed a moral difference between commission and omission but this difference only reveals itself when we are talking about benefits, as opposed to harms. Perhaps, in short, the moral difference thesis holds for *benefits* but not for harms. Nesbitt seems to think that this is true:

> Is there a corresponding doctrine about acts and omissions which *benefit* some person or persons? Such a principle would presumably be the mirror image, so to speak, of what we have been calling the acts and omissions doctrine. That is, it will assert, not that it is worse to actively do good to someone than to let good come to him, but that it is *better* to do the former than the latter. Let us refer to this as the 'positive' acts and omissions doctrine. Although I am not aware of any explicit defenses of this doctrine, it is one, I think, which most people would accept on reflection.[25]

I take Nesbitt's point to be that, all else being equal, commission bringing about

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between act and omission, but rather on the grounds of expediency.

[25] Nesbitt, EDAO, p. 254-255

benefit is better than omission bringing about benefit. The positive acts and omissions doctrine, if defensible, has a bearing on the throat cancer case. It is better, according to the positive acts and omissions doctrine, to actively benefit this man than it is merely to allow benefit to come to him. In the throat cancer case, benefit is a good death. Therefore, it is better actively to promote the good death than it is passively to allow a good death to occur. Ostensibly this seems to correspond to what Rachels claims. He is advocating euthanizing the man with throat cancer. However, he is not doing so on the grounds that acts or omissions, whether bringing about benefit or harm, are, by themselves, morally different. Remember that the condition of the positive acts and omissions doctrine is that all else is considered equal. This is not so in the throat cancer case. It is not that this man will die a good death regardless of whether the end is actively or passively promoted. If a good death is not promoted, then, in this case, a bad death will result. The choice then is not between actively or passively benefitting this man, the choice is between benefitting and harming him. If we act, we are in a position to benefit him by bringing about a good death; and if we omit to act, we are in a position of harming him by bringing about a bad death. Nevertheless, if the positive acts and omissions doctrine is tenable — when all else is, in fact, equal — then it poses a challenge to the moral equivalence thesis.

The problem that I have with Nesbitt's argument is that while he discusses which doctrine ought to be applied to what situation, he does not address what seems to be the central question: whether or not acting and omitting, while logically different, are morally equivalent. This question would seem to me to be the central issue in confirming or denying Rachels equivalence thesis. It seems to be the case that Rachels thinks that acting and omitting are morally equivalent when the outcome of either acting or omitting is an equivalent harm. Should the outcome be a benefit, however, Nesbitt says that there may be a difference in acting and omitting. Specifically, if the outcome is a benefit, then it is morally correct conduct to choose active means of conferring a benefit on another rather than merely allowing that benefit to befall another.

If it were demonstrable that Rachels' equivalence thesis only holds when the outcome is a harm, then the thesis would be considerably, even perhaps fatally, weakened. Allow me to explain. The moral equivalence thesis is tied to the bare difference argument. The bare difference argument asserts that the bare difference between action and omission is not a sufficient basis on which to ground a difference of moral judgement. Now if the action and omission are only morally equivalent when the outcome is a harm, then bare action and bare omission cannot be assessed independently of the outcome and the bare difference argument does not get up and running. In other words, one cannot claim that there is no moral difference between an act and an omission, found another claim on this one, and then conclude that there is in fact a difference between act and omission given certain outcomes. Such a set of claims seems to be self-contradictory.

Rachels, however, does not make a self-contradictory set of claims. He allows that there may be other factors that discriminate between killing and letting die, but none of those factors is a claim that an act is somehow substantially morally different from an omission. Thus if there is a difference between killing and letting die in a particular case, that difference stems from some other factor such as length of death process or the pain and suffering attached to killing and letting die.

Nesbitt does not address the moral difference thesis directly, but from what he says about its applicability we can assume that he has no major challenge to offer. He concludes, with no argument save an appeal to intuition, that there is in fact a moral difference between commission and omission when there is a benefit involved. Thus one can only assume that when a harm is involved, he would be consistent and assert that there is a difference between act and omission. Of course, he does not have to commit himself one way or the other, since his aim is only to show that the moral difference thesis as it applies to cases where harm is involved, is inapplicable to the case of euthanasia since in these cases the question concerns the conferring of a benefit, i.e., a good death.

This question of consistency, however, needs to be put to rest. I have claimed that Rachels is indeed consistent in his application of both the bare difference argument and the equivalence thesis. Rachels has been challenged by the suggestion that these only hold when there is harm involved and not when there is benefit involved. This would be very troublesome for Rachel's argument since (the good) death is counted as a benefit where the patient is already dying.

The intuition about where Rachels may have gone wrong is that while it may be difficult to say exactly why Jones' conduct is no better than Smith's conduct, thus forcing us to conclude that they are both equally morally blameworthy, it is an easy matter to point out the more appropriate conduct when benefit is involved. The underlying suggestion is that because Rachels used an example involving harm, he muddied the waters enough to fool our intuition about the correctness of the moral difference thesis. Thus there is a difference between killing and letting die, and there is a difference in what we think of the conduct of Smith and Jones, we just cannot get at it because the example provides a smoke screen. I would like to answer this challenge, and in so doing defend Rachels with a bare difference argument of my own.

Consider Uncle Harry and Uncle Silas. Uncle Harry decided to transfer $20,000 to Sally's account to help with her education. He goes to the bank and arranges the transfer. He confers a benefit by action. Uncle Silas is wondering whether to transfer $20,000 to Jesse's account to help in her education. Before he makes his decision, he notices that the bank has mistakenly already transferred the money to Jesse's account earlier in the day. Silas decides at that point not to notify the bank of the mistake and to allow the transfer to stand. He "does nothing", i.e., he omits to act to prevent the benefit.

I take the Harry-Silas example to be analogous to the Smith-Jones example save for the fact that the former involves a benefit and the latter a harm. Now if we are prepared to say that there is no significant difference in the moral assessment of the conduct of Smith and Jones, then for the sake of consistency we ought to be able to say that there is no significant difference in the moral assessment of the conduct of Harry and Silas. If this is correct, then there is no problem holding the moral equivalence thesis. Whether there is harm or benefit involved, the status of each as an end is fixed and it makes no difference whether the means to attaining that end constitute an action or an omission. I hasten to add that there may be other ways to discriminate between the means to an end; the point is merely that these other ways will not include appeal to doing or refraining by themselves, independently of other considerations.

CONCLUSION

The goal of death management is a good, rather than a bad, death. To this end, Battin suggested that we use informed refusal to promote a good death. The problem with informed refusal is that it *merely allows for* the *possibility* of an easier death, and does not necessarily *bring about the easiest death.* It was determined that the easiest death was preferable to the possibility of a merely easier death. However, the difficulty that arose was that pursuing the easiest death goes beyond the bounds of the passive means of informed refusal. Actually doing something to bring about a good death — the easiest death — requires *active* measures. In order for the pursuit of the good death to be viewed as legitimate, the moral difference thesis — which sees a morally relevant difference between allowing and bring about a death — would have to be overcome. In other words, in order for death management to be achieved, the doctor has to be free morally to pursue a good death for her patient, and this means being free morally to assess all options, both passive and active. If the good death is to be achieved, the doctor cannot be restrained in her pursuit of this end by having only passive means available. As we saw in the discussion of Battin, such a restraint may, in some but not all cases, lead to an easier death; but in many cases it prevents the achievement of this goal, and in most certainly prevents the achievement of the *easiest* death. And from the discussion of the responsibility of the doctor we know that typically only the easiest death will meet the role-responsibility of furthering a dying patient's wellness, and thus the doctor may be liable for a bad death, even if that death is easier, but not the easiest, death given the circumstances of the case.

In order to overcome this obstacle of the prohibited use of active measures, it was necessary to enter into the active versus passive euthanasia debate. Starting with Rachels I outlined reasons for denying that there is any significant moral difference between commission and omission. From this it follows that there is no moral difference between active and passive euthanasia based on a supposed difference between act and omission. This conclusion and its attendant applications and ramifications, were in need of defense against all sorts of challenges. The first set of objections were drawn from Callahan, who objected to the collapse of the active-passive distinction primarily on the ground that this would result in a conflation of cause and culpability. Callahan's objections stemmed mostly from his concern about nature and human control. Callahan wanted to eliminate the drive towards total human control over death. He wished to make clear that nature, and not human agency, should be the cause of a person's death. If we retain the illusion that humans can and should always attempt to exert control over death, even to the point of controlling its occurrence, then we make every death a moral failing. In collapsing the distinction between active and passive measures, Callahan charges, Rachels has fallen prey to this dubious illusion and its corresponding false ideal.

Callahan, however, failed to consider an essential point. He claims that the crux of the matter is the cause of death. In a case of letting die, it is the underlying condition that causes death. In the case of a lethal dose of morphine, it is the person administering the drug that is the cause of death. But Callahan fails to distinguish human control and human agency. Additionally, Callahan fails to acknowledge that human control over nature admits of degrees and is almost always present no matter what the circumstances might be. The crux of the matter is that agency is involved in some way or another in either the passive or the active case. The decision to withdraw or withhold a life extending treatment involves human moral agency just as much as the decision to turn the morphine drip up to a lethal dosage. It is the decision and the effects of the behavior based upon it that must be assessed; not whether the decision which led to those effects did so via active or passive behavior.

Nesbitt offered another sort of objection to Rachels' argument. His basic objective was to show that the moral difference thesis does not apply in the dispute between active and passive euthanasia because the moral difference thesis only applies in cases of harm, and euthanasia is a benefit. Interesting though this argument was, it led us to consider that, in the end, there is a moral difference between commission and omission and that it emerges in cases where *benefits* are involved. The suggestion was that Rachels disputes the moral difference thesis using a case of harm, but that were the case one of benefit, he would have found a moral difference between active and passive conduct. Put another way, if Rachels' equivalence thesis were to be accepted, the consistency question would have to be answered. We considered an example regarding benefit to show that Rachels' conclusions were not, in fact, based on an inconsistency.

The point of providing a strong defense of the equivalence thesis is to establish the legitimacy of a doctor actively (as well as passively) promoting a good death for a patient. According to the equivalence thesis, if a passive promotion of a good death is permissible, and there is, all else being equal, no moral difference between active and passive measures, then actively promoting a good death is, all else being equal, likewise permissible. This leaves open the most promising treatment option for the pursuit of the good death; the doctor is not prohibited from using active measures in order to attempt to achieve wellness for a dying patient. As we have seen, it is this option that promises the best death for the patient, fulfillment of the role-responsibility of the doctor, and avoidance of liability for a bad death.

Most, if not all, attempts to establish some moral difference between a bare act and a bare omission are attempts to suggest that there is something about *doing* that makes it more morally volatile than *refraining*. Why would this be if one's conduct — which includes both doing and refraining — is the moral issue? That is to say, why would there be a difference if *doing* can be either morally acceptable or not, and *refraining*, as well, can be either morally acceptable or not? I think the answer to this lies in the mistaken idea that what we do is indicative of what we intend or what we want to be involved in, and refraining is indicative of absenting one's self from involvement. As such, this is just another instantiation of the moral difference argument. But this time, it is not the nature of the person's conduct that is in question (i.e., whether it is active or passive) but rather whether or not the person should in any way be involved in the situation. I turn now to a discussion of the doctrine of double effect which is an attempt to maintain the status quo of condoning non-involvement with a person's death, while condemning involvement.

CHAPTER 5:

THE DOCTRINE OF DOUBLE EFFECT AND DEATH MANAGEMENT

Even if the moral difference thesis is ultimately susceptible to challenge, it is not the only thesis or doctrine designed to condone one sort of death and condemn another based on a conceptual distinction. For the moral difference thesis, the distinction rested on the idea that to actively kill was worse than to merely allow to die. The doctrine of double effect is similar to the moral difference thesis in that it too rests on a distinction which attempts to discriminate between acceptable conduct bringing about a death and unacceptable conduct bringing about the same result. The DDE rests on the claim that there is a moral difference between conduct with which one intends to bring about some effect and conduct where one merely foresees but does not intend to bring about that effect. According to the DDE, it may be permissible to follow a course of action when that course of action has more than one effect, and at least one of those effects is a harm, where the harm brought about was not directly intended (though it was foreseen) and the harm brought about is not instrumental to the good effect(s) intended by the course of action. As such, the DDE may be thought to present another challenge to my contention that a doctor ought to be permitted actively to promote the good death of a patient already dying. Actively promoting a good death, it could be argued, is tantamount to aiming at or intending a death, and since death is a harm, the ultimate harm some might say, the DDE prohibits the doctor's intentional involvement in pursuing the good death. In contrast, the argument continues, passively allowing a patient to die an earlier death is a case where the aim of the early death is foreseen but not intended. As such, passive measures may be permissible where active measures, because the harm is intended, are not.

I shall begin by presenting what I think is the strongest case in favor of the DDE. After explaining the doctrine and its apparent advantages, I will discuss two potentially damaging challenges to the DDE. I will endeavor to show that the DDE used properly, is largely inapplicable to cases of death management, and that any relevance it might have is consistent with, and not in opposition to, the permissibility of death management.

FOR THE DDE

The DDE is useful in explaining, so say its supporters, certain kinds of cases where the interests of people conflict. Philippa Foot says the following in explaining the doctrine:

> The doctrine of the double effect is based on a distinction between what a man foresees as a result of his voluntary action and what, in the strict sense, he intends. He intends in the strictest sense both those things that he aims at as ends and those that he aims at as means to his ends. ...The words "double effect" refer to the two effects that an action may produce: the one aimed at, and the one foreseen but in no way desired. By "the doctrine of the double effect" I mean the thesis that it is sometimes permissible to bring about by oblique intention what one may not directly intend.[1]

Taken without further qualification, the doctrine has been thought to justify some strange results. For example, take the two cases of the poison cooking oil. In one scenario, merchants out to make a living sell the poison cooking oil to customers several of whom die as a result of using the oil. In the other scenario, out of work grave diggers hand out the cooking oil in the hopes of getting some business. The grave diggers aim at the deaths, that is to say, the deaths are part of their plan. Meanwhile the merchants can be excused because even though they foresaw the deaths, they did not aim at or intend anyone's death.

Such an application of the DDE, says Foot, is not at all what supporters of the doctrine had in mind. She says:

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[1] Philippa Foot, "The Problem of Abortion and the Doctrine of the Double Effect" in Moral Problems in Medicine, eds., Samuel Gorovitz, Ruth Macklin, Andrew L. Jameton, John M. O'Connor, and Susan Sherwin, (Englewood Cliffs, New Jersey: Prentice-Hall Inc., 1983) p. 296 [hereafter referred to as PADDE]

> The first point that should be made clear, in fairness to the theory, is that no one is suggesting that it does not matter what you bring about so long as you merely foresee and do not strictly intend the evil that follows. ...What they [supporters of the doctrine] are committed to is the thesis that *sometimes* it makes a difference to the permissibility of an action involving harm to others that this harm, although foreseen, is not part of the agent's direct intention. An end such as earning one's living is clearly not such as to justify *either* the direct or oblique intention of the death of innocent people, but in certain cases one is justified in bringing about knowingly what one could not directly intend.[2]

The logical question to follow such a qualification of the doctrine would be : What are the circumstances in which it *does* make a difference to the permissibility of an action? In answering this question Tom Beauchamp lays out the circumstances in which the DDE should be applied. He says that:

> According to the mainstream formulation of the DDE, four conditions or elements must be satisfied for an act with good and bad effects to be permissible. Each is a necessary condition and together they form jointly sufficient conditions of a morally permissible action, despite the bad effect.
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> 1. *Good or neutral act.* The act must be morally good or morally neutral, independent of its effects.
> 2. *Intention.* The agent must intend the good effect only. The bad effect can be foreseen and permitted but not intended.
> 3. *Direct Means.* The bad effect must not be a means to the good effect (because then the agent would intend the bad effect in pursuit of the good effect).
> 4. *Proportionality.* The good effect must proportionally

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[2] Foot, PADDE, p. 297

> outweigh the bad effect. This outweighing compensates for permitting the foreseen bad effect.[3]

Given these conditions then, we can see why the DDE ought not be used to justify the conduct of the merchants. Knowingly selling poison cooking oil is not a morally good or morally neutral act. In addition, conditions 3 and 4 are violated. Since the means to making a living is killing people with tainted oil, the merchants are using the death of the customers instrumentally to gain money. Consider as well that the good effect of making a living does not outweigh the bad effect of the death of even one person, let alone several people.

What types of cases, then, is the doctrine suited to? Foot contends that the doctrine helps us to explain why we might allow a certain action in one case but not in another. Take, for example, the judge case, and the tram driver case. In the judge case, the judge is faced with an angry mob bent on killing five hostages if a particular criminal is not brought to justice. Now the judge has no idea who this criminal is. He is faced with the prospect of framing an innocent person or the five hostages die. In the tram driver case, the driver of a run-away tram must choose between two tracks. On one track there are five men working while on the other track there is one man working.

Foot contends that while we would be horrified at the conduct of the

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[3] Tom L. Beauchamp, ed., Intending Death: The Ethics of Assisted Suicide and Euthanasia, (Upper Saddle River, New Jersey: Prentice-Hall Inc., 1996) p. 12

judge were he to hang an innocent man to save the hostages, we would think the conduct of the tram driver correct were he to steer toward the track where one man instead of five was working. The numbers of lives at stake are even as in each case we are talking about the death of one versus the death of five. We certainly think that all other things considered equally, the death of one man, while tragic, is the better alternative to the death of five people. Why then, can we not argue from the tram driver case to the judge case? The reason is because in the judge case the judge has to *aim* at the death of the innocent man as part of his plan to save the five hostages. In the tram driver case, the driver does *not aim* at the death of the man even though he foresees it as an effect of the action to save the five men working on the other track. The death of the one man is a foreseen but completely undesired effect. Foot drives home this point about the aim of the conduct when she says:

> Perhaps he [the one man working on the track] might find a foothold on the side of the tunnel and cling on as the vehicle hurtled by. The driver of the tram does not then leap off and brain him with a crowbar. This judge, however, needs the death of the innocent man for his (good) purposes. If the victim proves hard to hang he must see to it that he dies another way.[4]

Again, using another pair of examples we can see how the DDE is useful in sorting out justified harms from unjustified harms. In the first example of the pair,

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[4] Foot, PADDE, p. 298

a man needs a large dose of a rare medication. Just before the drug can be administered there arrive at the hospital five sick people who could be saved with one fifth of the dose necessary for the other patient. In this instance the assumption is that we are justified in saving the five people even though we know it will mean the death of the other man. In the second example of the pair, we have five fatally ill people who could be saved if we killed one man and made a curative serum out of his body. Yet in this case, which is in some respects similar to the other of the pair, we are not justified in killing the man to save the five patients. Again, the doctrine provides us an explanation of why this is so. In the latter case, but not in the former, we would have to aim at, or directly intend, the death. In the former case, but not in the latter, the death of the one patient is a foreseen but entirely undesired effect.

It is interesting to see the parallels in explanation between the DDE and the moral difference thesis. Notice how, according to the DDE, in the "rare dose" and "serum" pair of cases, we are not justified in *killing* a man even to save five others. We are, however, justified in *allowing* one man to die in order to save five others. An application of the moral difference thesis would yield the same results. It would be thought to be morally worse to kill a man outright than merely to allow a man to die in order to save the five other people. While the moral difference thesis and the DDE ostensibly net the same results in this particular pair of examples, the DDE represents an improvement over the moral difference thesis.

That the DDE is a superior tool of moral analysis when compared to the moral difference thesis is evident when we consider that the DDE recognizes that it is possible to aim passively at a harm. This is, in fact, one of the major stumbling blocks faced by the moral difference thesis which fails to consider that evil ends can be sought through passive conduct. Foot mentions this difference between the moral difference thesis and the DDE:

> ...the distinction between what one does and what one allows to happen is not the same as that between direct and oblique intention. To see this one has only to consider that it is possible *deliberately* to allow something to happen, aiming at it either for its own sake or as part of one's plan for obtaining something else. [5]

For example, I could set things up so that a blind woman were in the path of an oncoming bus. I stand on the sidewalk and "allow" her to die. In this example, I deliberately allow something to happen. In accordance with the DDE my conduct could be judged deplorable even though my conduct was passive because regardless of the active or passive nature of my conduct, I intended the death of the blind woman.

So the DDE is an improvement on the moral difference because instead of basing a moral distinction on the active or passive means to an end, it bases a moral distinction on what the agent intends, or aims at by whatever

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[5] Foot, PADDE, p. 299

means. By focusing in on what the agent intends by her conduct we get closer to a valid assessment of her conduct than we do were we to view the conduct merely in terms of commission and omission.

Given the Catholic origins of the DDE it is not surprising to find that its original application was to the problem of abortion. Specifically, the doctrine was designed to sort out what to do when a pregnant woman's life was in danger. Take yet another pair of examples: the case of uterine cancer, and the craniotomy case. In the first case the pregnant woman has uterine cancer and will die unless the uterus is removed. Of course removal of the uterus will result in the death of the fetus. The procedure has, nevertheless, been thought to be sanctioned by the DDE since the death of the fetus is not desired or aimed at but merely a foreseen consequence of removing the diseased organ from the woman. In the craniotomy case, a woman in labor will die unless a craniotomy is performed on the fetus. Should the craniotomy not be performed, the fetus can be safely removed by caesarean after the death of the woman. In this case, since a craniotomy would require the intention of killing the fetus it is thought to be forbidden by the DDE. The death of the woman would count as a foreseen but unintended effect. In these dramatically difficult decisions, the DDE is supposed to help us see the right thing to do.

Discussion of the DDE can get confusing, especially since it seems we always end up talking about pairs of cases, both of which have two alternative courses of action. Having explained the DDE using such pairs of examples, I would like now to take a moment to talk about the DDE in a more abstract sense.

The purpose of the DDE is to help decide whether or not a course of action is permissible when that course of action has more than one effect, and one (or more) of these effects is a harm. Providing the course of action meets the requirements of the DDE, it is permissible in spite of its harmful effect. Those requirements include, as we have seen from Foot and Beauchamp, that the harm is not directly intended, is not instrumental to the good effect(s) intended by the course of action, and that the good effect(s) proportionally outweigh the harm.

Suppose for instance that I need open-heart surgery. Such a course of action would have several effects including enduring a very long and painful recovery, and the mending of a currently malfunctioning heart. One of the two effects listed could be counted as a harm, while the other effect represents a good effect. Since the course of action in question has more than one effect, and at least one of these effects is a harm, we can apply the DDE to determine whether or not we might still follow the proposed course of action. According to the first condition of the DDE the act must be morally good or neutral independent of its effects. Necessary surgery certainly meets this condition as surgery is not like, say, torture which would be morally evil regardless of its ultimate effects. The second condition of the DDE stipulates that the agent must intend the good effect only. The bad effects may be foreseen, but not intended. Certainly, the surgeon's intention in performing the surgery is to mend my heart. She foresees the long recovery time, but she does not intend this for itself. The third condition is that the harmful effect must not be the direct means to the good effect — since this would mean that the agent would have to intend the bad effect in pursuit of the good effect. While the long recovery time is anticipated before I feel the benefits of surgery, the long recovery time is not necessary to the good effect. Let us say that I fully recover from the surgery in an amazingly short time. This does not alter the benefit I receive from the surgery. So while the (typically) long recovery time *goes with* the benefit of surgery it is not *instrumental* to the good effect of the surgery. The fourth and final condition of the DDE is that the good effect must proportionally outweigh the bad effect. Certainly a mended heart is adequate compensation for the recovery time. The surgery then, even though it has a bad effect, is a permissible course of action all things considered. Notice how in deciding whether or not a course of action is permissible the intention of the agent is paramount, and that not just any harm is allowed, but only those which meet the conditions of the DDE.

LIMITATIONS OF THE DDE

The DDE as a tool of moral assessment is not without its critics. Some think there are very serious and perhaps fatal problems with the DDE. Veatch, in his discussion of the DDE cites two such challenges:

> Some critics of the Catholic doctrine [DDE] question how the mere sequence of events can affect their morality. They argue that if the good effects are proportional to or greater then [sic] evil effects, than [sic] it should not make any difference in what order they occur. Another area of contention is whether intention per se can make an action moral or immoral. Other critics would argue that intention should affect the praiseworthiness or blameworthiness of the actor, but not whether the action was right or wrong, especially in cases where the evil is foreseen though not intended. They argue that while an unforseen evil need not be taken into account (for example, an idiosyncratic toxic reaction of a patient that produces death), one that is or should be anticipated (for example, the death of a fetus in the case of the removal of the fallopian tube in an ectopic pregnancy) should not be less significant morally because it is not intended. Either the foreseen event is justified on grounds of proportionality or it is not, regardless of whether it is intended. [6]

These criticisms of the DDE could be quite damaging. However, what is most obviously taken from these criticisms is a caution that the DDE is not meant to be applied to each and every case of multiple effects and that the DDE is not the only basis on which we may make moral judgements about agents or their actions. In other words, there may be cases of a course of action having multiple effects that are nevertheless not suited to an application of the DDE — that is to say the DDE does not do significant moral work in each and every case of a course of action

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[6] **Robert Veatch, Death, Dying and the Biological Revolution, (New Haven: Yale University Press, 1989) p. 77-78.**

having multiple effects. There may be good reasons in a particular case to argue that the DDE is not a relevant tool of moral assessment. For example, as the criticism cited by Veatch suggests, there may be a case where the benefits glaringly outweigh the instrumental harms of a course of action to such a degree that this alone is sufficient for justifying the course of action. In such a case the DDE does not even come into play. It is not needed since the question of the permissibility may be settled on more relevant or obvious grounds.

Similarly the second criticism cited by Veatch could be taken to suggest that the intention of the agent is not always the most relevant moral consideration. It could be the case that the consequences of a course of action are so catastrophic that they greatly outweigh the fact that they were not directly intended. But to say that there are cases in which it is not appropriate to appeal to the DDE is not to say that the DDE is never appropriately appealed to. There are some cases, for example those discussed by Foot, where other methods of moral assessment are either ineffectual or yield dramatically counter intuitive results. It is in these sorts of cases where appeal to the DDE in making a moral judgement might be appropriate.[7]

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[7] To delineate exactly the types of cases for which application of the DDE is appropriate, and those for which it is not is outside the scope of my present concern. I make the point about the appropriate use of the DDE only to suggest that even if it is not *always* appropriate to invoke the DDE, it may be *sometimes* be appropriate to invoke the DDE.

THE DDE AND DEATH MANAGEMENT

Even having said that the DDE is not appropriate in all cases, it is typically thought that the DDE has an application in the types of cases with which I have been primarily concerned. That is to say, the DDE is thought to apply when deciding a course of action with regard to dying patients. For example, consider the standard morphine case. A dying patient is in tremendous pain. She requires ever increasing doses of morphine to mitigate the pain. Now giving large doses of morphine can have two effects: first it can mitigate or control pain, and second, in high enough doses it can suppress respiration such that the person dies. According to the DDE, we can sometimes tolerate a negative or harmful effect if it is the case that the harmful effect was merely foreseen and was not the directly intended outcome. Such is the case with palliation which hastens death. The point of giving morphine when palliating is to mitigate or ameliorate pain, though we foresee that such a course of palliation may also hasten death. What the DDE claims is significant is that we are not aiming for the death of the patient in order to ameliorate the pain. In other words, the death of the patient is not the means by which we attempt to mitigate the pain. Rather, the death of the patient is the foreseen but unintended outcome of attempting to ameliorate the pain. Hart runs through this type of standard application of the DDE to the morphine case:

> This doctrine has its most interesting application where doctors may consider taking steps which will accelerate a

> patient's death. The simplest case is that of the administration of drugs to relieve the pain of a person slowly dying in agony. According to the latest Papal pronouncements a distinction must be drawn between the case where the drug is given and the patient ceases to feel pain, but as a further consequence his death is accelerated, and the case where he ceases to feel pain because a drug has been administered to kill him as the only way of saving further pain. In the first case, the acceleration of death and the extinction of pain are both effects of the drug, but independent of each other; in the second case the extinction of pain is not causally independent of the death, and the death is not merely a foreseen but unwanted outcome, but is sought as a means to the extinction of pain.[8]

Given this example and what I have discussed above, it looks as though the DDE would lead to prohibiting death management. It looks as though appeal to the DDE would prohibit directly aiming at the death of a patient, but permit that same death were it only a secondary effect of directly intending something else such as the mitigation of pain. Since death management is in fact the *intentional* promotion of the death of a patient, it seems as if death management would be prohibited by appeal to the DDE. On the contrary, however, I submit that the DDE not only does *not* represent a challenge to death management, but that, in some respects, conforming to the DDE is consistent with supporting death management.

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[8] **H.L.A. Hart, "Intention and Punishment," in Punishment and Responsibility: Essays in the Philosophy of Law, Hart., (New York: Oxford University Press, 1963) p. 122 [hereafter referred to as IP]**

Consider the type of case in which the DDE is most effective. The DDE does the most moral work in a situation where a course of action has more than one effect or outcome, some of which include harm. The question is whether or not that course of action is morally permissible. Should the harmful effects of a course of action conform to the DDE, that course of action may be permissible in spite of the harmful effects. A harmful result is tolerable if it is not the intended outcome, and if it is not instrumental to the intended outcome.

A case of death management does not fall under the category of cases to which the DDE typically applies. While I am not prepared to delineate all the possible types of cases to which an appeal to the DDE might be appropriate, this much at least can be said: the DDE is not applicable unless there is more than one effect foreseen, and at least one of these effects is harm. By definition, death management is the promotion of a good death and the avoidance of a bad death. Neither of these anticipated effects of a course of action involving death management counts as a harm.

That the DDE is sometimes thought to apply to the case of a terminal patient is likely because there remains an assumption that death is counted as a harm and continued existence, among other things like alleviation of pain, as a benefit. But in the cases with which I am concerned the patient is already dying — which means that death itself is no longer counted as the ultimate harm. For the dying patient, the good death is a benefit and the bad death is a harm. Taking these assessments of what counts as harm and benefit into account, death management — a course of action aimed at promoting the good death and avoiding the bad death — is not a course of action having more than one effect, at least one of which is harmful. Thus, while it may be thought that the DDE has an application to the case of the dying patient, if we consider the conceptual differences between the dying and non-dying patient, we find that the DDE really does not have an application. This is only to say that the DDE does not have any moral work to do in the case of death management as none of the effects is harmful.

RESPONSIBILITY VERSUS THE DDE

The DDE does not apply to the standard case of death management. However, the DDE raises some concerns about agent intention and its relevance to the moral assessment of conduct. These concerns are adequately dealt with by the notions of at fault and responsibility as illustrated by their application to the judge case — a case which Foot puts forward as a paradigm case for the use of the DDE.

Furthermore, it seems to me that in a case of death management more is at play that just the intention of the doctor who participates in death management. Using notions of role-responsibility we can take moral consideration of the wellness of the patient, and how wellness might mean different harm and benefit determinations for the dying and those not dying. The concerns of the DDE do not reach this far. The DDE is meant only for those cases in which intention and ensuing harm are the pivotal factors. Without meaning to diminish the importance of these factors, I only wish to point out that more than just these factors are pivotal in a case of death management.

Even if the issues brought out by the DDE are taken seriously — as I have tried to do — the DDE still does not represent a challenge to the permissibility of death management. Moreover, where the issues brought out by the DDE are at all relevant, they can be addressed by a richer, more appropriate system of moral evaluation. So while application of the DDE or concern over the issues it raises may in some cases be relevant, the DDE adds nothing of significance to the discussion of death management.

CONCLUSION

The doctrine of double effect looked like a challenge to my contention that the active pursuit of the good death is permissible. The DDE in fact, does represent an improvement over the moral difference thesis. The main problem with the moral difference thesis was that it ignored the fact that passive conduct or omission could just as deliberately bring about a wrong as could active conduct or a commission. It is this problem that seems solved by the DDE. The DDE rests on the distinction between direct and oblique intention. It says that it is sometimes permissible to indirectly bring about a harm which one could not directly intend.

Two potential problems concerning the DDE were briefly mentioned. Instead of taking the criticisms to cripple the DDE I took the criticisms as attempts to limit the application of the DDE. What the criticisms succeeded in pointing out is that the DDE is clearly not the most generally applicable tool of moral assessment. Frequently, there are more appropriate means of determining the permissibility of an action with more than one effect, at least one of which is a harm. Of course if other means of determining moral permissibility somehow fail or are themselves inapplicable for some reason, the DDE remains viable for select cases. In other words, the DDE is in fact workable, but only in a limited range of cases such as those typified by the judge and tram driver case pair.

It has been thought that cases of dying patients were indeed inside the range of the DDE's applicability. However, for this to be true, one has to be working with erroneous (though perhaps common) notions as to what counts as harm and what counts as benefit for a dying person. If one assumes that for a dying person death remains the ultimate harm and that continued existence counts as a benefit, then, indeed, the case seems to be suited to an application of the DDE. Once, however, it is acknowledged that the dying person counts his or her benefits and harms differently from the person not dying, the inapplicability of the DDE becomes clear.

Cases of death management fall outside the range of applicability of the DDE. While death management as a course of action may be thought to have more than one effect, none of these need be harmful. Therefore we do not need the DDE to help determine if any harmful effects are tolerable.

In fairness to the DDE, even though it is not directly applicable to cases of death management, it does raise some concerns about agent intention. It was my contention, however, that these concerns were already dealt with by using the notions of at fault and responsibility to judge conduct. Thus the addition of the DDE to an analysis of the permissibility of death management is needless.

CHAPTER 6:

CONCLUDING WITH CONCERNS

I have been arguing that, on the basis of several factors, the promotion of a good death is the responsible response of a doctor to the possibility of a patient's bad death. It is the doctor's responsibility to aid the patient in achieving wellness, whatever wellness might mean to a particular patient under his or her particular circumstances. For a patient already dying, whose primary concern is avoiding the bad death, wellness will most likely mean achieving the good death. If this is the case, and a doctor either knowingly leaves the patient to a bad death or through recklessness or negligence creates an unreasonable risk of that patient experiencing the bad death, then that doctor is liable for this harm to the patient. In other words, a doctor can be held responsible (liable) for the bad death of a patient should said doctor not do what he or she can to ensure the good death.

It is important to stress, once again, that this instantiation of responsibility only arises when the patient is already dying. Once a person is already dying she or he enters a different conceptual space from that previously occupied. Once a person is already dying, determinations of what counts as a harm change, and our presumed standards of intervention change. This can best be seen when illustrated against the background of suicide. The difference between suicide and death management — the promotion of a good death and the avoidance of a bad death — is that in the case of death management, the person is already dying and seeks a good death. In a case of suicide, the person is not already dying (or if already dying, seeks death for reasons unrelated to the desire to avoid the bad death). Where one is already dying we may presume that intervention to assist in the good death (and avoidance of the bad death) is more appropriate than intervention to prevent death altogether. This is opposite to our presumptions about intervention in the standard case of suicide. If a person who is not already dying wants assistance in dying, the presumption is that we must intervene to prevent the death. An even stronger presumption is that it would be wrong to intervene to assist.[1]

Once a person is already dying and asks his or her physician to ensure a good death and prevent a bad death, the physician is responsible for providing all possible aid in achieving a good death. This may include active measures or conduct intending to bring about the earlier death of the patient. Failure to appreciate the necessity of these measures has long been a stumbling block in discussions of euthanasia. Owing to the initial appeal of the moral difference thesis

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[1] Of course, these are only presumptions, starting places if you will, and other factors or special circumstances could affect a particular case.

and the doctrine of double effect, it is often believed that it is worse actively to bring about a death than to merely allow it to happen; and that it is worse directly to intend that death than it is to perform actions (or omissions) with the foreseen but unintended consequence that death will occur.

The moral difference thesis fails to acknowledge that omissions can just as pointedly bring about an end as can commissions. Doing nothing, or omitting to act, does not absolve an agent from involvement with an event. In many instances, refraining from acting counts as conduct just as surely as acting itself counts as conduct. If there is no moral difference between bare acts and bare omissions, then, all else being equal, one cannot be morally permissible while the other is not. We must rely on the context in which an act or omission plays a role in order to assess it morally. In the case of death management the context may be such that active measures are required if the doctor is to meet her or his responsibilities and help a patient achieve a good death and avoid a bad death.

The DDE fares no better. Even though the DDE ostensibly applies to death management, analysis has shown that in fact, the DDE has very little to add to an assessment of death management. Achieving a good death and avoiding a bad death often means aiming at the death of a patient. To be sure, in most contexts, aiming at the death of another, is wrong. As the DDE recognizes, sometimes we can excuse conduct that brings about the death of another if that death was not intended and was not a means to the intended end. However, there is often no excuse for directly intending or aiming at the death of another. What those who would use the DDE to argue against the permissibility of death management fail to factor in however, is that death, in all situations, does not count as a harm. In some cases, like that of death management, it is not death itself that counts as a harm but the nature of the dying process. But once we acknowledge that the effects of death management do not include foreseeable harms, the DDE becomes inapplicable.

If my analysis so far is sound, then we have very good reason to believe (at least until proven otherwise) that the pursuit of active death management is one of the responsibilities of health care professionals. More specifically, if I am right, then it is morally incumbent upon a doctor to ensure (so far as he or she is able) the good death of a dying patient. The doctor is not limited in promoting such a death by either the DDE or the moral difference thesis. The doctor is free to promote the good death by active and direct means and thereby meet her or his responsibilities to the dying patient.

So far, I have been focusing on individual cases rather than on policy. My attempt has been to show that it is morally permissible to participate in a case of death management. In fact, I have argued that participation in death management is often required of doctors if they are to meet their moral responsibilities. I have been concerned with the moral evaluation of the conduct necessary to effectively create the good death. Of course, the universalizability of moral judgements means that what is permissible in one case is then permissible in all other relevantly similar cases, and what counts as a responsibility in one case will count as a responsibility in all other relevantly similar cases. We must therefore consider our conclusions within the broader context of social policy. Would these conclusions change if instead of focusing on the situation of an isolated health care professional and her responsibilities toward individual patients, we focused on the possibility of our conclusions becoming enshrined in general policy, or in the law? It is beyond the scope of this thesis to consider fully the complex questions which emerge with this shift in focus. But I would be remiss were these questions ignored entirely. I would like to conclude, therefore, with a brief discussion of the important policy issues.

Talking about death management as a social *policy* or legal *rule* raises some issues which are different from those raised through a discussion of a *case* of death management. Specifically, there are a number of concerns which people will have at the very thought that euthanasia — a certain type of which I have been calling death management — might be decriminalized or legally sanctioned. These concerns tend to sort themselves into three broad but related categories. First there are concerns about possible abuses of the policy, and the policy's safeguards, or the lack thereof. The second set of concerns is a continuation of the first, and raises the specter of the slippery slope. Third, there are concerns about resources and the quality of care should a more permissive policy on euthanasia be adopted. While I would like to briefly look at each of these categories of concerns, I would like to stress, once again, that my responses will be necessarily brief and only an outline of what a fuller answer might look like. It is not within the scope of the present project to deal fully with these issues.

ABUSES AND SAFEGUARDS

According to many people, if full-scale death management were to be legalized or decriminalized, we would be assuming a permissive attitude toward killing. A permissive attitude toward killing, even killing for a "good purpose", will only ultimately provide another cover for murder. Despite our best efforts, we will not be able to distinguish between justified death management and unjustified killing. In other words, legalization of full-scale death management is the endorsement of a conduct we are desperately trying to contain. Moreover, constructing a law so as to include safeguards is next to impossible. We simply do not have the resources in creating law to cover every contingency. Thus the law would rest on an incomplete description of what counts as justified killing, and abuses would abound.

So goes one argument against legalizing or decriminalizing death management. Basically the worry is that while we might legalize death management for good reasons, we will not be able, in our laws, to distinguish adequately between cases where death management is legitimate and those where it would be morally condemned. Our good intentions would be thwarted by our inability to construct clear legal categories which match our considered moral judgements about the scope of morally permissible death management. Attempting to construct legal categories, we would presumably take care to include certain safeguards such as the requirement that there be an explicit request by the patient for death management, and that the patient be indisputably in a terminal condition. But how would we enforce these safeguards? How could we be assured that in every case of death management there was an explicit request, and a terminal condition? Of course absolute guarantees are probably impossible. This would make it that much harder to get successful legal action in a case of suspected abuse of the policy.

The authors of a follow-up to the original Remmelink Study address one aspect of this problem with safeguards:

> To understand Dutch euthanasia practice it is essential to know that the request of the patient is not the only basis for the physician's decision. No patient is guaranteed euthanasia, and no physician is obliged to comply with a request for it. Apart from the request there must always be the doctor's conviction that euthanasia is the only acceptable way out of the suffering. In our opinion this is an important safeguard if the practice of euthanasia is to

be a responsible one.[2]

In an effort to waylay fears about abuse, the authors of the Remmelink Study believe that putting faith in the integrity of the physician is paramount. I would agree. Putting the responsibility of morally permissible conduct in the hands of doctors is essential in these cases.[3] As I have tried to show, it is already within the scope of the responsibility of the doctor to manage a patient's care, whether this care be directed at cure, or pain management. We trust physicians to take the primary role in these aspects of our care. There is no reason to deny them primary responsibility when it comes to actively pursuing the good death.

It might be argued that this is placing too much power in the hands of an elite group. This is practically inviting abuse. Visions of mad doctors cavalierly terminating the lives of random patients loom as the future of medicine. I think that while this is a troublesome picture, it is in no way realistic. Furthermore, it should be stressed once again that I am not suggesting that we *add a new* responsibility to the doctor's duties. I have argued that death management is already embedded within the doctor's basic responsibility toward a patient's wellness. I have merely

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[2] Johannes J. M. van Delden, Loes Pijnenborg, and Paul J. van der Maas, "The Remmelink Study: Two Years Later," in The Hastings Center Report, vol. 23, no. 6, Nov-Dec 1993, p. 26 [hereafter referred to as RS2]

[3] Please note that I am not now at this stage attempting to introduce a new condition of a doctor's involvement with death management. I want merely to point out that such a weight of responsibility already rests on the shoulders of HCPs.

demonstrated that wellness for a particular patient takes on a different dimension once that patient enters the dying process. We already trust doctors with the mandate to promote wellness. Unless we are given a significant reason for doubting, we generally trust a doctor to perform a careful diagnosis, to schedule only required tests, to seek guidance from other doctors, to prescribe appropriate treatment and so on. That is, we generally trust a doctor to meet his or her responsibilities unless we have a good reason not to. I am not suggesting that we do any more than we already do. The authors of the Remmelink Study appear to argue in the same direction.

> The importance of the physician's conviction is reflected in our data: physicians rejected two-thirds of all explicit requests for euthanasia or assisted suicide. The reasons were mostly that the physician saw alternatives or had objections in the particular case. Our conclusion is that doctors themselves are responsible moral agents, not simply instruments of the patient's will.[4]

Two points are exemplified by the above quotation. First, it echoes what I have been saying about physicians as morally responsible. We hold physicians, because of the power they wield, to a very high standard of morality. If we already trust them with our lives, it makes no sense to not trust them with our deaths. The second point arising from this quotation is that we have significant empirical evidence to believe that legalized euthanasia would not result in a breakout of crazed killing

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[4] van Delden, et. al., RS2, p. 26

doctors. Two-thirds of requests for aid in dying were rejected. In other words, doctors were far from taking every opportunity to end a life.

While I acknowledge that policies concerning euthanasia should be carefully worded, and cases under the law ought to be carefully monitored, I do not think that these concerns are weighty enough to justify a complete ban on active death management. Of course, against these concerns I am placing a heavy emphasis on the responsibility of a physician. Physicians have always had a considerable power over our lives and our deaths. Making their responsibilities for our deaths as explicit as we have made doctor's responsibilities for our lives, seems a small step to take in the face of the bad death.

There is another form of feared abuse of a legitimization of death management. This abuse takes the form of circumstantial and/or ideological manipulation.[5] David Mayo and Martin Gunderson explain the impetus behind circumstantial manipulation:

> Prior to legalization, critically and terminally ill persons are seen for the most part as helpless victims of their unfortunate circumstances, and as such they are felt to have a special claim to our compassion. Following legalization this may no longer be the case. Legalization will provide them with another option — an "escape". As a consequence some may come to be viewed less sympathetically — especially if they are seen as stubborn

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[5] The concepts of circumstantial and ideological manipulation come from Margaret Pabst Battin, The Least Worst Death: Essays in Bioethics on the End of Life, (New York: Oxford University Press, 1994) p. 195-204

> when they are thought of as plausible candidates for physician assisted death but opt instead to remain alive and continue to require our care.[6]

Viewing those near the end of life less sympathetically could mean that those people would be treated badly, perhaps badly enough that they would be led to view euthanasia as their best alternative. In other words, their decision concerning death management could be manipulated by horrible living conditions such that they decide on euthanasia when in better circumstances they would have chosen otherwise.

If it becomes generally accepted that in certain situations euthanasia is the norm, pressure will be created to conform to this norm. In other words, people who really want to live will feel that to do so would only burden their families, society, and the health care system. They would be thought selfish for their decision not to request euthanasia.

The problem of circumstantial manipulation may be exaggerated. We need only to see that our sympathetic view of a dying person is not based necessarily in their helplessness. The dying person is a "victim" whether or not he or she has options *after* the dying process begins. It is not necessarily the case that once the person has options, we stop caring about which option they might

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[6] David J. Mayo, Martin Gunderson, "Physician Assisted Death and Hard Choices," in The Journal of Medicine and Philosophy, vol. 18 (3), June 1993, p. 334 [hereafter referred to as HC]

choose. No reason has been provided to think that our view of a dying patient would change if death management were to become an accepted practice. The patient is, after all, dying and is, after all, still a victim. Yet even if our attitude did change to some extent, and circumstantial manipulation were to become a reality, abuses would be still punishable. Even if one is not sympathetic, one is still not allowed to coerce a dying person into a decision to end life.

Ideological manipulation in particular cases is much more insidious as there is often no tangible evidence of its presence and effect. People just learn to think from a different perspective and from that perspective make decisions they might not have otherwise made. But it must be recognized that people are presently being manipulated by the prevailing ideology which is no less insidious than the ideology which is claimed might arise if death management becomes policy. People are currently being pressured to live as long as technologically possible. It is generally presumed that everyone wants to live as long as possible, whatever the cost. We also labor under the ideology that life is sacred, and that we ought not to take our lives (or our deaths) into our own hands. Under this present ideology we are manipulating people to decide to "live" when otherwise they would choose to participate in death management.

There are no easy answers to the issues of abuses of euthanasia policy. What I have tried to do is to show that while the answers are not simple, the questions are at the very least open. It is possible to defend a policy allowing death management, and such defenders should be given serious consideration.

THE SLIPPERY SLOPE

Slippery slope arguments generally contend that once we take one step on the hill, even if this step is justified, there will be no barrier to further steps and we will slide down the slope landing in a situation we originally sought to avoid. In the case of euthanasia, it is often argued that if we legitimize the practice in cases of an explicit request and a terminal illness, we will not be able to stop the practice from spreading to incompetent patients or those not already dying.

A number of arguments in favor of the legitimization of a permissive euthanasia policy focus on the patient's autonomy and the patient's suffering. Euthanasia is thought to be acceptable if the patient wants it and if there is no other way to relieve the patient's suffering. If we do not find euthanasia acceptable in these circumstances, then we are violating autonomy and sanctioning suffering. In essence we are abusing the patient in these circumstances if we refuse to acknowledge that the circumstances justify euthanasia.

While those who invoke slippery slope arguments are sympathetic to these concerns, their worry is that euthanasia will not be confined to the cases described above. Consider the appeal to the principle of autonomy. When a competent patient requests something, this request must be taken seriously. We believe that competent patients ought to be allowed to make decisions for themselves, and if my arguments have been sound, we should include decisions concerning the initiation of death management. But what about incompetent patients? Typically the supposition is that competent people are best able to make decisions for themselves in their own best interest. The incompetent patient should also have his or her interests served and since they cannot manage decisions for themselves, someone else will have to do so on their behalf. There are two ways that a proxy can make such a decision. First, the proxy can decide what to do based on what the proxy thinks that person would have wanted. We might call this the subjective test for proxy decision making. Alternatively, the proxy might decide on the basis of what a person in that patient's position would have wanted. We might call this the objective test for proxy decision making. On either alternative, the door is open for a proxy to make a request for euthanasia for an incompetent patient. Walking through this open door means moving away from the requirement that the patient make an explicit request for death management and towards allowing others to make this request on behalf of the patient. Of course, instead of appointing a proxy decision maker, a person fearing future incompetence can make out an advance directive.[7] This directive would tell the

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[7] It is worth noting that the decision to appoint a proxy might not have been made by the patient when he or she was competent. The fact that the proxy in such a case will not have been selected by the patient herself places us even further away from our original case where a competent patient who is dying requests death

physician what to do in the case of loss of competence. Advance directives have problems of their own,[8] but they still represent yet another step away from the situation where a patient in a terminal condition explicitly requests death management.

Whether the request is made through a proxy, by advance directive , or in some other way, it is important to realize that we have begun to stretch the principle of autonomy beyond its initial limits. We seem now to have a basis on which to allow more and more cases of euthanasia. The concern is that taking a step down this slippery slope will eventually lead to vulnerable persons being killed whether they wish it or not. Incompetent patients might be killed when this is not what they want, or would have wanted.

The other major factor in arguments favoring a permissive policy on active death management is the desire to relieve suffering. This factor is of even more concern to those who fear the slippery slope. People can suffer greatly even if what they are suffering from is not terminal. Additionally, people can be *thought* to be suffering when in fact they are not. It was once thought that children born with Down's Syndrome suffered a great deal in their lives. Now, through

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management.

[8] For example, see: Ronald Munson, ed., Intervention and Reflection: Basic Issues in Medical Ethics, (Belmont California: Wadsworth Publishing Company, 1992) p. 154-155.

awareness programs, community living endeavors, and the like, we no longer hold this to be true. However, if we truly thought that a person was suffering a great deal the question would inevitably arise. Why not put them out of their misery? Anyone who lived, in the eyes of others, a life of low quality would be at risk of being "put down" in order to relieve what is perceived as suffering. This is darkly reminiscent of the Nazi euthanasia policy where anyone deemed substandard was killed. No one would want the slide down the slippery slope to end here.

In response to these slippery slope arguments I would first point out that they are almost always based on pure conjecture. While I understand that conjecture paints a *possible* picture, it does not necessarily paint the *probable* picture. The only hard empirical evidence we have to either confirm or deny the conjecture comes from the Netherlands. There is one statistic in particular that has caused quite a bit of controversy. The Remmelink study gathered information on 10,000 deaths in a year.[9] The annual death rate is about 129,000 people. Overall in the year studied, there were 2,700 cases of euthanasia (1.8% of all annual deaths) and assisted suicide (.3% of all annual deaths).[10] Now the statistic in

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[9] All following statistics are taken from van Delden et al, RS2, p. 24

[10] This follow-up study does not explicitly define the difference between euthanasia and assisted suicide. The authors do define euthanasia as "ending a patient's life at the patient's explicit request" (van Delden et al, RS2, p. 24) so one can assume that in euthanasia the doctor him or herself ends the patients life, where as in assisted suicide the patient ends his or her own life with the help of the physician.

question was that 1,000 cases (.8% of all annual deaths) of life-terminating acts occurred without the patient's explicit request. These 1,000 cases were taken as proof of a slippery slope. Allowing a liberal policy on euthanasia had resulted in a thousand deaths were no explicit request was made.

There is, however, more to this statistic than the mere fact that 1,000 life-terminating acts occurred without the patient's explicit request. "Without explicit patient request" includes cases where there was patient involvement in the euthanasia decision even if this involvement did not take the form of an explicit request. The authors report that

> In 59 percent (600 of the 1,000 cases) of the cases in this category there was some such patient involvement. The whole category involving no explicit request can best be characterized as concerning patients who were near death and clearly suffering grievously.[11]

While this fact seems to assuage fears that the statistic substantiates the existence of a very slippery slope, concerns that the Dutch are on a slippery slope to involuntary euthanasia persist nonetheless. The authors address this point.

> Thus the impression may have arisen that the Dutch began by hastening the end of life on request and ended up with life-terminating acts that the patient has not explicitly requested. This, however, is not necessarily true. First of all, we simply do not know whether unrequested life-terminating acts occurred less or more often in the past. To demonstrate a slippery slope one would need to show that something changed after introducing a new practice,

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[11] van Delden et al, RS2, p. 24

> and for this at least two investigations would be required. Unfortunately, there is no 10- or twenty-year-old equivalent to our study. ...We conclude that no empirical data can be marshaled to support the slippery slope argument against the Dutch.[12]

in other words, the rate of unrequested life-terminating acts is only *assumed* to be higher than it had been or would be without the liberal Dutch policy on euthanasia. It could, in fact, be that the rate has remained the same, or even fallen lower. And it is important to remember, once again, that in 60% of the cases where no explicit request was made, the patient was involved in the decision that was ultimately made.

While there is no data that can confirm the rise of death-without-request, this, of course, does not put the issue to rest. That an increase has not been proved does little to assuage fears that it exists nonetheless, or will eventually develop because of the change in attitude that inevitably accompanies a liberal policy on euthanasia. A softer version of the slippery slope argument is that if euthanasia is practiced, doctors will become more cavalier in their attitudes about putting people to death. The authors of the Remmelink study have evidence, however, to show that this is not necessarily the case.

> In spite of the lack of older studies, we have an indication that Dutch doctors are not becoming more permissive with respect to euthanasia. At interview we asked the physicians whether their opinion concerning euthanasia

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[12] van Delden et al, RS2, p. 26

> had changed over the years. All physicians who had changed their opinion (39%) were asked to elaborate. Their answers suggest that doctors who start with strong value-laden opinions either in favor of or against euthanasia gradually move toward a more moderate position.[13]

I acknowledge that slippery slopes can be dangerous. But what I have tried to show is that there is at least as much evidence against a slide happening as there is for it. This being the case, fears of a slippery slope do not provide sufficient reason to prohibit the kind of death management for which I have been arguing in this thesis.

RESOURCES AND PALLIATION

With health care systems short of funds, and limited by the availability of resources, there is a concern that the practice of euthanasia will pull money away from research into palliation, and will generally lower the quality of care for dying patients. Concerning the latter, J. Gay-Williams claims that

> Doctors and nurses are, for the most part, totally committed to saving lives. A life lost, is for them, almost a personal failure, an insult to their skills and knowledge. Euthanasia as a practice might well alter this. It could have a corrupting influence so that in any case that is severe doctors and nurses might not try hard enough to save the patient. They might decide that the patient would simply be "better off dead" and take the steps necessary to make that come about. This attitude could then carry over to their dealings with patients less seriously

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[13] van Delden et al, RS2, p. 26

> ill. The result would be an overall decline in the quality of medical care.[14]

The evidence provided by the Remmelink study, indicating that Dutch doctors are not becoming overly permissive in handing out death, is sufficient response to this hyperbolic portrayal of the medical professions. In addition, it is highly questionable that the ideals of medicine could be so radically changed in the ways Gay-Williams suggests. It takes a lot of argumentation, justification and explanation to make death management seem acceptable to physicians in the most clear-cut of cases. There is clearly a reticence on the part of doctors to participate in anything resembling a course of conduct designed to bring about the death of a patient. It is only when they can be shown that such conduct is, in fact, morally permissible (or required), and is in actual fact a confirmation of their principles as opposed to a denial of them, that they are likely to accept active death management as a practice to which they are willing to subscribe. With this kind of resistance I strongly doubt that the cavalier attitude described by Gay-Williams will ever become a reality for doctors and nurses.

The concern about allocations of resources should euthanasia become a practice is one to which it is more difficult to respond. How much money we as a society put into health care, and where within the health care system that money

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[14] J. Gay-Williams, "The Wrongfulness of Euthanasia," in Interventions and Reflections, ed., Ronald Munson (Wadsworth Publishing Company, 1992) p. 158

goes, is a reflection of our health care priorities. The more people there are dying of cancer, the more cancer is a concern, and the more money we allot for cancer research. So a question about resources is really a question about priorities. If there is not enough money to go around, and something has to be left out, hopefully it will be something of low priority. The worry seems to be that if euthanasia becomes a practice, palliation or care while dying will be bumped out of its current high priority slot and denigrated to a much lower priority. Thus people who do not want to participate in death management, or people who are dying a good but not quick death, will be left without adequate care.

It must be remembered, however, that the number of cases where death management would be an option is probably very low. If this is correct then death management, even if encouraged, would not effect a large enough portion of the population to garner an extremely high priority. It seems unlikely that death management would be given such a high priority that it would constitute a threat to any other established priority.[15] This is not to say that resource allocation is not a problem; it is, but it was a problem before death management became a topical issue and will probably continue to be so after another issue becomes topical.

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[15] I would even venture to suggest that if the nature of the dying process *is* a large enough issue to draw public support then maybe it *ought* to be a priority even at the expense of some other priority.

FINAL THOUGHTS

There are, no doubt, many other difficulties which could be cited by those concerned about the prospect of active death management becoming a practice. I have only looked at a few. It has not been my purpose to argue for death management as a legally sanctioned practice per se. Thus I have not been complete in my responses to the problems presented by the practice. I have however, tried to say something about the most commonly cited objections and to show that a plausible defense of the practice of death management is possible, though not simple or necessarily conclusive.

In this project I have not been as concerned with what will happen should death management become an acceptable practice as with what will *continue* to happen if death management is rejected out of hand as morally unacceptable. If my arguments are successful and active death management is accepted as part of the moral responsibility of physicians and other HCPs, problems with policy and practice will have to be addressed. But for now, it is enough to have shown that death management, as the promotion of the good death and avoidance of the bad death for the dying patient, is part of the moral responsibility of the primary health care provider.

BIBLIOGRAPHY

Barrington, Mary Rose. "Apologia for Suicide," in Moral Problems in Medicine (2nd ed) ed. Samuel Gorovitz, Ruth Macklin, Andrew L. Jameton, John M. O'Connor and Susan Sherwin. Englewood Cliffs, N.J.: Prentice-Hall Inc., 1983, p. 472-475.

Battin, Margaret Pabst. The Least Worst Death. New York, N.Y.: Oxford University Press, 1994.

Battin, Margaret Pabst. Ethical Issues in Suicide. Englewood Cliffs: Prentice-Hall, 1982.

Battin, Margaret Pabst, Thomas J. Bole, III. "What If Euthanasia Were Legal? Introducing the Issue." in Journal of Medicine and Philosophy, vol. 18, 1993, p. 237-240.

Battin, Margaret Pabst, David J. Mayo. ed. Suicide: The Philosophical Issues. New York: St. Martin's Press, 1980.

Bayles, Michael D. Professional Ethics. Belmont: Wadsworth Publishing Company, 1989.

Beauchamp, Tom L., Arnold I. Davidson. "The Definition of Euthanasia," in Moral Problems in Medicine (2nd ed) ed. Samuel Gorovitz, Ruth Macklin, Andrew L. Jameton, John M. O'Connor and Susan Sherwin. Englewood Cliffs, N.J.: Prentice-Hall Inc., 1983, p. 446-457.

Beauchamp, Tom L., ed. Intending Death: The Ethics of Assisted Suicide and Euthanasia, Upper Saddle River, New Jersey: Prentice Hall, 1996.

Braine, David, Harry Lesser. Ethics, Technology and Medicine, Aldershot England: Gower Publishing Company Limited, 1988.

Brim, Orville G., Howard E. Freeman, Sol Levine, Norman A. Scotch, eds., The Dying Patient, New York: Russell Sage Foundation, 1970.

Burgess, Michael. "The Medicalization of Dying," in Journal of Medicine and Philosophy, vol. 18 (3), June 1993, p. 269-280.

Callahan, Daniel. The Troubled Dream of Life: Living with Mortality . New York: Simon & Shuster, 1993.

Callahan, Joan C., ed. Ethical Issues in Professional Life. New York: Oxford University press, 1988.

Caplan, Arthur L. "The Ethics of In Vitro Fertilization," in Ethical Issues in the New Reproductive Technologies, ed., R. Hull. Wadsworth Publishing Company, 1990, p. 96-108.

Crane, Diana. The Sanctity of Social Life: Physicians' Treatment of critically ill Patients. New York: Russell Sage Foundation, 1977.

Cupit,, Geoffrey. "How Requests (And Promises) Create Obligations," in The Philosophical Quarterly, Vol. 44, No. 177, Oct 1994, p. 439-455.

Curzer, Howard J. "Is Care A Virtue For Health Care Professionals?" in Journal of Medicine and Philosophy, vol. 18 (3), June 1993, p. 51-69.

Dan-Cohen, Meir, "Conceptions of Choice and Conceptions of Autonomy," in Ethics, 102 Jan., 1992, p. 221-243.

Davion, Victoria. "Autonomy, Integrity, and Care," in Social Theory and Practice, vol. 19, No. 2, Summer 1993, p. 161-182.

DeGrazia, David. "Moving Forward in Bioethical Theory: Theories, Cases, and Specified Principlism," in Journal of Medicine and Philosophy, vol. 17, 1992, p. 511-539.

Doerflinger, Righard. "Assisted Suicide: Pro-Choice or Anti-Life?" in Readings in Biomedical Ethics ed. Eike-Henner W. Kluge. Scarborough, Ont.: Prentice Hall Canada Inc., 1993, p. 297-303.

Drane, James F. Becoming A Good Doctor: The Place of Virtue and Character in Medical Ethics. 2nd ed. Kansas City: Sheed & Ward, 1995.

Feinberg, Joel. "Sua Culpa," in Philosophy of Law (3rd ed), ed. Joel Feinberg and

Hyman Gross. Belmont: Wadsworth, 1980, p. 512-527.

Feinberg, Joel, Hyman Gross. Responsibility: Selected Readings, Encino California: Dickenson Publishing Company, 1975.

Feinberg, Joel. Doing and Deserving, Princeton, New Jersey: Princeton University Press, 1970.

Feinberg, Joel. Freedom & Fulfillment, Princeton, New Jersey: Princeton University Press, 1992.

Fisher, Rory H., Eric M. Meslin. "Should Living Wills Be Legalized?" in Readings in Biomedical Ethics ed. Eike-Henner W. Kluge. Scarborough, Ont.: Prentice Hall Canada Inc., 1993, p. 327-332.

Foot, Philippa. Virtues and Vices and Other Essays in Moral Philosophy, Berkeley and Los Angeles: University of California Press, 1978.

Ford, Anasa B., Ralph E. Liske, Robert S. Ort, John C. Denton. The Doctor's Perspective: Physicians View Their Patients and Practice, Cleveland, Ohio: The Press of Case Western Reserve University, 1967.

Francis, Leslie Pickering. "Advance Directives for Voluntary Euthanasia: A Volatile Combination?" in Journal of Medicine and Philosophy, vol. 18, 1993, p. 297-322.

Freedman, Benjamin. "What Really Makes Professional Morality Different: Response to Martin," in Ethics, vol. 91, July 1981, p. 626-630.

Freeman, John M. "Is There a Right to Die — Quickly?" in Moral Problems in Medicine (2nd ed) ed. Samuel Gorovitz, Ruth Macklin, Andrew L. Jameton, John M. O'Connor and Susan Sherwin. Englewood Cliffs, N.J.: Prentice-Hall Inc., 1983, p. 412-413.

Gay-Williams, J. "The Wrongfulness of Euthanasia," in Interventions and Refelctions, ed., Ronald Munson. New Haven: Wadsworth Publishing Company, p. 156-159.

Gillet, Grant R. "Learning to Do No Harm," in Journal of Medicine and Philosophy, vol. 18 (3), June 1993, 253-268.

Gomberg, Paul. "Autonomy and Free Expression," in Journal of Social Philosophy, Vol. 25 No. 2, Fall 1994, 97-104.

Gould, Donald. The Black and White Medicine Show: How Doctors Serve and Fail Their Customers. London: Hamish Hamilton, 1985.

Gray, Christopher. "Rights, Duties, and Virtues: A Categorical Map for Normative Disciplines," in Journal of Thought, Fall-Winter 1993, p. 17-29.

Group for the Advancement of Psychiatry. The Right to Die. New York: Jason Aronson, 1973.

Gunderson, Martin, David J. Mayo. "Altruism and Physician Assisted Death," in Journal of Medicine and Philosophy, vol. 18 (3), June 1993, p. 329-341.

Haji, Ishtiyaque. "Autonomy and Blameworthiness," in Canadian Journal of Philosophy, Vol. 24, No. 4, Dec 1994, p. 593-612.

Hart, H. L. A. Punishment and Responsibility: Essays in the Philosophy of Law, Oxford: Oxford University Press, 1963.

Hart, H.L.A. "Responsibility," in Philosophy of Law (3rd ed), ed. Joel Feinberg and Hyman Gross. Belmont: Wadsworth, 1980, p. 474-482.

Hart, H.L.A., A.M. Honore. "Causation and Responsibility," in Philosophy of Law (3rd ed), ed. Joel Feinberg and Hyman Gross. Belmont: Wadsworth, 1980, p. 483-495.

Hohfeld, Wesley Newcomb. "Rights and Jural Relations," in Philosophy of Law (3rd ed), ed. Joel Feinberg and Hyman Gross. Belmont: Wadsworth, 1980, p. 308-318.

Humphry, Derek. Final Exit. Eugene, Oregon: The Hemlock Society 1991.

Jones, Gary E. "Rights and Desires," in Ethics, Vol. 92, Oct 1988, p. 52-56.

Jones, W. T. "Public Roles, Private Roles, and Differential Moral Assessments of Role Performance," in Ethics, vol. 94, July 1984, p. 603-620.

Jonsen, Albert R. "Living with Euthanasia: A Futuristic Society," in Journal of Medicine and Philosophy, vol. 18 (3), June 1993, p. 241-251.

Kamisar, Yale. "Euthanasia Legislation: Some Non-Religious Objections," in Moral Problems in Medicine (2nd ed) ed. Samuel Gorovitz, Ruth Macklin, Andrew L. Jameton, John M. O'Connor and Susan Sherwin. Englewood Cliffs, N.J.: Prentice-Hall Inc., 1983, p. 458-465.

Kelly, Michaeleen. "Rights and Power: A Feminist Re-Thinking of Liberal Rights," in Journal of Social Philosophy, Vol. 25, No. 2, Fall 1994, p. 73-88.

Kinsella, T. Douglas, Marja J. Verhoef. "Alberta Euthanasia Survey: 1. Physicians' opinions about the morality and legalization of active euthanasia," in Canadian Medical Association Journal, vol. 148 (11), 1993, p. 1921-1926.

Kubler-Ross, Elisabeth. On Death and Dying. New York: Macmillan Publishing Company, 1969.

Lee, Kwang-Sae. "Some Confucianist Reflections on the Concept of Autonomous Individual," in Journal of Chinese Philosophy, Vol. 21, 1994, p. 49-59.

Lizza, John. "Persons and Death," in Journal of Medicine and Philosophy, vol. 18 (4) Aug. 1993, p. 351-374.

Lowy, Frederick, Douglas M. Sawyer, John R. Williams. "Canadian physicians and euthanasia: 4. Lessons from experience," in Canadian Medical Association Journal, vol. 148 (11), 1993, p. 1895-1899.

Lyons, David. "The Correlativity of Rights and Duties," in Philosophy of Law (3rd ed), ed. Joel Feinberg and Hyman Gross. Belmont: Wadsworth, 1980, p. 319-324.

Martin, Mike W. "Rights and the Meta-Ethics of Professional Morality," in Ethics, vol. 91, July 1981, p. 619-625.

Martin, Mike W. "Professional and Ordinary Morality: A Reply to Freedman," in Ethics, vol. 91, July 1981, p. 631-633.

May, William F. The Physician's Covenant: Images of the Healer in Medical Ethics. Philadelphia: The Westminister Press, 1983.

Mayo, David J, Martin Gunderson. "Physician Assisted Death and Hard Choices," in

Journal of Medicine and Philosophy, vol. 18 (3), June 1993, p. 329-341.

Meyer, Michael. "Patients' Duties," in Journal of Medicine and Philosophy, vol. 17 (5), 541-555.

Meyer, Michael. "Dignity, Death and Modern Virtue," in American Philosophical Quarterly Vol 32, No. 1, Jan. 1995, p. 45-55

Miller, Franklin G. "The Concept of Medically Indicated Treatment," in Journal of Medicine and Philosophy, vol 18, 1993, p. 91-98.

Morris, Herbert. "The Status of Rights," in Ethics, Vol. 92, Oct 1981, p. 40-56.

Motto, Jerome A. "The Right to Suicide: A Psychiatrist's View," in Moral Problems in Medicine (2nd ed) ed. Samuel Gorovitz, Ruth Macklin, Andrew L. Jameton, John M. O'Connor and Susan Sherwin. Englewood Cliffs, N.J.: Prentice-Hall Inc., 1983, p. 443-445.

Mullens, Anne. Timely Death: Considering Our Last Rights, Toronto, Canada: Alfred A. Knopf Canada, 1996.

Murphy, George E. "Suicide and the Right to Die," in Moral Problems in Medicine (2nd ed) ed. Samuel Gorovitz, Ruth Macklin, Andrew L. Jameton, John M. O'Connor and Susan Sherwin. Englewood Cliffs, N.J.: Prentice-Hall Inc., 1983, p. 442.

Needleman, Jacob. The Way of the Physician, San Francisco: Harper & Row, 1985.

Nesbitt, Winston. "Euthanasia and the Distinction Between Acts and Omissions" in Journal of Applied Philosophy, vol. 10, no. 2, 1993, p. 253-256.

Noggle, Robert. "Autonomy, Value, and Conditioned Desire," in American Philosophical Quarterly, Vol., 23, No. 1, Jan 1995, p. 57-69.

Novak, David. Suicide and Morality. New York: Scholars Studies Press Inc., 1975.

Nuland, Sherwin B. How We Die. New York: Alfred A. Knopf, 1994.

Pellegrino, Edmund D. Humanism and the Physician, Knoxville Tennessee: The University of Tennessee Press, 1979.

Pellegrino, Edmund D., David C. Thomasma. A Philosophical Basis of Medical Practice, New York: Oxford University Press, 1981.

Pellegrino, Edmund D. "The Virtuous Physician and the Ethics of Medicine," in Contemporary Issues in Bioethics, ed., Tom L. Beauchamp and LeRoy Walters, Belmont California: Wadsworth Publishing Company, 1994, p. 51-57.

Pincoffs, Edmund L. Quandries and Virtues, University Press of Kansas, 1986.

Prado, C.G. The Last Choice: Preemptive Suicide in Advanced Age. New York: Greenwood Press, 1990.

Rachels, James. The End of Life: Euthanasia and Morality. Oxford: Oxford University Press, 1986.

Rozovsky, Lorne. The Canadian Patient's Book of Rights. Toronto, Ont.: Doubleday Canada Limited, 1994.

Sawyer, Douglas M., John R. Williams, Frederick Lowy. "Canadian physicians and euthanasia: 2. Definitions and distinctions," in Canadian Medical Association Journal , vol. 148 (9), 1993, p. 1463-1466.

Sawyer, Douglas M. John R. Williams, Frederick Lowy. "Canadian physicians and euthanasia: 5. Policy options," in Canadian Medical Association Journal, vol. 148 (12), 1993, p. 2129-2133.

Shafer-Landau, Russ. "Vagueness, Borderline Cases and Moral Realism," in American Philosophical Quarterly, Vol. 32, No. 1, Jan 1995, p. 83-95.

Shorter, Edward. Bedside Manners: The Troubled History of Doctors and Patients, New York: Simon and Schuster, 1985.

Slote, Michael. From Morality to Virtue, New York: Oxford University Press, 1992.

Sullivan, Patrick. "Doctors to be surveyed about euthanasia, CMA Board of Directors decides," in Canadian Medical Association Journal , vol. 148 (7), 1993, p. 1190.

Sullivan, Roger J. "Kantian Critique of Aristotle's Moral Philosophy," in The Good Life and Its Pursuit, ed., Jude P. Dougherty, New York: Paragon House, 1984.

Troxell, Eugene A., "On Having A Sense of Responsibility," in The Journal Of Social Philosophy, vol. 25 No.2, Fall 1994, p. 2-28.

van Delden, Johannes, Loes Pijnenborg, and Paul J. van der Maas. "The Remmelink Study: Two Years Later," in The Hastings Center Report, vol. 23, no. 6, Nov-Dec 1993, p 24-27.

Veatch, Robert M. Death, Dying, and the Biological Revolution . New Haven: Yale University Press, 1989.

Velleman, J. David. "Against the Right to Die," in Journal of Medicine and Philosophy, vol. 17 (6), Dec. 1992, p. 665-681.

Verhoef, Marja J., T. Douglas Kinsella. "Aberta Euthanasia Survey: 2. Phsyicians' opinions about the acceptance of active euthanasia as a medical act and the reporting of such practice," in Canadian Medical Journal Association, vol. 148 (11), 1993, p. 1929-1933.

Vernon, Glenn M. Sociology of Death: An Analysis of Death-Related Behavior. New York: The Ronald Press Company, 1970.

Waitzkin, Howard. The Politics of Medical Encounters, New Haven: Yale University Press, 1991.

Wallace, Jay R. Responsibility and the Moral Sentiments, Cambridge Massachusetts: Harvard University Press, 1994.

Wanzer, S.H., D.D. Federman, S.J. Adelstein, et al. "The Physician's Responsibility Toward Hopelessly Ill Patients: A second Look," in Readings in Biomedical Ethics ed. Eike-Henner W. Kluge. Scarborough, Ont.: Prentice Hall Canada Inc., 1993, p. 304-313.

Wildes, Kevin W. "The Priesthood of Bioethics and the Return of Casuistry," in Journal of Medicine and Philosophy, vol. 18, 1993, p. 33-49.

Wildes, Kevin W. "Conscience, Referral and Physician Assisted Suicide," in Journal of Medicine and Philosophy, vol. 18 (3), June 1993, p. 323-328.

Williams, John R., Frederick Lowy, Douglas M. Sawyer. "Canadian physicians and euthanasia: 1. An approach to the issues," in Canadian Medical Association

Journal, vol. 148 (8), 1993, p. 1293-1297.

Williams, John R., Frederick Lowy, Douglas M. Sawyer. "Canadian physicians and euthanasia: 3. Arguments and beliefs," in Canadian Medical Association Journal, vol. 148 (10), 1993, p. 1699-1702.