**A Defence of a New Perspective on Euthanasia**

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## Abstract

In two recent papers, Hugh McLachlan, Jacob Busch and Raffaele Rodogno have criticised my new perspective on euthanasia.[1] Each paper analyses my argument and suggests two flaws. McLachlan identifies what he sees as important points regarding the justification of legal distinctions in the absence of corresponding moral differences and the professional role of the doctor.[2] Busch and Rodogno target my criterion of brain life, arguing that it is a necessary but not sufficient condition and that it is not generalisable.[3] In this paper I indicate flaws in all of these criticisms, and again suggest that my perspective does add something new to the debate.


## Introduction: the new perspective

In my original paper, I argued that a patient's body can itself constitute unwarranted life support that is keeping him alive against his will. To illustrate this, I provided two examples:

> In the first, Adam is dying of lung cancer and is on a ventilator. He is in constant pain and needs help eating, drinking, washing and going to the toilet. He regards his life as no longer worth living and, with the consent of his family, requests that the doctor disconnects the ventilator. In the second case, Brian is dying of stomach cancer. He is in constant pain and needs help eating, drinking, washing and going to the toilet, although he can breathe easily. He regards his life as no longer worth living and, with the consent of his family, requests the doctor to administer a medication that will end his life.

These examples show that the only difference between Adam and Brian is that one is being kept alive against his will be a machine, and the other by his body. I further argued that the central aspect of personhood in patients like Brian is their minds, or their "brain life", and suggested that one of the reasons doctors tend to have problems with euthanasia is that they are used to keeping patients' bodies functioning; therefore, the idea that a body could itself provide invasive, unwanted "treatment" that keeps the mind alive against the patient's will might take some getting used to.

## Legal and moral distinctions and the doctor's role

McLachlan argues that the moral equivalence of killing and letting die is not as important as my paper suggests, and that one can justify legal distinctions on non-moral grounds. His other main point is that we might consider euthanasia to be contrary to the professional role of the doctor, even if there are no ethical objections to the practice in general.

McLachlan begins his argument with a concession. He states that he accepts "that Brian's body can be regarded as a provider of unwanted life-support" but that "It does not follow that there is no moral difference between switching off

a ventilator and administering a lethal injection."[2] He then adds that "Even if there is no moral difference, it is not necessarily unreasonable to choose to make a legal difference." Although he reiterates these moral and legal difference points throughout his paper, at no point does he actually offer a justification for them.

In addition, at no point does McLachlan actually indicate what the purported moral difference actually is. He states that "to kill is not morally the same as to let die, despite the similarity of the outcomes: it can matter how and why what is done is done, who does it and to whom it is done".[2] He then says that we can set this issue aside, but this is the very crux of the matter: if Brian and Adam have the same doctor, and the why, what and whom are the same, what difference does the "how" really make? McLachlan uses the example of shooting Brian, but we can easily imagine a situation where a button is pushed that will administer a lethal drug to his system, and this button looks the same as the button that turns off Adam's life-support machine. Once more, what's the difference?

Neither does McLachlan say on what grounds we would justify a legal difference if the actions were really morally identical; he just moves quickly on to doctors' duties. But the fact that he thinks doctors should not provide euthanasia cannot be the reason for the legal distinction where no moral one exists, as he says that other people could legitimately provide it. McLachlan provides four examples of cases where there is no moral difference but there is a legal one: punishment for murder and attempted murder, driving on the left or the right side of the road, hate motivation for murder, and marginally underage sex. Quite apart from the fact that many people might think that there is a moral difference between murder and attempted murder, none of these is a valid comparison for the marginal differences between Adam and Brian. If we accept that Brian's body is keeping him alive against his will, as McLachlan does, what are the grounds for treating his situation differently from Brian's? It can only be moral squeamishness about abandoning the supposed distinction between killing and letting die. If the argument is that we have to draw a line somewhere, it should be between expressing a wish to die and not doing so rather than between two different causal methods of bringing about death. McLachlan has tried elsewhere to explain what the moral difference is between killing and letting die,[4], but even here, as John Coggon has pointed out, "If he is correct to assert that there is a moral difference between active and passive euthanasia, he fails to demonstrate why."[5]

McLachlan's other main point concerns the professional duties of doctors. He states that "euthanasia and assisted suicide are contrary to the role and professional duty or, at the very least, the central role and professional duty of doctors" and also argues that matters of professionalism are not simply matters of medical ethics. His conclusion is that doctors are professionally obliged not to perform euthanasia, even if euthanasia is morally permissible. To take the second argument first, if something is really contrary to a professional's role, it is almost certain to be unethical in some respect. McLachlan provides the example of doctors having sex with their patients as an example of unprofessional but not unethical behaviour. It is somewhat

surprising that he simply states this as fact: many would argue that this behaviour is both unprofessional and unethical. It is unethical because it could be an abuse of power, there could be coercion involved, it might affect how the patient is treated with harmful consequences, and there might even be a therapeutic misconception (no pun intended). McLachlan also states that “the BMA would be a laughing stock if it were thought to permit doctors to kill their own patients but not to have sex with them.”[2] This is a hasty comment: in fact, killing one’s patient at their request could be both in the patient’s best medical interests and a professional duty; having sex with one’s patient would be neither, in addition to being unethical for the aforementioned reasons.

Secondly, it is far from obvious that it would be unprofessional in any sense for a doctor to provide euthanasia, and a case could well be made that it should be ethically obligatory in cases like Brian’s. Doctors are obligated not simply to prolong their patients’ lives, but also to alleviate their suffering. In cases where prolongation of life is no longer in the patient’s best interests or treatment is futile, the alleviation of suffering must become the priority, as I have argued elsewhere.[6] (As I stated in my paper, “In refusing VAE and AS requests, it is almost as if doctors are obeying the “wish” of the patient’s body rather than the patient’s mind, as keeping bodies functioning is what doctors are habituated to.”[1]) McLachlan states that “Euthanasia and assistance in committing suicide are not forms of healthcare treatment. They are called for only when healthcare treatment has become futile or unwanted by the patient.”[2] He seems not to realise that the same is true of the withdrawal of life support, which also kills the patient and is the doctor’s duty. Given McLachlan’s insistence that “shooting patients is the same as giving them lethal injections”, it is somewhat surprising that he does not say why turning off life-support is any different. And in any case, I would argue that assisted dying can constitute healthcare treatment, as they aim at alleviating the patient’s suffering – that they do so by shortening life is an incidental feature. McLachlan also does not mention the fact that many patients die as a direct result of doctors increasing their morphine; this is also healthcare treatment that kills the patient and in so doing benefits him or her.

Furthermore, McLachlan clearly thinks that turning off ventilators is not contrary to the professional role of doctors. Why is this, if ‘active’ euthanasia would be? Once again, we are left to speculate, given his refusal to address exactly what the moral difference is between killing and letting die. He also argues that “The status and reputation of doctors might be endangered if their roles appear to be ambiguous”, but to many people their status is already ambiguous due to their failure to help patients like Brian.

Ultimately McLachlan’s rebuttal of my new perspective fails because he refuses to engage with its central assertion. He attempts to argue that we cannot derive legal conclusions from moral differences, but that was not the point of my original paper: it merely illustrated that there is no moral difference between killing and letting die, at least in the context of removal of life support and stopping a body working. Unfortunately, he cannot make his argument about legal distinctions without saying what the reasons for them are, and he cannot say what those reasons are without saying exactly what the moral difference is. To merely assert that there is no moral difference but that

doctors shouldn't aid patients in dying because of professional obligations is to sidestep the thrust of my original argument, and his interpretation of doctors' obligations is also flawed.

## Brain life and generalisability

Jacob Busch and Rafael Rodogno have a different criticism of the new perspective. Their two arguments are that the "brain life" criterion that I introduce is a necessary, but not a sufficient criterion for personhood, and that the criterion is not generalisable to other contexts. They represent my argument as follows:

> Premise 1: If X is brain dead then X is dead. i.e. being not brain dead (brain alive)
> is a necessary condition for being alive (for being a person)
>
> Premise 2: If being brain alive is a necessary condition for being alive (for being a
> person), then brain life is the central aspect of personhood in terminally ill patients (i.e. not bodies).
>
> Conclusion: Brain life is the central aspect of personhood in terminally ill patients (i.e. not bodies) [3]

Busch and Rodogno claim that the conclusion does not follow from the premises. In fact, it seems obvious that it does follow, given that premise two actually includes the conclusion. We can only suppose that they meant to say that the second premise is itself false. The first of their two main criticisms is that "even if brain life is a necessary condition for being a person, other conditions could be necessary as well."[3] In other words, it is wrong to assume that brain life is the central aspect, even if it is a necessary condition. The other criticism is that I "assume that this criterion of personhood, once agreed upon in one context, is generalisable to other contexts." [3] In other words, it poses a problem for the new perspective if the brain life criterion does not work in other situations.

To take the second of these criticisms first, their argument about generalisability fails. I originally limited the applicability of the brain life argument to terminally ill patients, and stated simply that: "If we agree that brain death is the end of a person, we should adopt brain life as the central aspect of personhood in terminal patients and accept that the body is merely another type of life support."[1] I may have been mistaken to say that "we should adopt" the brain life criterion, as it is already used inasmuch as brain death is used to determine when a person is no longer present. In this sense, brain life is already a crucial concept in end-of-life situations; as I said in the original paper, "If the definition of the death of a person is brain death, it follows that "we" as persons are not identical with our bodies."[1] Nonetheless, I think that the brain life criterion is indeed the central aspect of personhood in all contexts. Even if it is not itself sufficient for personhood due to the biological fact that brains need bodies to function, it is clearly the most necessary criterion, and we can all imagine existing without our bodies, while

the converse is not true. In end-of-life situations, as our bodies fade and fail, our minds and brains become even more central to who we are. Busch and Rodogno claim that my perspective should at least be generalisable to other areas of medicine, arguing that patients who are about to undergo a gynaecological examination are allowed some degree of privacy and sensitivity form their doctors. But even if brain life is the central criterion of personhood, people are obviously very attached to their bodies, even if their bodies are not persons according to my view; it is not surprising that we are sensitive about how our bodies are treated. As I have argued, however, "Although persons obviously have feelings for their bodies that they do not have for external equipment such as a ventilator, such feelings lose all moral power when a patient decides that his or her body is now a burden."[1]

Unfortunately, Busch and Rodogno seem to take their second criticism as a given in order to support their first. They seek to provide an example that illustrates that other conditions are necessary for personhood and argue that a concert pianist whose arms and legs are amputated will be a different person from before the accident that necessitated this surgery. First, we should bear in mind that I never claimed that brain life was a necessary and sufficient condition for personhood; I merely said it was the central aspect. I certainly did not claim that brain life was a sufficient condition for being the *same* person, which is all that their example illustrates. They state that the pianist would not regard herself as the same person after the emergency surgery, but she would obviously still regard herself as *a* person. Actually, the fact that she still regards herself as a person despite having lost a great deal of her body would tend to support my central thesis that the person is the mind and brain life is the central criterion. The same applies to their other examples of face-transplants and deaf people: their discussion focuses on criteria for someone being the *same* person, while the brain life criterion focuses on whether someone is *a* person. Busch and Rodogno seem to have mistaken my claim that brain life is the central aspect of personhood in end-of-life situations for a much wider claim about personal identity across a wide variety of situations. Another way of looking at this is to consider how things change for Brian. For most of his life his body is part of him as a person. Then it begins to fail, eventually causing him to regard it as something that is keeping him alive against his will. In this sense, the patient himself adopts the brain life criterion and decides that his body is no longer part of his person, just as the concert pianist had to accept that her arms and legs were no longer part of her.

A third, minor criticism of my argument is also mentioned. Busch and Rodogno also claim that my dualistic perspective faces the problem of explaining whether the brain is part of our bodies, in which case it is part of the unwarranted system, or it is not part of our bodies, "which seems implausible". In fact, this is not as much of a problem as it appears. First, I do not claim that people are their brains, but that they are their brain activity, or their minds, so the criticism is somewhat misplaced. And given that people are their brain activity, it makes perfect sense to regard the brain as part of the unwarranted life support system.

## Conclusion

The papers by McLachlan, Busch and Rodogno offer interesting perspectives on my new perspective on euthanasia, but the objections that they raise are all flawed. McLachlan's argument about legal distinctions fails because he fails to say what they ought be grounded on in the case of euthanasia, and his argument about the role of the doctor is based on a misconception. Busch and Rodogno overlook the fact that the brain life criterion is not one of personal identity, and thus do not realise that brain life is indeed the central condition of personhood. Indeed, brain life would be sufficient for personhood even if the brain was entirely artificial. Busch and Rodogno claim that I have merely provided "a perspective that makes the conclusion that there is little distinction between voluntary active euthanasia and voluntary passive euthanasia seemingly more palatable".[1] In fact, that was my only intention when I wrote the original paper, and I believe that my new perspective on euthanasia does indeed make it clearer than before that there is no distinction between killing and letting die.

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