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## **The withdrawal of life-sustaining treatment Ethics and law: principles and practice**

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### ***In this issue***

The two articles in this issue address a set of ethical issues to do with medical treatment and nursing care at the end of life. Gerald Gleeson considers some challenges posed by the principles found in the Catholic moral tradition.

Stephen Buckle analyses some philosophical assumptions at work in recent debates about proposals to legalise euthanasia.

Few decisions involve more anguish for families and healthcare professionals than the decision to withdraw a medical treatment that is sustaining a patient's life. Nonetheless, under certain conditions, it can be, and often is, morally right to withhold or to withdraw life-sustaining treatment. Just what those conditions are is the controversial issue raised by the recent judgment of the Victorian Supreme Court authorising removal of tube feeding from a woman with advanced and debilitating dementia.

To many of us who do not live in Melbourne, it seemed strange that the Catholic Church was questioning the removal of percutaneous endoscopic gastronomy (PEG) feeding from a woman of whom the court said: "She has not appeared conscious, or to have any cortical activity, for approximately three years. She appears to have no cognitive capacity at all and has no bodily functions, other than those which are reflexive. Further, she appears to have no conscious perception of input from any of her sensory pathways." To insist on continued artificial feeding of a patient, in particular one who (it seems) had indicated that she would not wish to be kept alive in such a condition, would in the minds of many of us, simply play into the hands of the advocates of euthanasia.

The view of the Catholic authorities in Melbourne was different. First, they described the woman's condition differently. Fr Anthony Fisher wrote in the *Herald-Sun* (2/6/03): "She is not in pain. Not on a life-support machine. Not dying. That's the problem. 'BWV' suffers from progressive dementia and is fed through a tube. Though awake, capable of following people around the room with her eyes and responsive to some stimuli, she is now uncommunicative." Fisher quotes expert opinion that "though BWV will continue to decline, she has been stable for the past few months and were 'nature left to take its course' she would likely live for a few more years. So now [Fisher adds] her food and water are to be stopped."

Secondly, it seems that euthanasia advocates have in fact been involved in this case for quite a while. They recently embarked upon a new strategy, viz. that in place of seeking explicit legislation they would use court decisions condoning death by deliberate omission as steps towards euthanasia, and then argue that an act of commission would be more humane. Fisher quotes pro-euthanasia campaigner Dr Rodney Syme (someone who had supported the family of BWV in bringing this case to court) as now arguing (*Herald-Sun* 30/5/03) that what is proposed for BWV is "cruel death by dehydration and starvation" - thus implying that what she really needs is a lethal injection.

Clearly this case, and the politics of its coming to court, are more complex than many of us had assumed. In this article I wish to reflect on three matters: first, "matters of description"; secondly, the relationship between law and ethics in this kind of case; and thirdly, the notion of therapeutic benefit.

### **Matters of description**

In the quotation above, the condition of the patient BWV is described in diverse ways. The court's description sounds clinical; it reflects a "detached" viewpoint. Fr Fisher's description is less clinical; it reflects a more "personal" viewpoint. Are they both describing the same patient? Which description is more accurate? Disputed descriptions also arise in relation to the

removal of PEG feeding. Dr Syme and Fr Fisher agree that to remove the tube would be to starve BWV to death, and on this basis draw conflicting conclusions. The court, however, endorsed Margaret Somerville's argument that it is wrong to equate artificial hydration and nutrition with natural food and drink. Somerville argues that decisions to cease PEG feeding should be based on its characterisation, not as the cessation of food and water, but as the cessation of *artificial life support*.<sup>1</sup>

These conflicting descriptions remind us that it is common for actions and cases to be amenable to various descriptions depending on the describer's needs and purposes. It is crucial to moral evaluation, however, that one does not smuggle into one's preferred description assumptions that would pre-empt the moral evaluation. The claim that BWV is "not on a life-support machine" is problematic because it *pre-empts* the question whether PEG feeding is or is not analogous to artificial life support. Likewise, to say that BWV is "responsive to some stimuli" circumvents the question of what sort of response BWV is making: the merely reflexive or the conscious and deliberate? Again, the statement that "now her food and water are to be stopped" pre-empts the moral evaluation of the cessation of PEG feeding and hydration. On the other hand, simply describing PEG feeding as a "medical treatment" (as the court held) does not of itself settle the ethical question whether this treatment for this patient ought to be stopped or continued.

I believe two points can be made about these matters of description. First, arriving at the most illuminating and accurate description of an action often goes hand in hand with the moral evaluation of the action. In complex cases, evaluation and description are *conclusions* reached jointly. If we are trying to determine whether PEG feeding may rightly be withheld or withdrawn, we should not *begin* by describing it as "starving a person to death". That may or may not emerge as the correct evaluation/description of the action. In some cases the cessation of PEG feeding would indeed amount to starving a person to death - but not in all cases. Arriving at a correct evaluation/description requires

an examination of an agent's goals and intentions, as well as the proposed means of action in the circumstances of the case. I will return to these issues shortly.

Secondly, from the fact that description and evaluation of moral actions are interwoven, it does not follow that a non-question begging search for the accurate description of an action should begin from utterly neutral and impersonal descriptions. On the contrary, "personal" descriptions will be essential. For example, in the case of patient BWV, family and friends will be in the best position to interpret her "responses" and communicative abilities. At this distance, I am in no position to adjudicate between the court's statement that BWV "appears to have no conscious perception of input from any of her sensory pathways" and Fisher's statement that she is "capable of following people around the room with her eyes". Is BWV totally unaware of her surroundings, or simply "uncommunicative"? Only personal engagement with the patient by those most closely involved will help to answer this question. In short, sound ethical evaluation presupposes an accurate understanding of the condition of the patient as a person in relationship to other persons.

## Law and ethics

In New South Wales, the Health Department has Guidelines for clinical and ethical decisions about care of the terminally ill. In Victoria, these decisions are governed by legislation, the *Medical Treatment Act 1988*. This Act allows competent patients and guardians to refuse "medical treatments" under certain conditions.

A number of different questions arise in relation to the Victorian Act. First, how should the Act be interpreted? The court decided that PEG feeding is an *artificial* medical procedure that does not fall under the definition of palliative care; if so, it becomes a "medical treatment" within the terms of the Act, the kind of treatment that a patient or guardian may legally refuse under certain conditions. In the case of BWV, her guardian may refuse treatment if it would cause unreasonable distress to the patient, or if there are reasonable grounds for believing the patient, if competent, would consider the treatment unwarranted (Act, S. 5.2).

The significance of the way in which Judge Morris reached this conclusion is that if PEG feeding is a medical treatment, then it is not what the Act calls

the "reasonable provision of food and water" - something that would be an obligatory part of good "palliative care". It could well be argued, however, that if PEG feeding were simply regarded as a way of providing food and water, then it would be open to a patient or guardian (and the court) to judge whether or not it would be "reasonable" in the case of a patient like BWV. On this line of argument, it would not be necessary to decide whether or not PEG constitutes a "medical treatment" within the terms of the Act. By taking the approach it did, the court's decision tends to support the pro-euthanasia lobby's argument for a right to refuse or omit what may, in many cases, be quite "ordinary" forms of life sustaining treatment.

Secondly, we should ask, does the *Medical Treatment Act 1988* correctly articulate the ethical basis for the withdrawal or withholding of life-sustaining medical treatment? The Catholic moral tradition does not require a perfect overlap between law and morality: not everything that is unethical ought to be illegal, and an ethically deficient law may be preferable to no law at all. Nonetheless, a major criterion for evaluating any law is whether it is in keeping with sound ethical principles.

A decade ago Professor John Finnis criticised the Victorian *Medical Treatment Act* on the grounds that it exaggerates the "rights" of self-determination and ignores the difference between refusing treatment because it is futile or burdensome and refusing treatment in order to hasten death.<sup>2</sup> Catholic moral teaching emphasises the crucial role of *intention* in distinguishing between these two kinds of refusal. The former refusal need involve no intention that a person die, even if this effect is foreseen. The latter refusal makes a person's death the means to an end such as the relief of suffering.

Increasingly the courts and legal theorists have come to ignore the role of intention. As in the famous *Bland* decision in England, lawyers are tending to look only to the physical causality of actions and their foreseeable effects, and on this basis imputing "intention" to agents. On this view, the removal of PEG feeding is regarded as an omission that causes death, and since this effect is foreseen, the agent is held to be necessarily intending to cause death; by contrast, a lethal injection is said to be a commission (a "positive act") that causes, and is intended to cause, death. The contrast, however, is spurious: once the cases are described in this way, people are entitled to ask: If one may rightly *intend* to cause death by a (so-called) "negative act", why is it wrong to intend to cause death by a "positive act"? Or, more

colloquially, if so-called "passive euthanasia" is permissible, why isn't "active euthanasia" also permissible? So runs one well-known argument for euthanasia.

Catholic moral teaching agrees that in this context the omission/commission (or "passive"/"active") distinction is spurious, but for a different reason. On the one hand, a deliberate omission causing death can be just as wrong as a commission causing death. On the other hand, not every active intervention that leads to death is morally wrong. In all cases, what matters is not whether one's action is "positive" or "negative", nor whether it is a "treatment" or "palliative care" but whether one's action is explained by the intention to cause death (either as an end or as a means). Moreover, in determining whether and how death is intended in an action, it is not enough simply to observe the physical causality of the action, e.g. to observe whether or not it "directly kills" the patient.

The omission/commission distinction appeals to the different causal pathways involved when, for example, a patient is poisoned (killed by a lethal injection) by contrast to when a patient is starved to death (as a consequence of nutrition and hydration having been withdrawn). The *Bland* decision found this causal difference to be legally significant. The pro-euthanasia lobby argues this causal difference is not morally significant. Both positions are mistaken because they try to evaluate the omission/commission solely from the perspective of an external observer.

Moral actions can only be properly described in relation to their agents' practical reasoning, intentions, and choices (in relation to, what Pope John Paul II calls, the "perspective of the acting subject").<sup>3</sup> From the agent perspective, one can successfully intend to bring about death (whether one's own or another's) as much by "doing nothing" as by doing something. In terms of moral responsibility, "doing nothing" (not resuscitating a patient, withholding life-support, ceasing to administer medication, etc.) is in truth doing something, which it may or may not be right to do, depending on one's obligations and intentions.

The priority of the agent's perspective and intention does not make physical causality irrelevant to moral evaluation. There is an important causal difference between an omission (not providing PEG) and a commission (a lethal injection). The latter has only one proper "result" – death – a result that

defines the action (as a *lethal* injection). So whatever a person's further purposes may be, to intentionally give a lethal injection is to intend to kill. The former, by contrast, has one proper result – the patient does not receive a treatment – a result that can in turn have various "consequences": removing an unwanted burden from a patient, leaving a patient without nutrition and hydration, stopping unpleasant side-effects, hastening death etc., not all of which need be intended by the agent.<sup>4</sup> This is why the removal of life-sustaining treatment may or may not involve the intention to hasten death, and may or may not be morally permissible.

The *Code of Ethical Standards for Catholic Health and Aged Care Services* carefully enunciates these ethical principles: "Patients have the moral right to refuse any treatment which they judge to be futile, overly-burdensome or morally acceptable" (1.16).<sup>5</sup> Notice that this is not an unfettered right to refuse treatment for any reason whatsoever; the right is limited by one's normal responsibility to care for one's life and health. "Healthcare practitioners may not override any refusal of treatment by a competent patient who is not mentally disturbed, clinically depressed or suicidal, irrespective of whether or not they agree with the patient's refusal" (1.16). Notice that this duty to respect a patient's decision includes respecting decisions one believes to be foolish, unreasonable, and/or morally wrong. Once again, it is the agent's perspective that reveals why the range of decisions by patients to which respect is owed differs from – and is larger than – the range of decisions that are morally right for patients to make.

Having clarified these ethical principles, we are in a position to evaluate the Victorian *Medical Treatment Act* with respect to refusals of treatment. A further aspect of Finnis' criticism was that the Act is ambiguous. Those educated in the Catholic moral tradition might well read its conditions for when treatment may be refused as referring to the traditional criteria of futility and burdensomeness. Others, however, might not restrict the Act in this way: they might reject treatment as "unwarranted" simply because they prefer non-treatment as a means of ensuring that death occurs, particularly if they have come to regard life as no longer worth living.<sup>6</sup> Given the educative influence of the law, Finnis believes the Victorian Act will encourage people to think that treatment may be refused as "unwarranted" with respect to whatever their wider

goals may be - including suicide and homicide. He argues that the Act should have included a more believe the Victorian Act will encourage people to think that treatment may be refused as "unavoidable" with respect to whatever their wider goals may be - including suicide and homicide. He argues that the Act should have included a more explicit prohibition of intentional killing and assistance in suicide, together with reminders about the only ethically valid reasons for refusing treatment.

These astute criticisms prompt the question: What should we expect of the law? To what extent should we expect an Act to embody sound ethical principles? This question involves both legal and political considerations - the former a question of jurisprudence, the latter a question of what can be achieved in a pluralist democracy where we may have to settle for less than ideal laws. To my mind, the law is often a rather crude instrument, and even the best-framed laws are likely to lack the subtlety of sound ethical principles. Nevertheless, the law ought to be able to reflect the distinction between conduct in which death is *directly intended* and conduct in which death is *foreseen, but unintended* (indeed, the law used to do this, before it succumbed to the recent emphasis on individual autonomy and the utilitarian assessment of physical consequences).

From the discussion to this point, it should be clear that, at least in the case of legislation that is open to misinterpretation, a determination of the legal issue does not of itself determine the ethical issue. The Victorian court found that PEG feeding was the kind of treatment that might legally be refused under the Act. Whether in the case of BWV or any other patient PEG feeding *may rightly be refused* is a separate question, to which I now turn.

### Therapeutic Benefit

The traditional criteria for legitimately refusing life-sustaining medical treatments are "futility" and "burdensomeness". In many cases, the application of these criteria is straightforward enough. If the death of a terminally ill patient is imminent, treatments to prolong life generally would be futile; if the side-effects of treatment are unduly burdensome for the patient or others, treatment may be forgone. However, in the case of incompetent patients like BWV the application of these criteria is problematic because death from an underlying disease such as advanced dementia is not imminent, and the side-effects and burdensomeness of the treatment may be minimal.

Decisions in these more difficult cases will be easier if a patient has previously expressed their wishes in regard to life-sustaining treatment. Thus John Finnis allows that, although "human life even in irreversible unconsciousness is of intrinsic value... someone contemplating being in so radically deprived a state [might] reasonably decide that any use of hospital and specifically medical resources would be excessive... If so, he could judge that the duty to give and accept ordinary care requires no more than this: the giving of such food, water and nursing care as can be provided from the resources available in one's home". A patient reasoning in this way would be relying on the principle that one is not obliged to pursue a benefit (prolonged life) if it involves an undue burden (including "excessive expenditure"). A patient wishing to forgo life-sustaining treatment for this reason would not be intending to hasten death, but only to avoid being (what he or she judges) an undue burden on others.

What if a patient has not previously expressed their wishes? What are the obligations of healthcare professionals and family with respect to incompetent and unconscious, demented or gravely debilitated patients who can no longer receive food and water by mouth? Of the two relevant criteria, *burdensomeness* is the less controversial. If the difficulties and burdens involved in PEG feeding of a patient like BWV become grave, then there will be no obligation to continue with that method of feeding. The judgment about burdensomeness can only be made on a case-by-case basis by those most closely involved. In the case of BWV, the court could have found (and rightly, many believe) that PEG was no longer a "reasonable" (i.e. non-burdensome and "ordinary") way of sustaining life.

The criterion of *futility*, by comparison, is much more difficult to apply in these cases. First, there is some debate within the Catholic moral tradition about how "futility" should be understood. The more cautious Catholic approach holds that any treatment that does what it is designed to do (e.g. PEG feeding that successfully nourishes a patient) is therapeutically beneficial and so is not futile. Others within the Catholic tradition take a broader view of futility and hold that a treatment that might be therapeutically beneficial might, nonetheless, not be beneficial for a particular patient. Furthermore, there is in our society a new, so-called "quality of life" ethic, which asserts that some lives are just not worth living; according to this new ethic, if a person's life is not worth living we would do better to bring about the person's death (either by "active" or "passive"

means). People are rightly concerned that the recent Victorian judgment could be read as supporting this new, "quality of life" approach, thus opening the way to the withdrawal or withholding of life-sustaining treatment simply on the grounds that some patients would be "better off dead".

It is in part because of the difficulties associated with judging when life-sustaining treatments are "futile" or "beneficial" that it is easier and "safer" simply to endorse the burdensomeness test. Thus, the *CHA Code*, like the US Bishop's *Ethical and Religious Directives* (1994), affirms a presumption in favour of nutrition and hydration unless they do not in fact sustain life or "their only mode of delivery imposes grave burdens on the patient or others" (5.12).

Whilst we should reject the new, "quality of life" ethic, I believe we should be willing to explore broader notions of *benefit* and *futility* in difficult cases like that of BWV. Indeed, it is difficult to see how assessment of the burdensomeness of PEG for a patient can exclude consideration of the condition of the patient, and of the benefit that PEG will provide given the patient's prognosis. If PEG is no longer deemed a "reasonable" (or "proportionate") way to provide nutrition to BWV, is this not in part because it no longer provides a benefit to BWV, indeed, that it only prolongs her dying?

In thinking along these lines, we must retain the principle of *sanctity of life*, so that decisions are not based on the belief that continued life itself is bad or that the patient is better off dead. At most, decisions may involve the thought that a patient's gravely debilitated condition is such that, while we must continue to care for the patient, we should not do anything to prolong the patient's ordeal, nor to postpone the death whose coming, sooner rather than later, might well be regarded as a "blessing" for the patient.<sup>8</sup>

The "intuition" behind the hesitation that many of us feel about the use of *medical treatments* to sustain the life of persistently unconscious patients, or severely demented patients like BWV, is that in these cases the patient's condition is so poor and the progress to death is so inexorable, that resort to medical treatment amounts to prolonging dying, rather than preserving life.<sup>9</sup> In these cases, treatment would not be *therapeutic for the patient*. "Good medicine treats a person rather than a condition".<sup>10</sup> This approach accords with the Catholic moral commitment to the sanctity of human life, while recognising that a time comes when death ought not be obstructed. What is crucial is not a

qualitative judgment about the value of a person's life, but a judgment about the value of a medical treatment in the life of a particular patient.

Should we speak of treatment in these cases being "futile"? Clearly, there is a danger that, unlike the narrow notion of "therapeutic futility", the broader notion of treatment being "futile for a particular patient" could be misused as a rationale for omitting treatment with the intention of hastening death. Although the notion of futility and benefit are correlative, the notion of *benefit* seems less open to this misuse, for we are used to the principle that "therapeutic benefit" in the narrow sense needs to be subordinate to "benefit for the patient" in the broader, holistic sense, precisely because we are treating patients, not conditions. Of course, therapeutic benefit itself embraces many outcomes, not simply improvements or cure. Patients who cannot be cured can often be sustained in a condition they find satisfactory. Hence, among the purposes of therapeutic interventions the *CHA Code* includes: "to improve or to maintain the patient's health by curing an illness or slowing the course of an illness or stabilising the patient in a reasonably satisfactory condition, to relieve pain or other symptoms of illness, to nourish and sustain the patient" (1.12).

Given the poor condition of patients like BMW, it is unclear that "nourishing and sustaining a patient" is properly *therapeutic for the patient*. Keeping a person alive may or may not be a "benefit" in the broader sense, more holistic sense, depending on the condition and prognosis of the patient. Thus, life-sustaining treatment is always therapeutic when there is hope of cure or improvement - it tides the patient over the immediate crisis. Life-sustaining treatment is obligatory when it maintains a condition that is "reasonably satisfactory" to the patient. However, in the case of patients with incurable, gravely debilitating, progressive and terminal illnesses, when the point is reached at which they can no longer take food by mouth (and commonly such patients have already "naturally" begun to eat less and less), we need to stop and ask whether beginning (and/or, later, continuing) artificial provision of nutrition and hydration would be of any *therapeutic benefit for the patient*? We need to ask whether "death ought to [or may now] be accepted" as the natural outcome of the patient's deteriorating condition?<sup>11</sup>

In the case of patient BWV, it is commonly said that death is "not imminent" - but isn't this only because she is being kept alive by PEG? It might be objected that the withdrawal of PEG will cause death by

starvation. If that really is what is intended, then the withdrawal would amount to euthanasia. But, even though the withdrawal leaves the patient at the mercy of their debilitating condition, this withdrawal of treatment need only embody a recognition of the patient's progressive and certainly fatal illness, one aspect of which is the patient's inability to feed him or herself. Of course to the extent that a patient needs food and water, and/or is distressed by a lack of nutrition and hydration, we should ensure that ordinary measures are taken to meet these needs.

In short, while some who argue for the withdrawal of PEG may be intending thereby to cause death, I am suggesting that this need not necessarily be the case. At some point in the care of a deteriorating patient, even a patient who is not "imminently dying" in the obvious sense, treatment might be withdrawn with the intention, not of hastening death, but of accepting the death that is the inevitable outcome of the patient's overall condition. Whether this point has been reached in the care of BWV is not for me, but those caring for BWV to say. In this somewhat abstract discussion, I have simply tried to identify the ethical principles at stake, and to suggest there is room for a little more flexibility in these cases than is provided by the more cautious "Catholic" approach.

## Conclusion

Recognition that a life-sustaining treatment will not be beneficial for a patient does not imply that the patient's life is futile or not worth living. It simply means that a medical intervention is no longer appropriate; the intervention would not be good medicine because (in the case of this patient) it would not do one of the things good medicine is supposed to do. Critics of the Victorian court decision are afraid it will be applied to many frail or elderly people whose lives other people deem not worth living. These fears should not obscure the point of principle that illnesses can be so debilitating that it would not be reasonable to maintain the patient's life by a properly medical treatment.

Nonetheless, the Victorian Court's ruling (and the way its judgement was framed) do open the way to bad clinical and ethical decisions. It would be a mistake to conclude that because tube feeding is a "medical treatment" that may *sometimes* rightly be refused, it is a treatment that is never obligatory, a treatment that may always be refused by oneself, or denied to another, with no questions asked. Tube feeding is often a quite "ordinary" and therefore, obligatory way of sustaining life.

Euthanasia is wrong because it involves deliberate measures to hasten death. It should be obvious that euthanasia can be performed as much by withdrawing a life-sustaining treatment as by giving a lethal injection. However, life-sustaining treatment may rightly be refused when it would be unduly burdensome, therapeutically futile, or no longer beneficial for a patient, given his or her overall condition.<sup>12</sup>

## Footnotes

1 Margaret Somerville, *The Ethical Canary*, p. 163.

2 John Finnis, "Living Will' Legislation", in *Euthanasia, Clinical Practice and the Law*. (Edited by Luke Gormally. London: The Linacre Centre, 1994), 167-176.

3 Pope John Paul II, *Veritatis Splendor*, 78.

4 For this stipulative distinction between "result" and "consequence", I am indebted to John Hill.

5 Catholic Health Australia, 2001.

6 Finnis, p. 170.

7 Finnis, p. 176.

8 In speaking, as we commonly do, of death as a blessing for some patients, we need not be claiming that death is good thing in itself, or that a person may be better off dead. We need only mean that for a person in this condition, a shorter life-span is preferable to a longer one.

9 Whether a treatment "prolongs dying" or "prolongs life" might be a matter on which reasonable may conscientiously differ, just as they may about whether some forms of reproductive technology "assist" or "replace" marital intercourse (cf. Code, 2.12).

10 Code, 5.3

11 Cf. Code Part I, No. 3.

12 My thanks to Bernadette Tobin, Nicholas Tonti-Filippini and other members of the Catholic Moral Theology Association of Australia and New Zealand for helpful discussion in the preparation of this article.

# Philosophical assumptions in the euthanasia debate:

A review of *The Right to Die?* by Miriam Cosic, Sydney, New Holland, 2003

Stephen Buckle

Miriam Cosic, a journalist at *The Australian*, has made a fair-minded and honest attempt to get to grips with the pros and cons of voluntary euthanasia. The book is clearly structured, beginning with a survey of historical views followed by a presentation of the arguments for and against, then turning to an account of the experience of different countries in handling the issue. A chapter on the important recent improvements in palliative care – and the insights revealed in this context – precedes a final summing-up. She ends not by offering a decisive judgement either for or against, but by emphasising the responsibilities that attach to each way of resolving the dispute: “If we ‘save’ people’s lives by refusing them assisted suicide or voluntary euthanasia, we must then walk beside them – physically, emotionally, and spiritually – for the rest of their journey. If we, as a society, decide to legalise assisted death, however, then we must frame the laws with great care, so that the free will of the individual concerned becomes the essential criterion, the *sine qua non*, for a premature departure from this world.” (273)

This conclusion bespeaks Cosic’s determination to be fair to both sides, and this is one strength of her book. Another strength is its up-to-date account of developments around the world. The British, American and Australian experiences are all discussed, and particular attention is given to the Netherlands’ experience both with a system of “benign neglect” and with subsequent decriminalization. Interviews with important actors and observers mean that the book’s discussions are always fresh and engaging.

The account of the Dutch experience is both enlightening and intriguing. Cosic spells out

the developments from the 1993 bill, the first attempt to legislate for the issue, to the 2001 law, which effectively removes cases of voluntary euthanasia from the purview of the prosecutor’s office. Cases must be reported to regional review committees, and further reporting is only necessary where there have been breaches of the approved procedures. The resulting situation is not full legalization, but the absence of direct legal purview obviously makes the actions of the medical practitioners much freer than in other jurisdictions. The outcomes are difficult to interpret. The total number of reported cases of euthanasia has shown an increase, but this is also what one would expect if reporting is now free of legal threat. Furthermore, there has also been a decrease in cases of non-voluntary euthanasia – so a case can be made that the much-feared “slippery slope” has either failed to eventuate, or even worked in the opposite direction.

But things are not entirely rosy. One important argument in favour of legalization is that it will be beneficial by ending the hidden practice of euthanasia, and so create a situation that is both consistent and transparent to the public eye. However, there is evidence that this has not occurred: that the increased reporting is in fact reporting only of those cases that meet the guidelines, and that the more permissive environment has encouraged yet more permissive practices – practices which, as before, are not reported precisely because they do not meet the guidelines. So the legislation may have failed to close the gap between official policy and actual practice, while shifting the accepted standard in a more permissive direction. If so, this is precisely the “slippery slope” that



opponents of legalizing voluntary euthanasia have predicted.

The figures are not beyond dispute, so whether there is such a slide must still remain in dispute. However, one dimension in which a slide does seem undeniable is indicated by the fact that, of those who have taken advantage of the new guidelines, only one-third have done so for the reasons commonly supposed in public debate to be crucial – unbearable physical pain. Far more common are cases describable as “existential pain”: including in its range the loss of dignity inherent in certain treatments (or their limitations), and even loneliness and despair. What this means is that doctors are, in many cases, being drawn into providing a “way out” for those who are simply “tired of life”. Whatever one’s stance on euthanasia, this is surely a disturbing development: the medical doctor taking on life-and-death decisions in straightforwardly *non-medical* situations. This is one instance where “slippery slope” concerns seem to be borne out, and so means that close scrutiny of the Dutch experience continues to be necessary.

The two philosophical chapters – presenting the arguments for and against – are less successful than the reporting chapters. One reason for this is that, although they are structured according to relevant issues (e.g. the relationship between moral and legal judgements), the style of presentation is at this point too journalistic – that is, too much given to quoting from doctors and other involved participants to provide a clear overview of what issues count, and why. The result is that issues are not always presented with the same care because the chosen spokespersons for the different views are not all equally careful or philosophically-adept. A noteworthy – and predictable – victim of this method is the principle of double effect. Its opponents are typically impatient with its assigning serious moral weight to the distinction between intention and foresight, and one symptom of impatience with the assigned moral weight is a comparable carelessness with the distinction itself. So the reader who comes to this book with no independent grip on that principle will not be enlightened by the distorted – and, indeed, only half-understood – versions of it offered by various interviewees.

A second reason stems, ironically, from Cosic’s admirable desire that the reader feel the force of each side’s view. In seeking to achieve this end, she presents both views in her own voice. Thus by the end of Chapter 3 the reader is convinced that Cosic

is firmly on the side of voluntary euthanasia, only to find, in the opening pages of Chapter 4, that she has equally firmly changed sides! The problem here is not that this is an unacceptable method of proceeding, but that Cosic does not tell the reader that that is what she is doing. In fact, her journalist’s methods to some degree obstruct her from doing so, since in these chapters, no less than in the comparative experience chapters, she begins with examples which serve to launch the ensuing argument.

This problem would have been circumvented by the insertion, between the example and the argument, of an explanatory section that specified main issues and sketched what is to follow. One problem with this style of approach would, however, have remained. It is that to present each position in one’s own voice is to deny oneself the space for presenting criticisms or reservations when this is most appropriate. The result is that – particularly in the “pro” chapter, where the argument is more unified – the presentation sometimes sinks to the dogmatizing of the unreflective adherent, thus undermining Cosic’s desire that the reader encounter the full strength of each side’s case. It is difficult to avoid concluding that the book would have been better served with chapters on each side’s positive case *together with* the main objections brought against it by its critics. The result would have been a clearer sense in the reader’s mind of the main issues on which the two stances hinge.

A striking feature of the book is its recurring reference to two pervasive assumptions that serve to shape debates on this topic: that the rise of demands for legalizing euthanasia reflect, first, the overcoming of taboos, and secondly, the rise of a compassionate concern for the dying. Since these assumptions are dubitable as well as pervasive – indeed, despite her tendency to rely on them, they are undermined by Cosic herself – they deserve a closer scrutiny.

The first assumption is a kind of historical myth, and runs as follows. The Renaissance and the scientific revolution called into question the traditional taboos of medieval, religious society. As a result, the religiously-inspired ideal of conformity with the demands of moral duty was replaced by the modern secular ideal of autonomy. At the level of moral theory, this perspective results in *deontology* (morality understood as the science of duty) being challenged by *consequentialism* (morality understood as the rational task of weighing up the benefits of alternative possible actions by reference to their

consequences). It is because of these shifts in perspective – shifts which can be summed up as “the rise of individualism” – that the modern call for legalized voluntary euthanasia is so insistent and (seemingly) unstoppable. The legalizing of voluntary euthanasia is, on this picture, morally *progressive* because it is the culmination of the moral revolution begun in the Enlightenment, and so one more touchstone of the extent of our liberation from the shackles of the pre-modern world.

There is no doubt that this is a powerful picture, its grip on the modern mind sufficiently attested to by the regularity with which the division of opinion over voluntary euthanasia is described as a division between “progressives” and “conservatives”. The problem, however, is that it is incoherent. Specifically, the substantive commitment to the fundamental value of autonomy is incompatible with the theoretical commitment to consequentialism. The value of autonomy is not defended by reference to its consequences – for example by the claim that respect for individual autonomy is the means by which the best social outcomes are to be achieved – but simply because it is taken to be a basic right, the violation of which is properly prohibited. Thus the formulation of the case for voluntary euthanasia is always in terms of rights (specifically, the right to die). Moreover, the fundamental shaping role of the idea of the inviolability of individual autonomy is shown by the conviction that the right to die is *implied by the right to life*. If (and only if) the right to life is understood to be the right not to mere existence but to *autonomous* existence is that conviction plausible – and, indeed, necessary. So it is indeed the case that the modern ideal of autonomy is underwriting the claim that there is a right to die. Since, however, my right to autonomy implies your duty not to violate my autonomy, the driving force behind the voluntary euthanasia case is undeniably *deontological*. Allegedly progressive moral consequentialism has little, if anything, to do with it.

Nor is this the end of the matter. Since one of the central arguments offered against legalized voluntary euthanasia depends on the claim that to do so would set us on a slippery slope to other kinds of assisted killing, it is precisely regard to *consequences* (if not full-blown consequentialism) that underpins one central plank of the opposition. It simply is not the case that the argument over voluntary euthanasia can be accurately caught in terms of a dispute between progressive rational assessment of consequences against the rigid avoidance of a taboo

– or, to the extent that it can, it is the *supporters of voluntary euthanasia* who find themselves on the unfortunate side of that divide!

This surprising conclusion might seem to be undermined by the fact that supporters of voluntary euthanasia sometimes appeal to *preference utilitarianism* to make their case. (This version of consequentialism holds that maximizing preference-satisfactions across a population is the measure of right actions. It is the official position of Peter Singer, for example.) But there are two reasons for dissatisfaction here. The first is that the examples thus appealed to are not handled in a plausibly utilitarian manner. This is because they do not seek to determine the policy or outcome that maximizes preference-satisfaction across a whole population, including those not directly involved (as the utilitarian must do), but only those lives most directly affected. This approach could *perhaps* be defended by reference to harmless simplifying assumptions (e.g. Pareto-optimality), but this is such a tempting excuse that one would like to see some serious argument before accepting it. In the interim, it is difficult not to conclude that the choice of examples by allegedly preference utilitarian thinkers owe their force to that very familiar piece of modern deontology, the duty to respect others' right to choose.

The second reason for dissatisfaction is directly theoretical. It is to note just what a curious view preference utilitarianism is, and to query whether the reason for its appeal is in the end anything more than that it gives utilitarianism a deontological face. The point is that classical or hedonistic utilitarianism is a perfectly well-motivated view, in the sense that it is plain why one would want to seek to maximize human happiness. But why would one be moved by the desire to maximize preference-satisfaction across a population? If the reason were that maximizing preference-satisfaction is (given the limits of our knowledge of one another) the best path to maximizing happiness, all would then be in good theoretical order: preference utilitarianism would then not be a distinct moral position at all, but an operationalized or applied version of pure (classical) utilitarianism. (The problem would be simply that it is not at all obvious that preference-satisfaction does lead to happiness.) If, however, the reason were that preference-satisfaction is intrinsically good, then we do need to ask why. It is then not easy to dismiss the thought that the reason why preference-satisfaction is thought to be a fundamental good is just because it is also thought that there is a *right* to satisfy one's preferences (the much-invoked right to

choose). If so, then preference utilitarianism owes its appeal to deontology: to the modern conviction that autonomy is the fundamental right.

That conviction is indeed modern, and so the historical myth is accurate at least in acknowledging that a bedrock concern for protecting autonomy is a distinctive feature of modern moral theorizing. (In the history of moral and political thought, it is sometimes put in terms of the shift from "natural law" to "natural rights" theories.) It does make a significant difference that we now expect people to make up their own minds about things – and expect others to allow them to do so – rather than expecting them simply to do what is right. In this respect the moral climate of the modern world is markedly different from that of the medieval world. But it is a curious blindness to think that this is a shift away from deontology. The duty to respect others' choices, whatever the consequences, is insisted on no less vigorously in our day than was any medieval duty in its own. The calculative, maximizing mentality of utilitarianism remains foreign to popular moral consciousness. The not infrequent claim that it is a progressive moral outlook steadily replacing old-fashioned deontological taboos must therefore be put down to a mixture of myopia and skilful PR.

The "rise of individualism" frequently alluded to by Cosic is therefore a social fact, but not the end of deontology. The real moral issue concerns just what kind of outlook individualism really is, and just what it might imply for issues like euthanasia. This question is not advanced by the fact that the term "individualism", and its companion term "autonomy", tend to be used in importantly different ways. Cosic herself notes this, pointing out that in Holland "individualism" refers to the necessity of making up one's mind for oneself – but not with one's eye only *on* oneself. In other words, it is an idea that emphasises personal responsibility without restricting that responsibility *to* one's own person. It is, in other words, a moral position with a markedly Kantian air, rather than the *apologia* for self-assertion it sometimes reduces to in other contexts.

The point here is that the appeal to individualism can mean a number of different things, some of which are more worthy of consideration than others. So we should not be swayed by claims that some action or policy is required by our individualist values – such

that we would morally compromise ourselves were we not to accept it. Where the terms "individualism" and "autonomy" are employed simply to legitimise self-assertion, they are actually being employed *in opposition* to the moral convictions that have led to their modern use. This is because those convictions concern the necessity of respect for *all* creatures like ourselves, and so cannot legitimise mere self-assertion – the act of advancing our own interests *irrespective of* the interests of others. Modern "individualism" is therefore not one view, but two different views markedly at odds with each other. The moral is that any appeal to the "rise of individualism" to explain – or, especially, to justify – contemporary moral attitudes is dangerously apt to mislead, because all too capable of dressing up *lack of regard for others* as a species of the modern conception of *respect for persons*. One part of the cure is to be wary of historical myths constructed in such general terms – especially where they aim to produce a practical effect. Cosic, to her credit, does not allow her intelligence to be coerced by this historical myth, but her frequent and uncritical references to it do help to nourish it and its tendencies, when clear thinking would be aided by bracketing it off – together with any other grand historical narratives that pretend to settle how we should think.

The second shaping assumption that recurs in Cosic's pages is that the contest between the pro and con views on voluntary euthanasia is a contest between compassion and cold-hearted rule-following. It is not hard to see why this view should arise. To be confronted by someone dying in intractable pain who actively seeks release from their ordeal, and to turn away from their call for help simply because it is illegal to accommodate them, is indeed to substitute unfeeling rule-following for compassion.

There are, however, at least two reasons for not being swept along by this thought, and Cosic herself draws attention to them. The first is that by no means all cases likely to be affected by changes to the law conform to this picture, and so the effect of any such legal innovation will be wider than those cases reasonably described in terms of the compassionate relief of suffering. This point has already been met with above, in the cases of euthanasia to relieve "existential pain". It is not at all clear that assisting in the killing of the sad and lonely, because they are

sad and lonely, can be accurately described as acting from compassion.

The second reason for pause follows from the first. It is that the experience of those involved in palliative care teaches that dying is not reducible to the physical unpleasantness of the experience (even when it is significantly unpleasant). Rather, the process of dying is for a great many – both for the dying person and for those left behind – the experience that “caps off” a life. In Cosic’s words, “to hasten death is to cut short the most crucial phase of life – the final reckoning, the process of summation which gives meaning to everything that came before” (240). Facing death compels honestly facing up to one’s life, to what it has and (perhaps regrettably) has not been. Plainly, this is not always a comfortable experience, but, if one is to believe those who report on it, it is the vital experience that closes and rounds off a life. To cut off an experience of this kind, however well-motivated, is not an act of compassion.

In fact, this whole picture can be stood on its head. That is, it is even arguable that it is the call for legalizing voluntary euthanasia that is short on compassion: not because it is cold-hearted rule-following, of course, but because it is the hasty “quick fix” to a problem that turns out, in no shortage of cases, to be existential. In a society in which it is time that has become scarce, and in which medical care has been so divided into specialities that the personhood of the patient is no longer an object of medical attention, the call for the right to end it all will not uncommonly be a call for attention and, indeed, affection. When one adds to this the possibility that those entitled to choose death might come to feel it their duty to do so – for example, to save others from the burden of looking after them – then it seems that it is the unthinking desire to co-operate with another’s demands, not the compassionate attention to their needs, that promotes the euthanasia option. This is not,

of course, to say that it is always the anti-euthanasia view that is the compassionate cause. The point is, rather, that once the sheer variety of cases and their wider ramifications, together with a more clear-headed sense of what dying involves, are properly taken into account, it becomes untenable to suppose that the issue can be put in terms like the “compassion versus rules” picture so favoured amongst some advocates. Cosic is aware of this – indeed, she provides clear evidence of the shortcomings of the picture – but her formulations sometimes give needless succour to such simplistic distortions.

To conclude. The virtues of Cosic’s book arise from her willingness to let informed participants speak for themselves, and her determination that the reader should feel the tug of each side’s point of view. Along the way, she provides food for thought in her handling of the Dutch experience, and the good news to do with improvements in palliative care. Since there is some reason to think that the public’s strong support for voluntary euthanasia reflects fear of what it will be like to die, the book’s recounting of moving cases of dying is reassuring, as is her evidence that the most-feared scenario of unbearable pain is in fact quite rare. The public attitude may, in other words, be based largely on misplaced fears. Nevertheless, where those fears are not misplaced, compassion does indeed demand a societal response that does not impose impossibly heroic demands on the dying. Whether the best solution to that problem lies in the Dutch direction of permissive legislation, or in some form of legal “benign neglect” of the actions of those unavoidably “at the coalface” – or, alternatively, through the elaboration and implementation of the principles of futile and burdensome treatment – remains, I think, an open question. For helping to bring these important issues into better focus, Miriam Cosic’s book is to be welcomed.

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