reference comes at the end of an extensive section of the Instruction detailing the likelihood of scandal and the degrees of cooperation in evil involved in the use of biological material derived from human cell cultures.

In short, the Instruction could be a most valuable source for those who feel drawn to compose a new Christian version of the Hippocratic Oath, incorporating some of the unique and positive perspectives from the Church's social teaching. Young researchers and health care providers should be assured that "the Church … views scientific research with hope and desires that many Christians will dedicate themselves to the progress of biomedicine and will bear witness to their faith in this field" (n. 3).

I would indeed recommend this valuable collection of essays compiled by Dr. Guinan on the Hippocratic spirit in medicine, particularly to students of bioethics and those preparing to enter the health care professions. These readers would benefit greatly from the articles that introduce them to the texts of the Hippocratic School itself and those that help them reflect on the place they will assume in passing on this great tradition to future generations.

I close with an observation by Dr. Ratner, who reminds us that "all readers of Hippocrates are patients, potential or actual. They should be concerned with medical tradition, for they are the ultimate gainers or losers" (9).

Rev. Robert E. Hurd, SJ, MD

Rev. Robert E. Hurd, SJ, MD, STD, teaches bioethics and endocrinology at Xavier University in Cincinnati, Ohio.

Debating Euthanasia

by Emily Jackson and John Keown

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Debating Euthanasia is volume 3 in Hart Publishing's Debating Law series, edited by Peter Cane. The book is divided into two parts: "In Favour of the Legislation of Assisted Dying," by Emily Jackson, and "Against Decriminalising Euthanasia: For Improving Care," by John Keown. Jackson, who is well known as a champion of euthanasia and assisted suicide in the United Kingdom, is a professor of law at the London School of Economics. Keown, who taught law and bioethics at Cambridge University for many years, is currently Rose F. Kennedy Professor of Christian Ethics in the Kennedy Institute of Ethics at Georgetown University, and is the author of *Euthanasia, Ethics, and Public Policy* (Cambridge, 2002).

Emily Jackson's "In Favour of the Legislation of Assisted Dying"

Jackson's thesis is that we owe it to those experiencing permanent and irreversible suffering and those who are worried that this may happen to them to do all we can to alleviate their distress; in a small number of cases, we must "allow" people to have their lives ended quickly and painlessly if they cannot be helped in any other way and if they believe that death offers the only possible relief from their suffering (1).

Jackson defines her terms as follows: *Euthanasia* is commonly done by a doctor using a lethal injection; if a relative or friend administers something lethal, the act is "mercy killing." "Voluntary active euthanasia" differs from "involuntary" and "passive euthanasia": "involuntary euthanasia" ends a person's life without their consent; "passive euthanasia" causes death by the withdrawal of life-preserving treatment, but Jackson prefers to call this simply "treatment withdrawal."[1] "Assisted suicide" differs from euthanasia and mercy killing in that the agent bringing about the person's death is the person herself (1–2).

Appealing to compassion, Jackson gives examples of persons whose intolerable suffering was not relieved by palliative care and who concluded that they could preserve their dignity—violated by loss of autonomy, loss of control of bodily functions, and such—only by choosing assistance in dying. Jackson argues that a regulated system in which euthanasia and assisted suicide are options that could extend and enhance the lives of such people. She characterizes her opponents as trying to impose on others their belief that it is wrong, but says that in a pluralist secular society in which people differ in their basic moral values, contradictory views must be accepted. People with faith-based objections refer to secular arguments against legalizing assisted suicide, and advocates of properly regulated laws permitting it can do nothing to persuade them to change their minds (4–6).

Jackson's reasoning to support her thesis rests on the assertion that assisted suicide (which she calls "assisted dying" and which is currently unlawful) coexists with a wide range of *lawful* practices that shorten the lives of patients and are frequently used in the medical profession. Since this is so, what is wrong with permitting doctors to end patients' lives quickly and painlessly using lethal injections? She notes in particular that currently-legal means of hastening death commonly result in more prolonged deaths than assisted suicide does (13).

As this reasoning shows, Jackson is a consequentialist, who thinks that consequences determine the moral value of an action. It also shows that she equates morally (a) the choice to end a patient's life deliberately because that *life* is an unbearable burden with (b) the choice to withdraw (or withhold) a life-preserving treatment because the *treatment* is either unduly burdensome or futile. This grave error undergirds her work.

Jackson gravely misunderstands the principle of double effect, rooted in St. Thomas Aquinas's argument justifying killing in self-defense (see *Summa theologiae* II, q. 64, a. 7). According to Jackson, the doctor who administers a potentially lethal dose of painkillers to a terminally ill patient must have decided that the patient's interest in pain relief outweighs his interest in continued life: "It may be that death is not the intended outcome, but it must have become a tolerable or a reasonable one" (14–16). But doctors and other health care personnel acting in accord with its conditions absolutely repudiate her claim that "relief of pain is more important [to terminally ill patients] than being alive." They are committed to defend the truth that life, which for living persons is their very being, is always a good gift from God, however heavily it is burdened. Similarly, her treatment of terminal sedation (16–18) fails to recognize the *moral* difference between euthanasia and providing sedation to comfort a dying person, recognizing that the sedation may hasten the person's death.[2]

Jackson claims that the line the law draws between normal treatment withdrawal and euthanasia turns on the difference between killing and letting die, or between acts and omissions. Both will lead to the patient's death, and the different bodily movements involved in injecting someone with lethal medication and removing a feeding tube do not justify these completely different legal responses. Since death inevitably occurs more quickly following lethal injection than following treatment withdrawal or letting nature take its course, Jackson asks how reaching the same inevitable result more quickly and painlessly can subvert the foundation of medical ethics. Once the decision for death has been made, the means chosen should protect the patient's dignity and reflect the values that were important to him during life (31–32).

Opponents of assisted suicide advance three major reasons for their opposition: the sanctity and value of life, the effect on the doctor–patient relationship, and regulatory difficulties. Jackson considers two versions of the first, one derived from the religious belief that life is not ours to dispose of as we please because this is to usurp God's sovereign dominion over life; the second derived from reasoning that if we can imagine circumstances in which some lives are not worth saving, we are making a moral judgment that is irreconcilable with the principle that all lives are of equal value. Jackson

disposes of the first because it is irrelevant to public policy in a secular society.

The second merits more consideration but is unpersuasive, because we know from many patients' personal testimonies that for them life has become an intolerable burden, and death would come as a welcome release. It would be cruel and condescending to disbelieve them (41).

Opponents also assert that legalizing assisted suicide would damage the physician–patient relationship. Jackson points out, however, that if we consult public opinion polls and surveys about patients' interest in making advance directives or living wills, this argument collapses. We know, Jackson writes, that "many elderly people fear going to the hospital because they are worried about the 'overzealous use of life-sustaining procedures … which would just prolong their suffering and compromise their dignity and quality of life'" (44). Ignoring their perspective and refusing to accept the validity of their preference for an assisted death is a strange way to foster trust in the health care professionals responsible for their care.

Jackson considers two important regulatory difficulties, the third major reason for opposing assisted suicide. One is that it would be hard to make sure that requests were voluntary, competent, and sufficiently informed. The other is that this would be so hard, in fact, that we would be on a slippery slope, and would end up extending access to assisted suicide to more people than intended.

Jackson disposes of the first argument by concluding that in jurisdictions where assisted suicide is legal, as in Oregon, provisions in the law adequately protect patients' rights, and she maintains that "a carefully regulated system might in fact offer much more effective protection than a blanket ban. An absolute prohibition may simply push the practice underground, thus ensuring that assisted dying will be unsafe and unethical" (53). She then identifies different kinds of slippery-slope arguments, one logical, one empirical, and another psychological. All assert in some way that once we permit assisted suicide in one set of circumstances, we will be led irresistibly to permitting it in others. After reviewing each sort of argument in some detail, she dismisses all of them by saying, "Accepting that euthanasia and assisted suicide are sometimes understandable and justifiable responses to unbearable suffering does not commit us to a progressive expansion of what we mean by 'unbearable suffering,' nor does it mean that we are inevitably set on a path that ends in the involuntary extermination of disabled people. … It is clearly false that a blanket ban is the optimum response to concerns about a practice's potential misapplication" (62).

Jackson concludes her apologia by stressing that for many, the experience of dying is prolonged and miserable, and we know that the desire for the option of assisted suicide exists among people who have access to high-quality care who have longed for this option because of their suffering. Since high-quality palliative care cannot help everyone's suffering, those who argue against the legalization of assisted suicide are forcing people who long for death to experience deaths they do not want. For the suffering patient, in effect, other people's values are more important than their own perception of their own suffering. In short, opponents of assisted suicide have no right to impose their values on others.

John Keown's "Against Decriminalising Euthanasia, For Improving Care"

It has always been against the law and against medical ethics for physicians or other health care personnel intentionally to kill their patients. Keown's paper is a reasoned argument to keep it that way. He notes that Emily Jackson, coauthor of this volume, had earlier written several articles on euthanasia and assisted suicide, among them "Whose Death Is It Anyway? Euthanasia and the Medical Profession" (*Current Legal Problems* 57.1 [2004]: 415–442). The purpose of his essay is to add support to an international consensus opposing assisted suicide by showing (1) that voluntary active euthanasia and physician-assisted suicide breach the basic human right not to be intentionally killed, (2) that the case for euthanasia on request logically leads to euthanasia without request,

and (3) that the availability of euthanasia and physician-assisted suicide pressures the competent but vulnerable to ask for an earlier death and leads to euthanasia without request for noncompetent patients.

Keown thinks that the definition of euthanasia by the House of Lords Select Committee on Medical Ethics in 1994—"a deliberate intervention undertaken with the express intention of ending a life so as to end intractable suffering"—should be extended to include any reason that death is thought to be a benefit to the person. Although he focuses on actions, not omissions, Keown does not deny the possibility of intentionally killing or assisting suicide by omission. Euthanasia is *voluntary* when carried out at the patient's request, *nonvoluntary* when the patient does not have the capacity to make a request, and *involuntary* when the patient is competent to make a request and does not do so.

The ten arguments for decriminalization are based on (1) autonomy, (2) compassion, (3) legal hypocrisy, (4) a right to suicide, (5) public opinion, (6) legal failure, (7) the Netherlands, (8) Oregon, (9) religion, and (10) economics. I will not consider Keown's rebuttal of all ten arguments; rather, I will illustrate how he refutes Jackson's presentation of the arguments based on autonomy, compassion, legal hypocrisy, a right to suicide, and religion. I will also mention his rebuttal of the argument based on economics, an issue not emphasized by Jackson but advanced by others.

Counterarguments to Autonomy. Keown offers five counterarguments to autonomy. The first addresses autonomy versus the inviolability of human life; the second contrasts the autonomous few versus the vulnerable many. The third asks, how autonomous would requests for euthanasia and assisted suicide be? The fourth identifies an unspoken belief on which the argument for euthanasia and assisted suicide rests, namely, that some patients are better off dead. And the fifth addresses autonomy's slippery slope, which is that if the patient's self-assessment is definitive, then why should euthanasia and assisted suicide be withheld from others who want to die? I will summarize the first two.

The counterargument based on the inviolability of human life shows clearly why the claim that autonomy justifies decriminalizing euthanasia is false. A person's self-determining choice, his exercise of autonomy, does not make what is chosen morally good or bad. Autonomy is valued precisely because its exercise makes for the well-being and flourishing of those who possess it. But it is clear that many self-determining choices damage the well-being of the life of the chooser and the lives of those affected by his choices. Autonomy has limits; one of the most important is the cardinal ethical principle of the inviolability of life; this principle is sometimes called the "sanctity of life," which has religious connotations, but it can stand on philosophical grounds alone.

The second counterargument contrasts the autonomous few with the vulnerable many. It shows that decriminalization would prejudice the vulnerable, both those who are autonomous and those who are not, making some elderly persons feel guilty for being a burden, pressuring them to choose assisted suicide or being pressured by family members to do so. A report issued by the New York State Task Force on Life and the Law concluded that decriminalization would be an unwise and dangerous public policy for this reason.

Counterarguments to Compassion. The compassion-based apologia for assisted suicide notes, "We shoot horses, don't we?" and claims that euthanasia and assisted suicide must be made available to terminally ill patients as a way of ending suffering they can no longer endure.

Four reasons show how fallacious the arguments based on compassion are. The first is that compassion is not a moral principle but a laudable emotion. Some of the most compassionate members of the health care community—doctors, nurses, and others—are leading opponents of euthanasia and assisted suicide. True compassion means "suffering with" their patients; caring for them, not killing them; affirming the patient's worth and acting in solidarity with them. We kill suffering animals out of mercy, but we should not treat human persons as animals.

The second reason is compassion's slippery slope. If compassion justifies giving a terminal or dying patient a lethal injection, wouldn't it also justify giving a lethal injection to someone who is physically unable to commit suicide; to a terminally ill, dying person who is not capable of requesting such an injection; or to a non-terminally-ill patient suffering from chronic rheumatic arthritis and similar painful maladies (102)?

The third reason is that the kind of palliative care pioneered by Cecily Hastings, founder of the hospice movement, meets the needs of suffering patients much better than do euthanasia and assisted suicide. Most UK physicians (95 percent) agree that, with improvements in palliative care, good clinical care can be provided within existing legislation, and patients can die with dignity.

The fourth reason is that legalizing euthanasia and assisted suicide violates the vocation of physicians and other health care workers to heal, and it erodes the trust in their physicians to which patients have a right.

Counterarguments to Legal Hypocrisy. Jackson's apologia for euthanasia and assisted suicide asserts that the law permits doctors and other health care workers to kill their patients by withdrawing life-preserving treatments.

There is a difference between foreseeing the evil effect of an action and *intending* that evil. The principle of double effect holds that it is permissible to bring about a foreseen bad effect if the effect is not intended either as end or means and if it does not violate other moral norms, especially fairness. Anglo-American law and professional medical ethics have long drawn an important distinction, recognized by sound philosophy and common sense, between the intended and merely foreseen hastening of death. Conflating euthanasia and palliative treatment ignores this crucial distinction.

Counterarguments to a Right to Suicide. Advocates of assisted suicide claim that in the United Kingdom, the crime of suicide was abolished in 1961; since then there is a right to commit suicide, and because of this the law cannot logically prohibit someone from helping another person exercise that right.

This is nonsense. The 1961 suicide act, as the records and parliamentary reports make clear, did *not* create a right to suicide. That was not its purpose. It framers explicitly condemned suicide as self-murder and a violation of the sanctity of life. Suicide was decriminalized because the law did not seem to deter people from committing suicide, it cast an unwarranted stigma on innocent members of the suicide's family, and it prompted the distasteful prosecution of attempted suicides.

There is no "absolute right" to refuse treatments. A person who refuses a treatment because he thinks his life in not worth living is making a suicidal refusal. Despite some confusion in UK law, courts have never held that "a doctor may, let alone must, withhold or withdraw treatment *with intent to assist* a suicidal refusal of treatment" (112, original emphasis).

Counterarguments about Religion. The claim is that religion, or a faith-based opposition to decriminalizing assisted suicide, should be prohibited from debate on public policy in a secular society. People of faith cannot impose their will on others.

This claim is surprising. It is, of course, true that many great religions—Judaism, Christianity, Islam—have long opposed euthanasia and assisted suicide. But such opposition has also been vigorously mounted by such organizations as the World Medical Association, the Royal College of Physicians, and the New York State Task Force on Life and the Law. One of the oldest and most cogent arguments against deciminalization is Yale Kamisar's classic article, "Some Non-religious Views against Proposed 'Mercy Killing' Legislation" (*Minnesota Law Review* 42.6 [May 1958], 969–1042).

Counterarguments about Economics. The claim is that legalization of euthanasia and assisted suicide would save immense health care and social resources that would otherwise be spent on the aging, the demented, and others.

This crass utilitarian claim is rarely made openly. But in truth, decriminalization would

reduce or eliminate entirely on the costs of caring for the aging, the demented, and those in need of therapy. Thus, a former UK minister of health said that soon physician-assisted suicide would be seen as cheaper than palliative care. Baroness Warnock (a supporter of euthanasia and assisted suicide) affirmed that the "demented" are wasting National Health Service resources, and patients in Oregon are bluntly told that while the state will fund physician-assisted suicide, it will not pay for therapy (138).

Keown goes on to analyze and criticize Professor Jackson's earlier writings on euthanasia and assisted suicide, in particular her essay "Whose Death Is It Anyway?" Many of his criticisms reiterate his critique of the ten arguments. In the essay, Jackson routinely identifies the choice to withdraw (or withhold) a life-preserving treatment or to inject diamorphine to reduce pain and also shorten a patient's life as morally the same as the choice to kill the patient or to inject potassium chloride to end his life quickly and painlessly, because both behaviors result in the death of the patient ("Whose Death?" 413–416). Keown shows that Jackson fails to see the crucial difference between judging a patient's *life* as burdensome or useless and judging whether a *treatment* is unduly burdensome or useless (141).

In that essay, Jackson also touts patient autonomy as justifying euthanasia and assisted suicide; we have already seen the insuperable problems with this, as well as with her repeated claims that palliative care includes the intention to shorten the patient's life, and her gross misunderstanding of the principle of double effect. "The recurrent problem with Professor Jackson's argument," Keown writes, "is its conflation of intention and foresight. This produces a confusion between, on the one hand, euthanasia and, on the other, medical conduct which need involve no intention to end life" (145).

In "Whose Death?," Jackson refutes arguments that legalizing euthanasia would make it hard to ensure that requests were voluntary and that there was no slippery slope leading to justifying the deaths of the noncompetent or of those who refuse to consent to this relief from suffering. Keown rebuts Jackson's arguments a with a host of new arguments, many based in English legislative history and citing the Walton Report (*Report of the Select Committee on Medical Ethics*, UK House of Lords session 1993–1994, HL paper 21-I).

Keown then turns to another of Jackson's earlier essays, "Secularism, Sanctity and the Wrongness of Killing" (*BioSocieties* 3.2 [June 2008],125–145). The positions she takes in this essay have already been rebutted by Keown in the ten arguments section, but he develops other arguments and invokes many authorities in support. Keown sums up the major themes of this essay: (1) Jackson seconds Ronald Dworkin's claim that the "sanctity of life," with its appeal to the intrinsic value of human life, makes no sense other than as an article of religious faith. (2) Jackson argues that not all human beings possess those human qualities—consciousness, moral reasoning, and self-awareness—that make our lives more valuable than, for example, those of animals, anencephalic babies, and patients in a persistent vegetative state. (3) Jackson contends that there are no rational grounds for recognizing an important difference between human beings and animals and asserts that a belief in the unique value of human beings can only be a matter of faith. (4) Jackson sharply distinguishes between "persons," that is, human beings capable of exercising cognitive powers, and "human beings" (like babies, the demented, and the comatose) who are not able to exercise these "personal powers." (5) Jackson claims that killing is wrong because it destroys everything that has been invested in a person's life and deprives the person of future experiences, but "where we can be certain that a human being's future contains no experiences at all, or only pain and suffering which have become unbearable, death may no longer be an instrumental harm." And finally, (6) Jackson rejects the idea of a slippery slope leading to coercion of the vulnerable and dependent, because "it is only possible to conclude that death is a good thing for a person if we can be certain that it would be better for them if they died now, and that this would be consistent with their wishes and values."

Keown, citing many sources and developing new arguments, shows how sophistic these claims are. Regarding the first theme, that the sanctity of life makes sense only as a tenet of religious faith, he notes that "the many atheists and agnostics who subscribe to the concept of inherent human dignity which underpins the Universal Declaration of Human Rights will be surprised to discover that they are religious believers after all" (159–160). The fourth theme, the distinction between "persons" and "human beings," is perhaps the central error Jackson and others make in their apologias, namely, that since some human beings do not have exercisable cognitive abilities, they cannot be persons. Keown, referring to Christopher Kaczor's recent and splendid *The Ethics of Abortion* (Routledge, 2010), points out the crucial difference between a *radical capacity* and an *exercisable ability.* An unborn baby, a person with dementia, and a person in a coma may not have the developed ability to reason and make choices, or an injury or accident may have inhibited its exercise, but they all have the radical capacity to do so (160). Regarding Jackson's rejection of the slippery slope, Keown cites the classic essay by Leo Alexander, MD, a consultant at the Nuremberg trials, in which Alexander declares that the grotesque experiments on human subjects made by Nazi doctors in the concentration camps had their beginning in "the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived" (161, quoting from "Medical Science under Dictatorship," *New England Journal of Medicine* 241.2 [July 14, 1949]).

Finally, Keown discusses the Joffe bill, which would have authorized physician-assisted suicide in the United Kingdom but was blocked in 2006 in the House of Lords. Keown shows that the bill failed to incorporate key recommendations made in 2005 by the Mackey Committee, that it invited both extension and abuse, that the principles it advanced to justify assisted suicide would also have justified voluntary and nonvoluntary euthanasia, and that the safeguards it contained were weak.

In his conclusion, Keown brilliantly recapitulates major themes developed throughout his essay. He puts his take-home message like this:

> First, either [physician-assisted suicide, voluntary active euthanasia, and nonvoluntary active euthanasia] are (as Emily Jackson thinks) all ethical, or (as I think) they are not. Secondly, they are wrong because they deny the inherent and inalienable dignity we all share in virtue of our common humanity, a dignity that grounds our right not to be intentionally killed. Thirdly, weakening the law's historic defence of that right would discriminate against the most vulnerable in our community, not least the dying, the disabled and disadvantaged. (174)

The volume concludes with a fine bibliography and list of important web sites on both sides of the debate.

William E. May

William E. May is the Michael J. McGivney Professor Emeritus of Moral Theology at the Pontifical John Paul II Institute for Studies on Marriage and Family at the Catholic University of America and senior research fellow at the Culture of Life Foundation, in Washington, DC.

[1] Here and later in her essay, Jackson falsely equates treatment withdrawal with euthanasia or assisted suicide.

[2] Providing sedation for comfort at the end of life differs from performing euthanasia because the *present intention* of the physician, which is the *proximate end* of the action (see *Veritatis splendor,* n. 78), is to protect the patient from useless or unduly burdensome *treatments.* This proximate end is the primary source of the object morally specifying the act.