

Euthanasia: What Is the Genuine Problem?

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ABSTRACT: The current impasse in the old debate about the morality of euthanasia is mainly due to the fact that the actual source of conflict has not been properly identified—or so I shall argue. I will first analyse the two different issues involved in the debate, which are sometimes confusingly mixed up, namely: (a) what is euthanasia?, and (b) why is euthanasia morally problematic? Considering documents by physicians, philosophers and the Roman Catholic Church, I will show that (a) ‘euthanasia’ is defined by the intention to bring about a patient’s death, and (b) the distinction between what is intentional and what is not does not represent the morally problematic reason against euthanasia. Therefore, although the debate on euthanasia so far has mainly focussed on the distinctions ‘active/passive’ and ‘intentional/unintentional,’ I argue that neither constitutes the genuine source of the controversies. I will clarify what the source of controversies is, and outline the minimal requirement for an argument against euthanasia.

INTRODUCTION

Euthanasia is one of the oldest and most debated topics in the history of bioethics. The debate is indeed so old that it seems that everything about euthanasia has already been said. We perfectly know the reasons for or against each side of the controversy. Still, people of neither side find the reasons of the other side convincing enough to drop their position. In this paper I will show that this impasse exists mainly because the genuine source of the controversy has not been adequately identified yet. My aim here is to indicate what this source is and, on the basis of that identification, to suggest what is required for a sound and conclusive argument against euthanasia. Whether such an argument can be effectively produced is an issue beyond the scope of this article.

The following example is emblematic of the current confusion around the concept of ‘euthanasia’. In July 2011 a highly debated bill on medical end-of-life decisions was voted by the Italian Chambers of Deputies and submitted to the assessment of the Senate.¹ The bill forbids doctors to withdraw artificial nutrition and hydration upon patients’ request (either actual or advanced). At the same

time, it allows in some circumstances the withdrawal of artificial respirators or other medical treatments. The reason provided by the Italian deputies for this distinction is that they did not want to authorize *euthanasia*.

The bill has been under discussion since 2009, immediately after the death of Eluana Englaro, a girl kept in a vegetative state for seventeen years through artificial nutrition and hydration. A heated debate arose in Italy after her father repeatedly asked to remove feeding tubes. Finally, the Milan Court of Appeal granted his request. The immediate reaction by most of the Italian politicians and by the Roman Catholic Church was very passionate. The Italian Prime Minister expressed his moral reprobation by declaring that the case had “serious implications for *euthanasia*.”

These occurrences of the term ‘*euthanasia*’ raise some questions which are of the utmost relevance for current debates on medical end-of-life decisions. Is the term ‘*euthanasia*’ as used by Italian politicians out of place? Does it ever make sense to speak of ‘*euthanasia*’ when physicians do not actively cause a patient’s death? And if it does, does it come down to saying that physicians’ conduct has been morally wrong?

Similar questions carry over into the more general debate as to what precisely the moral problem with *euthanasia* is. The issue is actually twofold. The first question is:

(1) what is *euthanasia*?

According to Italian deputies, withdrawing artificial nutrition amounts to *euthanasia*. But despite the efforts by many to set a clear definition,² there is no general agreement about whether withholding or withdrawing treatments are instances of *euthanasia*.

The second question is:

(2) what aspect(s) of *euthanasia* raise(s) the moral problem?

By deploying the expression ‘*euthanasia*’, the Italian Prime Minister intended to express a moral condemnation. But it remains to be explained why the label ‘*euthanasia*’ should be taken as equivalent to ‘morally wrong’.

Often the two questions are confusingly mixed up. In *Evangelium Vitae* Pope John Paul II wrote that “*euthanasia* . . . is the deliberate and morally unacceptable killing of a human person.”³ But the actual problem is understanding (1) *in what sense* *euthanasia* can be considered a deliberate killing of a human person, and (2) *why* (or when) the deliberate killing of a human person would be morally unacceptable.

This article will start by picking out the distinctive feature of *euthanasia*. By ‘distinctive feature’ I mean the feature which the different proposed definitions have in common and which therefore accounts for the way people usually involved in ethical debates (physicians, philosophers, religious authorities) use the term. It might be argued that each one deploys the term according to his own criteria and that one shared definition of ‘*euthanasia*’ simply does not and cannot exist. This relativistic argument would easily settle the matter by depicting a bleak outlook of reciprocal incommunicableness. However, given that current disagreement is

as often on definitions as on ethical values, it is worth enquiring as to whether a shared definition can be found. If it could, then it would also be possible to lay the foundation for an authentic ethical debate which would replace what often seems like a cluster of monologues.

In this respect, I will argue that disputants can consistently come to agree to the following:

- (a) 'euthanasia', in the clinical context, is not defined by its being a case of *active* killing as opposed to letting die;
- (b) rather, 'euthanasia', in the clinical context, is defined by the *intention* to bring about a patient's death so as to put an end to her suffering;

Points (a) and (b) answer question (1). As for question (2),

- (c) I will show that the distinction between what is intentional and what is not does not represent the morally problematic reason against euthanasia;
- (d) I will identify the more fundamental factor which makes the intention to bring about a patient's death morally problematic.

To identify that factor is to identify what precisely we are debating about when we debate about the moral status of euthanasia.

I should also make clear at this point that when I talk of euthanasia in this paper I refer to situations in which either the person who dies explicitly expresses an informed preference for this option, or the consent to the procedure can be reasonably inferred by a next of kin when the patient cannot formulate it (I will say nothing about the problem of how to correctly infer this consent).

'EUTHANASIA' IS NOT DEFINED BY ITS BEING A CASE OF ACTIVE KILLING AS OPPOSED TO LETTING DIE

In *Evangelium Vitae* we read that:

Euthanasia must be distinguished from the decision to forgo so-called 'aggressive medical treatments', in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family.⁴

However, when pathology imposes an equally excessive burden on the patient and his family, doctors are not allowed to "take control of death and bring it about before its time."⁵ This last phrase seems to be consistent with the commonly held conception of euthanasia: a doctor who actively kills a patient before death occurs for other causes.

Also many medical deontological codes seem at first glance to consider the active aspect of physicians' behaviour as the feature which distinguishes euthanasia from other practices they consider permissible. For example, according to the *Code of Medical Ethics* of the American Medical Association, euthanasia is "the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering."⁶ The code draws on the Association's report "Decisions Near the End of Life,"⁷ in which a distinction

is explicitly made between euthanasia and withholding or withdrawing life sustaining treatments. The British Medical Association states that euthanasia is “the *active* and intentional termination of a person’s life,”⁸ and the Australian Medical Association defines euthanasia as “the *act* of deliberately ending the life of a patient for the purpose of ending intolerable pain and/or suffering.” Furthermore, the Australian Medical Association explicitly excludes the following from the domain of ‘euthanasia’: “not initiating life-prolonging measures; not continuing life-prolonging measures; the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.”⁹

The problem is that, as a matter of fact, many definitions of ‘euthanasia’ do include passive practices. For example, the expression ‘deliberate killing’ deployed in *Evangelium Vitae* must be read in the light of the following statement we find in the *Catechism of Roman Catholic Church*:

An act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a *murder* gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator.¹⁰

‘Murder’ is used here to translate the Italian word ‘*uccisione*’ and the Latin word ‘*occisionem*’, both of which are used in the respective versions of the Catechism and both of which simply mean ‘killing’. And the fact that both acts and omissions are considered instances of ‘killing’ explains why the definition of euthanasia provided in the *Evangelium Vitae* does not appeal to the distinction ‘active/passive’: “Euthanasia in the strict sense is understood to be an *action or omission* which of itself and by intention causes death, with the purpose of eliminating all suffering.”¹¹

In the case of the Catholic Church, the fact that both acts and omissions define ‘euthanasia’ (and ‘murder’) might be explained by the assumption, which certainly the Catholic Church makes, that in certain circumstances there is a moral obligation to preserve life, so that the definition of ‘euthanasia’ provided above can be seen as morally loaded, rather than merely descriptive. However, many philosophers are convinced of the irrelevance of the distinction ‘active/passive’ for the definition of euthanasia at the merely descriptive level, even when they disagree with each other as to the moral evaluation. For example, according to John Keown euthanasia is “the intentional killing of a patient, *by act or omission*, as part of his or her medical care.”¹² The first condition in Michael Wreen’s definition of euthanasia is “A killed B or let her die.”¹³ According to Beauchamp and Davidson, the first requirement for an act to be considered one of euthanasia is that “A’s death is intended by at least one other human being, B, where B is either the cause of death or a causally relevant feature . . . (*whether by action or omission*).”¹⁴ John Harris maintains that the decision that a life will come to an end “may involve direct interventions (active euthanasia) or withholding of life-prolonging measures (passive euthanasia).”¹⁵ Bonnie Steinbock notes that the permissibility of withholding treatments ‘would have no implications for the permissibility of euthanasia, active or passive.’¹⁶

The concept of ‘passive euthanasia’ that lurks behind all these definitions is rather awkward. In fact, the scientific community does not commonly accept it.¹⁷ Nonetheless, all the definitions of euthanasia just reported state that failing to prolong a patient’s life by discontinuing therapies or by withholding therapies *can* be a case of euthanasia. The problem is: what does ‘can’ mean? And how should the definitions provided by Medical Associations be assessed, given that they seem to put forward the active aspect of bringing about a patient’s death as the core of the definition of ‘euthanasia’? The answer to these questions lies in the second aforementioned candidate for the role of defining feature of ‘euthanasia’, namely the intention to bring about a patient’s death.

‘EUTHANASIA’ IS DEFINED BY THE INTENTION TO BRING ABOUT A PATIENT’S DEATH

A distinction is often drawn between euthanasia and causing death unintentionally by means of sedatives. Even Pope Pius XII, while addressing a group of physicians in 1957, expressed the Roman Catholic Church’s moral approval for administering to terminally ill patients sedatives which, besides relieving him from pain, would foreseeably hasten death.¹⁸ Besides, the *Catechism of Catholic Church* states that:

The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable.¹⁹

But it is not only the Roman Catholic position that keeps euthanasia distinct from those situations in which “one does not will to cause death; one’s inability to impede it is merely accepted.”²⁰ For example, two authoritative philosophers who disagree with one another about the moral status of euthanasia both assume an intention-centred definition of it. John Harris, who considers euthanasia in the clinical context morally permissible, defines it as “the implementation of a decision that a particular individual’s life will come to an end before it need do so—a decision that a life will end when it could be prolonged”;²¹ John Finnis, who morally disapproves of euthanasia, defines it as “the adopting and carrying out of the proposal that, as part of the medical care being given someone, his or her life be terminated on the ground that it would be better for him or her (or at least no harm), if that were done.”²² While defending the validity of the concept of ‘passive euthanasia’ against the attempt to dismiss it by the European Association of Palliative Care, Garrard and Wilkinson distinguish cases of withholding or withdrawing treatments which count as ‘passive *euthanasia*’ from those that do not by appealing to the criterion that, in order for passive euthanasia to occur, “the main purpose (or one of the main purposes) of this withdrawing or withholding is to bring about (or ‘hasten’) the patient’s death,”²³ thus stressing “the intentional structure which is essential to euthanasia.”²⁴ In the same way, Bonnie Steinbock distinguishes the “*intentional* termination of a human life,” which characterizes euthanasia, from the withholding or withdrawing of life sustaining treatments explained by the intention of physicians to respect patients’ will not to undergo disproportioned and useless therapies.²⁵

But the question then arises as to why, and in what sense, medical associations tie the meaning of 'euthanasia' on the active conduct of physicians. To answer this question, we need to observe that, along with the active aspect, all the definitions provided by medical associations quoted above also include the intentional aspect of physicians' bringing about a patient's death. If we confront these definitions with those provided by most philosophers and the Catholic documents, we should draw the conclusion that it is the intentional aspect, and not the active aspect, which marks euthanasia in a way which sets the ground for a shared definition. Anyway, the matter is not so simple. An obvious objection to this conclusion is that in medical associations' definitions intention might be a necessary but not sufficient condition for labelling an intervention as one of 'euthanasia'; *both* intention and activity would need to be included in the definition.²⁶ Such an objection relies on the consideration that conduct might be passive and nonetheless adopted with the intention to bring about death. This kind of conduct would be considered 'euthanasia' according to the intention-centred conception of euthanasia, but it would contradict medical associations' definitions of 'euthanasia'.

My reply to the objection is that the concept of 'active' as deployed by medical associations can be defined in terms of, and indeed reduced to, the concept of 'intention'. I want to argue that the reason why medical associations' definitions of euthanasia always mention the distinction 'active/passive' is not that the distinction is itself relevant to their definition. Rather, the distinction 'active/passive' is deployed to emphasize the relevance of the intentional aspect in both defining and evaluating the physician's conduct. More precisely, from the physicians' perspective, active conduct is always an instance of euthanasia *because* it cannot but be performed with the intention to bring about death; passive conduct can be—and sometimes is—outside the domain of euthanasia *because* it can be—and sometimes is—performed without the intention to bring about death. There are two main reasons which justify this interpretation. Firstly, since in cases of active euthanasia the patient's request is not just to have treatments withdrawn, but to be actively killed, to respect his will means *eo ipso* to *intentionally* bring about his death; but this is not true in cases where all a patient asks is not to be treated. Secondly, since in cases of active euthanasia the cause of the death is not the pathology, but the drug the physician knowingly administers, the physician has no ground for claiming that his intention is not to cause the patient's death and that he just intends to respect the patient's decision about not being treated; but such a claim could instead be put forward in cases where the death is caused by the pathology for which treatments are withheld or not activated. Now, it can happen that a physician withdraws treatments with the intention to bring about death. In such a case his conduct would count as euthanasia according to the interpretation of medical codes' texts here provided. That is to say, such conduct would be considered "active" not with respect to the casual chain from the physician intervention to the patient's death, but rather with respect to the fact that the physician intends to make a certain event (e.g., death) occur when by acting differently that event would not have occurred.

This interpretation of the concept of 'active' as deployed by medical associations in terms of the concept of 'intention' is backed by many passages that can

be found in the Medical Codes. For example, the American Medical Association states that “[t]he principle of patient autonomy requires that physicians respect the decision to *forego* life-sustaining treatment of a patient who possesses decision-making capacity” (opinion 2.20, my emphasis). That is to say that in case of passive conduct—but not in that of active—the request by the patient allows the distinction, from the point of view of the physician, between the intention to bring about death—which is not permitted because it is euthanasia—and the intention to respect the patient’s will—which is permitted and therefore is not euthanasia. The Australian Medical Association is even more explicit in presenting the intention to bring about death as *the* reason for the moral ban on euthanasia, thus stressing the fact that what distinguishes euthanasia from other (permitted) practices is the intention to bring about death:

The AMA recognises that there are divergent views regarding euthanasia and physician-assisted suicide. The AMA believes that medical practitioners should not be involved in interventions that have as their primary *intention* the ending of a person’s life. (par. 10.5)

The main reason why intention is more fundamental than activity for the definition of euthanasia provided by medical codes is that doctors should have a well-defined attitude towards their profession. Namely, their social role is defined by their being “healers of disease and injury, preservers of life and relievers of suffering.”²⁷ For example, according to the American Medical Association,

Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. . . . The physician who performs euthanasia assumes unique *responsibility* for the act of ending the patient’s life. (opinion 2.21)

and although “there is an autonomy interest in directing one’s death, . . . this interest does not override considerations of professional responsibility.”²⁸ Once again, patient autonomy can prevail only insofar as physicians do not have to intentionally bring about patients’ death in order to respect the principle of autonomy.

The British Medical Association warns that “[i]f euthanasia were an option, there might be pressure for all seriously ill people to consider it even if they would not otherwise entertain such an idea,”²⁹ thus implying that doctors should not transmit that pressure. Clearly, the pressure mentioned here would not derive from the fact that the option would be available to bring about death actively, but rather from the fact that there would be doctors who *intentionally* help people die and who are therefore disposed to take “responsibility” (to use the poorly specified concept deployed by the American Medical Association) for the death.

Intention to bring about a patient’s death by medical means has thus revealed the best candidate for the role of *definiens* of euthanasia. *Euthanasia* can therefore be defined as a *medical intervention intended at bringing about a patient’s death upon the patient’s explicit or presumed request or consent (which might be inferred on the basis of consideration about the “best interest” of the patient)*. (In this paper I will not deal with the issue of how to justify the presumptions of requests and consent that are not explicitly formulated).

Given this definition, the answer to the question whether the case of Eluana Englaro in Italy, or other similar cases such as that of Terry Schiavo in the USA, are cases of euthanasia depends on the answer to the question of what the intention was which motivated the decision to withdraw artificial nutrition and hydration. If physicians intended to bring about death, those were acts of euthanasia; if otherwise, they were not. The problem is now that of understanding if and why euthanasia would be morally problematic or even morally wrong. As I said in the introduction, although this debate is quite old, there seems to be a consideration which has been left out of the discussion and which I aim to bring to the surface. In this way, I will make it clear what is actually required from an effective argument against euthanasia, so as to suggest a possible way out of the impasse. In order to do so, it is necessary first to briefly present what seems to be the current source of controversies, in the light of the definition of euthanasia given above.

THE DISTINCTION BETWEEN WHAT IS INTENTIONAL AND WHAT IS NOT DOES NOT REPRESENT, BY ITSELF, THE MORALLY PROBLEMATIC REASON AGAINST EUTHANASIA

The alleged moral relevance of the distinction ‘intended/foreseen’ is based on the Doctrine of Double Effect (DDE). For the purposes of this discussion, DDE can be taken as expressing the following principle: conduct which has a positive effect (e.g., end of suffering) and a negative effect (e.g., death) is only permissible if the positive effect is actually intended by the agent and the negative effect is merely foreseen, and if the negative effect is not the means through which the good effect is brought about.³⁰ Although euthanasia literally means “good death,” hardly can death be seen as something good *in itself*. It can be said that “death” is a bad outcome even if, *all things considered*, it is the “best” (or least bad) thing one can hope for.

DDE is a legacy of Christian morality. Its origins can be traced back to Thomas Aquinas’s *Summa Theologica*.³¹ However, it has been widely accepted even outside the texts of the Christian and the Roman Catholic doctrine. For example, Hans Jonas maintains that

To hasten death in this manner, as a byproduct of the quite different purpose of making the remainder of a doomed life tolerable, is morally right and should be held unimpeachable by law and professional ethics alike, even though it adds another lethal component to the given lethal condition.³²

The distinction as applied to end-of-life issues had a relevant role in the juridical outcome of one of the most debated cases in the history of bioethics, that of Karen Ann Quinlan. In 1976 New Jersey’s Supreme Court ruled in favour of parents’ request to withdraw the respirator from Karen, who had been in a permanent vegetative state for almost a year following a collapse due to consumption of high quantities of drugs and alcohol. The Supreme Court’s decision made explicit reference to the religious convictions of Karen’s father, who was appointed as legal guardian of the daughter and was a devout Roman Catholic. Relying on his Church’s doctrine, he requested the withdrawal of the respirator

because he did not intend to cause Karen's death but only to forgo disproportionate futile treatments. It is worth noting, though, that the subsequent vegetative state of Karen continued for nearly a decade after the withdrawal of respirator because the same principle was not applied to the withdrawal of artificial nutrition and hydration.

Let us then consider the idea that the distinction 'intended/foreseen' actually supports the *moral* difference between euthanasia and withholding or withdrawing disproportionate treatments, or between euthanasia and terminal sedation. In order to rebut such a thesis it would be sufficient to show that the distinction 'intended/foreseen' is not always *by itself* relevant to a moral evaluation. That is to say, it would be enough to imagine a scenario in which the fact that an outcome is intended rather than just foreseen does not make any difference to its moral assessment. Now, there are plenty of such examples in philosophical literature. Perhaps the most famous one is that of the contrasting cases named the '*tactical bomber*' and the '*terror bomber*', presented by Jonathan Bennett.³³ The tactical bomber is a pilot in a war mission who intends to bomb an enemy's factory so as to lower enemy's morale and to increase the chances of his country winning the war, which is stipulated would be a very good outcome as it would spare many lives in the future. Unfortunately, he foresees that by bombing the factory, he will also cause the death of many civilians. Nonetheless, he decides to bomb the factory. His fellow terror bomber also knows that killing civilians would lower enemy morale. But he *intentionally* kills civilians as a means to lowering enemy's morale. It can hardly be argued that there is a moral difference between the two conducts: if there was, it would mean that all that is required to turn the very same action from permissible into impermissible would be a change in the focus of the bomber's intention, or a different bomber (with a different mind-set) performing the very same action. Such examples³⁴ seem to back up the following thesis: foreseeing an unintended negative outcome as a side-effect of an intended positive outcome is morally equivalent to intending that negative outcome as a means to obtain the positive outcome. Replace the words 'negative outcome' with 'death'³⁵ and 'positive outcome' with 'ending sufferings' and you will have a statement about the moral equivalence of, on one side, terminal sedation or withholding disproportionate treatments and, on the other side, euthanasia. If *in some circumstances* a *merely* foreseen death is generally (for example by many physicians, philosophers, and by Roman Catholic doctrine) considered morally permitted, then *in the same circumstances* also euthanasia should be.

But why, then, do so many people keep on assessing euthanasia and withholding life-sustaining treatments differently, if examples can be so easily produced to show them that what distinguishes euthanasia from practices they held as permissible is not morally relevant? It would be unfair to think that they just ignore or refuse to consider these arguments. More likely, there is some other aspect in the concept of 'euthanasia' which actually raises the moral problem and that we have so far failed to take into account.

IDENTIFICATION OF THE MORE FUNDAMENTAL FACTOR WHICH MAKES THE INTENTION TO BRING ABOUT A PATIENT'S DEATH MORALLY PROBLEMATIC

To detect this further aspect it is necessary to focus on one expression just deployed: "in some circumstances." What circumstances precisely?

According to the perspective of the opponents of euthanasia, the justification that death was just foreseen, and that the physician only intended to relieve pain or to forgo disproportionate treatments, can only be consistently put forward when the following condition (which I will call "C") occurs as a necessary condition for the patient's death to come about soon after the physician's intervention:

C: the patient is terminally ill, is kept alive only by means of medical treatments, is severely suffering and/or is no longer able to appreciate his being alive, and is without reasonable expectations of improving the quality of his life for the short amount of time left to live. Whatever the conduct of the physician, the patient will die soon.

According to the anti-euthanasia positions presented above, when C is not a *necessary condition* for the death of the patient to come about soon after the physician's intervention, the moral distinction between permissibly bringing about death and euthanasia would not apply, and bringing about death would always be impermissible. The reason is that when C is not a necessary condition for the death to come about soon after the physician's intervention, the physician needs to *intentionally* bring about death if death is wished for; or, to put it differently, he needs to 'actively' bring about death, according to the conception of 'active' implied by medical codes. On the other hand, in cases in which the patient would die anyway (and therefore C is a necessary condition for the death to come about soon), the physician can merely intend to grant patient's requests or to sedate patients' pain, and the wished death will occur 'by itself', as a predicted but not necessarily intended side-effect.

But here is where we come across the key concept: 'by itself'. Euthanasia is 'problematic' not because it presupposes the physician's intention to bring about death, but rather because of what such intention means in terms of human intervention affecting the course of events. To ask whether euthanasia is morally permissible is to ask whether it is morally permissible for an agent to decide that an event will occur in circumstances in which the occurrence of that event might be evaluated positively should it happen 'by itself', or 'naturally', without the physician's intervention. To presuppose such a difference in the evaluation of the physician's behaviour means to assume that 'morality' has more to do with the recognition and acceptance of what simply occurs (what is 'natural') than with a reflection on how to relieve people's suffering. If arguments can be produced to back such a conservative thesis, they should be at least strong enough to overshadow the plain statement of fact that what simply occurs, including dying, often entails more suffering than would be the case if we only did something to reduce it—something like, for example, euthanizing.

Endnotes

1. The so called "Calabrò Bill," available at <http://www.senato.it/japp/bgt/showdoc/frame.jsp?tipodoc=Ddlpres&leg=16&id=607562> [Accessed 14 June 2013]
2. For example T. Beauchamp and A. Davidson, "The Definition of Euthanasia," *Journal of Medicine and Philosophy* 43 (1979): 294–312; Michael Wreen, "The Definition of Euthanasia," *Philosophy and Phenomenological Research* 48 (1998): 637–53
3. John Paul II, *Evangelium Vitae*, (1995), available at http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html [Accessed 14 June 2013], §65.
4. *Ibid.*, §65.
5. *Ibid.*: §64.
6. American Medical Association, *Code of Medical Ethics. Current Opinions with Annotations* (Chicago, IL: American Medical Association, 2011). Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page?> [Accessed 7 Aug 2011], opinion 2.21, at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion221.page?>, last access 13 June 2013. Unless otherwise stated, quotations of American Medical Association's opinions in the following parts of this paper refer to this text.
7. American Medical Association, "Decisions Near the End of Life," *The Journal of the American Medical Association* 267 (1992): 2229–33. Available at [http://www.AmericanMedicalAssociation-assn.org/American Medical Association1/pub/upload/mm/code-medical-ethics/221a.pdf](http://www.AmericanMedicalAssociation-assn.org/American%20Medical%20Association1/pub/upload/mm/code-medical-ethics/221a.pdf) [Accessed 14 June 2013].
8. British Medical Association, "End of Life Decisions. Views of the BMA," (2009). Available at http://www.bma.org.uk/images/endlifedecisionsaug2009_tcm41-190116.pdf [Accessed 7 Aug 2011]. Quotations of British Medical Association's opinions in the following parts of this paper refer to this text.
9. Australian Medical Association, "The Role of the Medical Practitioner in End of Life Care" (2007): par. 2, my emphasis. Available at <http://ama.com.au/node/2803> [Accessed 7 Aug 2011]. Quotations of Australian Medical Association's opinions in the following parts of this paper refer to this text.
10. *Catechism of the Catholic Church* (1993), n. 2277. Available at: http://www.vatican.va/archive/ENG0015/_P7Z.HTM [Accessed 14 Jun 2013].
11. John Paul II, *Evangelium Vitae*, §65, my emphasis
12. John Keown, "Introduction," in *Euthanasia Examined*, ed. J. Keown (Cambridge, UK: Cambridge University Press, 1995), 1, my emphasis.
13. Wreen, "The Definition of Euthanasia," 637.
14. Beauchamp and Davidson, "The Definition of Euthanasia," 300, my emphasis.
15. J. Harris, "Euthanasia and the Value of Life," in *Euthanasia Examined*, 6.
16. Bonnie Steinbock, "The Intentional Termination of Life," in *Killing and Letting Die*, ed. B. Steinbock and A. Norcross (Fordham: Fordham University Press), 126.
17. American Medical Association, "Decisions Near the End of Life," 2, says that "At one time, the term 'passive euthanasia' was commonly used to describe withholding or withdrawing life sustaining treatment" [*sic*]. However, most experts now refrain from using the term 'passive euthanasia'. A case against the idea of 'passive euthanasia' is also put forward by the European Association for Palliative Care in L. J. Materstvedt et al., "Euthanasia and Physician-Assisted Suicide: A View from an EAPC Ethics Task Force," *European Journal of Palliative Care* 10 (2003): 63–6.

18. Pio XII 1957, "Discourse on the Religious and Moral Implications of Sedation, 24th February 1957." The text of the address is available only in the Spanish version at http://www.vatican.va/holy_father/pius_xii/speeches/1957/documents/hf_p-xii_spe_19570224_anesthesiologia_sp.html

19. *Catechism of Catholic Church*, par 2279.

20. *Ibid.* note 2278.

21. John Harris, "Euthanasia and the Value of Life," 6.

22. John Finnis, "A Philosophical Case Against Euthanasia," in *Euthanasia Examined*, 24, my emphasis.

23. E. Garrard and S. Wilkinson, "Passive Euthanasia," *Journal of Medical Ethics* 31 (2005): 64–8, 65.

24. *Ibid.*, 68.

25. Bonnie Steinbock, "The Intentional Termination of Life," 122–5.

26. See for example Torbjörn Tännsjö, "Terminal Sedation: A Swedish Case Study," in *New Essays in Applied Ethic*, ed. Li-Yeung (Basingstoke: Palgrave MacMillan, 2007).

27. American Medical Association, "Decisions Near the End of Life," 3.

28. *Ibid.*, 7.

29. British Medical Association, "End of Life Decisions," 5.

30. A more detailed analysis of DDE can be found in Jonathan Bennett, *The Act Itself* (New York: Oxford University Press), 194–225.

31. The Thomistic origin of DDE is sustained for example by Alison McIntyre, "Doctrine of Double Effect," *The Stanford Encyclopedia of Philosophy* (Fall 2009 Edition), ed. Edward N. Zalta, <http://plato.stanford.edu/archives/fall2009/entries/double-effect/>, but is challenged by others, for example Jonathan Bennett, *The Act Itself*, 200.

32. Hans Jonas, "The Right to Die," *Hastings Center Report* 4 (1978): 31–6, 35.

33. Jonathan Bennett, *The Act Itself*, n28, 198ff.

34. Another famous one is the 'hospital case' presented by Philippa Foot: in a room there are five patients who can be saved only by means of manufacturing a certain gas, whose fumes are known to be lethal for another patient in the room beside, who cannot be moved from his room. The only means to save five people foreseeably entails the death of the one person. But hardly can anyone say that we are morally allowed to sacrifice a patient's life to obtain the much better outcome of saving five lives (See Philippa Foot, "The Problem of Abortion and the Doctrine of Double Effect," in P. Foot, *Virtues and Vices, and Other Essays in Moral Philosophy* (Oxford: Clarendon Press, 2002), 29.

35. Another way to sustain the moral equivalence of euthanasia and non-intentional termination of life is by arguing that when a patient is enduring terrible unrelievable suffering, death is no bad effect at all, so that DDE does not even apply. See G. Seay, "Euthanasia and Physicians' Moral Duties," *Journal of Medicine and Philosophy* 30 (2005): 517–33, 528.