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

BONNIE STEINBOCK

The Intentional Termination of Life

BONNIE STEINBOCK teaches philosophy at the State University of New York at Albany. She has published widely on ethical issues at the beginning and end of life. Among her books are Life Before Birth: The Moral and Legal Status of Embryos and Fetuses (1992) and Killing and Letting Die (1994).

ACCORDING to James Rachels and Michael Tooley, a common mistake in medical ethics is the belief that there is a moral difference between active and passive euthanasia. This is a mistake, they argue, because the rationale underlying the distinction between active and passive euthanasia is the idea that there is a significant moral difference between intentionally killing and intentionally letting die. "This idea," Tooley says, "is admittedly very common. But I believe that it can be shown to reflect either confused thinking, or a moral point of view unrelated to the interests of individuals." Whether the belief that there is a significant moral difference (between intentionally killing and intentionally letting die) is mistaken is not my concern here. For it is far from clear that this distinction is not the basis of the doctrine of the American Medical Association which Rachels attacks. And if the killing/letting die distinction is not
the basis of the AMA doctrine, then arguments showing that the distinction has no moral force do not, in themselves, reveal in the doctrine's adherents either "confused thinking" or "a moral point of view unrelated to the interest of individuals." Indeed, as we examine the AMA doctrine, I think it will become clear that it appeals to and makes use of a number of overlapping distinctions, which may have moral significance in particular cases, such as the distinction between intending and foreseeing, or between ordinary and extraordinary care. Let us then turn to the statement, from the House of Delegates of the American Medical Association, which Rachels cites:

The intentional termination of the life of one human being by another—mercy-killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

The cessation of the employment of extraordinary means to prolong the life of the body when there is irresistible evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.

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

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

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

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

However, there can be a point (to the cessation of life-prolonging treatment) other than an endeavor to bring about the patient's death, and so the blanket identification of cessation of treatment with the intentional termination of a life is inaccurate. There are at least two situations in which the termination of life-prolonging treatment cannot be identified with the intentional termination of the life of one human being by another.

The first situation concerns the patient's right to refuse treatment. Both Tooley and Rachels give the example of a patient dying of an incurable disease, accompanied by unreliqable pain, who wants to end the treatment which cannot cure him but can only prolong his miserable existence. They, too, may agree to the patient's request to end treatment, but not provide a patient in a similar situation with a lethal dose. The answer lies in the patient's right to refuse treatment. In general, a competent adult has the right to refuse treatment, and the question of prolonging life. Indeed, the right to refuse treatment has been upheld even in the patient's reason for refusing treatment is generally agreed to be inadequate. This right can be over-ridden (for example, the patient has dependent children) but, in general, no one can legally compel you to undergo treatment to which you have not consented.

Rachels, surgically, surgical intrusion has been considered a technical baffle, the person and one to be excused by consent of the patient, or justified by necessity created by circumstances of the moment..."

At this point, it might be objected that if one has the right to refuse prolonging treatment, then one demands that one have the right to end his life and to obtain help in doing so. The idea is that the right to treatment somehow implies a right to non-treatment, and we need to consider someone might think this. The right to refuse treatment has been considered a violation of the patient's privacy or, better, the right to bodily determination. You have the right to decide what happens to your body, then you have the right to choose to end your life, and you have the right to get help in doing so.

However, it is important to recognize the right to refuse treatment...
ore him but can only prolong his miserable existence. Why, they ask, may a doctor accede to the patient's request to stop treatment, but not provide a patient in a similar situation with a lethal dose? The answer lies in the patient's right to refuse treatment. In general, a competent adult has the right to refuse treatment, even when such treatment is necessary to prolong life. Indeed, the right to refuse treatment has been upheld even when the patient's reason for refusing treatment is generally agreed to be inadequate. This right can be overridden (if, for example, the patient has dependent children) but, in general, no one may legally compel you to undergo treatment to which you have not consented. “Historically, surgical intrusion has always been considered a technical battery upon the person and one to be excused or justified by consent of the patient or justified by necessity created by the circumstances of the moment. . . .”

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

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

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

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

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

The decision here to cease anticancer treatment cannot be construed as a decision that the patient die, or as the intentional termination of life. It is a decision to provide the most appropriate treatment for that patient at that time. Rachels suggests that the point of the cessation of treatment is the intentional termination of life. But here the point of discontinuing treatment is not to bring about the patient's death but to avoid treatment that will cause more discomfort than the cancer and has little hope of benefiting the patient. Treatment that meets this description is often called "extraordinary." The concept is flexible, and what might be considered "extraordinary" in one situation might be ordinary in another. The use of a respirator to sustain a patient through a severe bout with a respiratory disease would be considered ordinary, its use to sustain the life of a severely brain damaged person in an irreversible coma would be considered extraordinary.

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

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

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

Such a doctrine perhaps does not need further refutation, but this is not

the AMA doctrine. For the AMA statement criticized by Rachels allows for the cessation of extraordinary means to prolong life when death is imminent. Neither of these conditions is satisfied in this example. Death is not imminent in this situation, any more than it would be if a normal child had an attack of appendicitis. Neither the corrective surgery to remove the intestinal obstruction, nor the intravenous feeding required to keep the infant alive until such surgery is performed, can be regarded as extraordinary means, for neither is particularly extensive, nor does either place an overwhelming burden on the patient or his parents. (The continued existence of the child might be thought to place an overwhelming burden on its parents, but it has nothing to do with the characteristic of the means to prolong life.) Rachels, however, describes the condition as "extraordinary." If it had, then feeding a severely defective child who required a great deal of care could be regarded extraordinary. The chances of success for the operation are not very good, though there is always a risk of complications occurring on infants. Though the Down's syndrome will not be alleviated, the infant will proceed to an otherwise normal infancy.

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

In a film on this subject,"Who Should Survive?", a doctor defended a decision not to operate on a child since the parents did not consent. Although the operation, the doctors' having a legal obligation to provide care. The importance of the ordinary/extraordinary care distinction lies partly in its connection to the doctor's intention. The withholding of extraordinary care should be seen as a decision not to inflict painful treatment on a patient without reasonable hope of success. The withholding of ordinary care, by contrast, must be seen as neglect. Thus, one doctor says, "We have to draw a distinction between ordinary and extraordinary means. We never withdraw what's needed to make a baby comfortable, we would never withdraw the care a parent would provide. We never kill a baby... But we may decide certain heroic intervention is not worthwhile."

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

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

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

Withholding treatment in this case is the intentional termination of life because the infant is deliberately allowed to die; that is the point of not operating. But there are other cases in which that is not the point. If the point is to avoid inflicting painful treatment on a patient with little or no reasonable hope of success, this is not the intentional termination of life. The permissibility of such withholding of treatment, then, would have no implications for the permissibility of euthanasia, active or passive.
intentional termination of life, does that make a difference, morally speaking? If life-prolonging treatment may be withheld, for the sake of the child, may not an easy death be provided, for the sake of the child, as well? The unoperated child with spina bifida may take months or even years to die. Distressed by the spectacle of children "lying around, waiting to die," one doctor has written, "It is time that society and medicine stopped perpetuating the fiction that withholding treatment is ethically different from terminating a life. It is time that society began to discuss mechanisms by which we can alleviate the pain and suffering for those individuals whom we cannot help."

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

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**PATRICIA MANN**

**Meanings of Death**

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We philosophers are always trying to get a grip on death, and always failing. Anthropologists and social historians are likely to do better than philosophers in their efforts to characterize death, insofar as they can investigate the many faces of death in different cultural contexts.

Death in battle may be heroic; death in youth may be tragic; death in old age benign. In different times and different cultures death means very different things, as is clear when we read of suttee, the Hindu widow's immolation of herself on her husband's funeral pyre, or of seppuku, the suicidal disembowelling done by Japanese for infractions of honor.

Yet all these so-called meanings of death are more precisely identified by different social practices and associated surrounding death. Death itself can be a powerful event that exceeds our human capabilities to wrest meaning from occurrences in the world. Strangely in our world and time death is also elusive yet absolute of our world. As when we speak of death in self-conscious metaphorical ways. We speak of a person's dying in terms of their "leaving," "passing," or "passing away." But when we say they have left us, we mean that they are no longer capable of interacting with us in everyday physical interactions. We didn't really see them again, and we have no real idea of where they have gone, even if we believe in a second life and the immortality of the soul. They do not fully leave us, represented in our memories, or in the letters they have written or in the things they have knitted or in the projects they began for us to finish.

Similarly, when we say someone has passed away, we experience a physical absence, but we don't express their actual passing to another realm, whether to nothingness or some spiritual realm. The event of death is such that we only understand from the perspective of the living. A person who dies passes from one part of our culture, but its not clear how or where. We have no physical, temporal, or conceptual grasp upon them, they are going, and so there is no obvious border between our world and death. As Jacques Derrida notes, "The crossing of a border always announces itself according to the moment of a certain step—and of that step that crosses a line... Conceptually, where the figure of the step is represented..."