It is sometimes remarked that physicians have difficulty in accepting death, especially the deaths of their patients. This attitude raises the question of whether, in inculcating a total repugnance to killing, we have evoked a repugnance to death as well. In short, there might be confusion between inflicting death and death itself. We know that failure to accept death, when allowing death to occur would be appropriate, can lead to overzealous and harmful measures to sustain life. We are most likely to elicit a repugnance to killing while fostering an acceptance of death - and we are most likely to avoid confusion between a repugnance to killing and a failure to accept death - if we speak of and seek to convey a repugnance to killing, when that is the appropriate word (although it is an emotionally powerful one), instead of death. Achieving these aims would be very difficult in the context of legalized euthanasia.

The Art of Medicine

Finally, I propose that it is a very important part of the art of medicine to sense and respect the mystery of life and death, to hold this mystery in trust, and to hand it on to future generations - especially future generations of physicians. We need to consider deeply whether legalizing euthanasia would threaten this art, this trust, and this legacy.

CONCLUSION

Every country will need to decide whether to legalize euthanasia. Making this choice will be, and will require, a complex process. It is crucial that all of us in each of our roles - whether as concerned citizens, professional organizations, or policy-makers - engage in the euthanasia debate.

This debate will involve many questions about euthanasia at both the individual and societal levels, but three of the most important are the following: First, would legalization be most likely to help us in our search for meaning in our individual and collective lives? Second, how do we want our grandchildren and great-grandchildren to die? And third, in relation to human death, what memes (fundamental units of cultural information that are inherited by being passed from generation to generation) do we want to pass on?

7 Euthanasia by Confusion

"There's glory for you!"
"I don't know what you mean by 'glory,'" Alice said.
"I meant, 'there's a nice knock-down argument for you!'"
"But 'glory' doesn't mean 'a nice knock-down argument,'" Alice objected.
"When I use a word," Humpty Dumpty said in a rather scornful tone, "it means just what I choose it to mean - neither more nor less."

Lewis Carroll, Through the Looking-Glass, chapter 6

The euthanasia debate is beset by confusion - a condition caused both by accident and by design. One important way to promote the legalization of euthanasia is through various types of confusion. First, the examples of such confusion span the domain of semantics: confusion in definition; confusion created by choice of language; and confusion of association and analogy. Second, they span important areas of ethical and legal analysis: confusion of means and ends; confusion in the use of the legal concepts of intent and causation; and confusion in interpreting common-law precedents. We need to examine, understand, and, where possible, dispel these confusions.

CONFUSION IN SEMANTICS

Confusion in Definition

The definition of euthanasia, as of physician-assisted suicide, is highly confused. For the sake of clarity, as proposed elsewhere, euthanasia should be defined as "a deliberate act or omission that causes death, undertaken by one person with the primary intention of ending the life of another person, in order to relieve that person's suffering." The paradigm case of euthanasia is the giving of a lethal injection to a suffering, terminally ill person who requests it and gives informed consent. Yet neither a requirement for informed consent nor that the person be terminally ill is an element of the definition given above. This definition, therefore, includes both non-voluntary euthanasia (the patient is incompetent to give or withhold consent) and involuntary euthanasia (the
patient is competent, but euthanasia is administered without asking for consent). In the Netherlands, by contrast, the guidelines previously governing the country’s de facto legalization of euthanasia defined it as requiring “explicit consent.” And that country’s new legislation governing euthanasia and physician-assisted suicide5 spells out the requirements for due care on the physician’s part, which include that the patient’s request for euthanasia must be voluntary, well considered, and lasting. As a result, non-voluntary and involuntary interventions aimed at ending life are not regarded as euthanasia, although, in practice, some Dutch doctors seem unaware of this distinction.5

Another way in which confusion arises is that many people who support euthanasia lump together, under the broad category of “medical decisions at the end of life,” decisions concerning palliative care, pain-relief treatment, refusals of treatment (including of life-support treatment and especially of artificial hydration and nutrition), and physician-assisted suicide and euthanasia. They argue that all these decisions, aimed at trying to ensure that patients experience a “good death,” but that could or would shorten their lives, involve euthanasia. Although this is true in a broad etymological sense, this definition of euthanasia can give rise to serious confusion.

Physicians and nurses who accept such a broad definition, and who are asked in surveys whether they have ever been involved in euthanasia, are likely to state that they have. These statistics can be used as evidence that many healthcare professionals are carrying out euthanasia secretly and that it would be safer for individuals and society to legalize euthanasia, bringing it out into the open and ensuring that it is not used abusively. This line of reasoning is sometimes taken further, to imply that people who oppose legalization should reconsider their position because legalization would result in fewer cases of euthanasia being performed than if euthanasia were to remain prohibited. Quite apart from the fact that there is no evidence to indicate that any reduction would occur — indeed, the results of over twenty-five years of de facto legalization in the Netherlands would suggest the contrary — this argument entirely misses the point. The primary objection of many who oppose euthanasia is that to kill another person is inherently wrong. The fear of the abusive use of euthanasia, if it were to be legalized and even if it were not, is a secondary, though important, objection. If the basic objection to physician-assisted suicide and euthanasia is that they are different in kind, not just degree, from other decisions about medical treatment at the end of life, then lumping all these procedures together assumes what must be proved: that physician-assisted suicide and euthanasia are morally and ethically the same as other forms of end-of-life medical care that could or would shorten life. If physician-assisted suicide and euthanasia are to be justified, it must be on their own merits, and not by false association with other interventions that are considered ethically and legally acceptable.7

Definitional confusion is also generated by describing all decision-making relating to medical care and treatment at the end of life as “medical decisions.” This term is a misnomer; many of these decisions are not medical decisions at all. They have foundations, aspects, and effects far beyond medicine and are better referred to as “decisions at the end of life in a medical context.” These characterizations are important because they alert us to the wide range of considerations beyond medicine that must be taken into account and also to people other than healthcare professionals who should be involved.

Within a narrower context, the term “physician-assisted suicide” is also confusingly used. Often it refers to euthanasia — physicians intervene on patients with a primary intention of killing them, most often by giving lethal injections — which is homicide, not suicide. As I have discussed elsewhere, this term is sometimes changed to “physician-assisted death,” which can mean euthanasia or physician-assisted suicide, but also connotes a broad range of procedures that physicians undertake — indeed, that they have ethical and legal obligations to undertake — to help dying people. We all want physicians to assist us in those ways, but we do not necessarily mean in stating this wish that we agree with physician-assisted suicide and euthanasia.

The euthanasia debate is too important to carry out on the basis of confusion over what does and does not constitute euthanasia. The most honest and clear approach would begin with a debate over whether we agree that the law should be changed to allow physicians to give lethal injections to terminally ill, competent adults who request and give their free and informed consent. This is not the only question we need to answer about euthanasia. Others are, for example, if we reject euthanasia, should we allow physician-assisted suicide? Or, if we allow euthanasia, should it be available in the case of some incompetent people? But we need to deal first with a situation in which we all agree that euthanasia is involved. We should start with the most straightforward one, that of physicians giving lethal injections to competent, suffering, terminally ill people who request and consent to it. This restriction of the analysis should help us to eliminate from the debate the confusion over the definition and what flows from it — such confusion is bad for all of us, whether we are for or against euthanasia.

Confusion in Language

A matter related to confusion in definition is the confusion that can occur from our choice of descriptive language. A vastly different
impression is made, or emotional reaction evoked, or behaviour elicited by describing euthanasia as “a merciful act of clinical care” or as “killing.” In this respect, an interview I conducted with Roger Hunt, an Australian palliative-care physician who was influential in the legalization of euthanasia in the Northern Territory of Australia, is instructive.

When I asked Dr. Hunt, “Tell me why you think doctors should be allowed to kill dying patients who want this?” he objected to my use of the word “kill.” He said he “prefer[red] to be specific about terms that we use in medicine” and that we should talk of “voluntary euthanasia” rather than “killing.” Kill is a broad word that includes murder, manslaughter, and various other types of killing. We’re [people who are pro-euthanasia] talking specifically about VAE [voluntary active euthanasia]. Now if doctors are involved in VAE, I think most people expect it of doctors not to turn their back on someone who is dying and suffering, and walk away.”

Not only most people, as Hunt states, but probably everyone expects doctors not to walk away from suffering, dying patients. But do they expect most doctors also to provide euthanasia? Moreover, is this approach likely to cause confusion? Something with which we all agree – the primary obligation of personal care that physicians owe to their patients – is inextricably linked with euthanasia through language and sentence structure. This link is created by the word “it,” which refers both to doctors not walking away and to voluntary active euthanasia.

The term itself and the fact that it has been reduced to an acronym (VAE) are noteworthy. Does the acronym make euthanasia seem less threatening, more familiar, and ordinary? The terms “passive euthanasia” and, less often, “voluntary passive euthanasia” are used by people who are pro-euthanasia to describe withdrawals or refusals of treatment that result in death. They argue that if these procedures are morally and legally acceptable – as most people who are against euthanasia agree they are, provided various conditions are fulfilled – these same people should agree that euthanasia is acceptable. In other words, they contend that all these interventions constitute euthanasia and that it should make no ethical or legal difference whether it is done by passive or by active means. In contrast, those who are anti-euthanasia base their case on the proposition that there are long-established, well-understood, profound, and important differences between allowing people to die and making them die – putting them to death.

To be consistent with this position, and to avoid confusion as to what is and what is not euthanasia, they oppose the use of the term “passive euthanasia” to describe justified withdrawals of treatment that will result in death.

Then, too, there can be confusion about what dying people mean to communicate by their language. Many people, at some stage of terminal illness, express the wish to die. Indeed, accepting death could be an important part of the dying process. This acceptance is very different from wanting to be killed. We need to keep this distinction in mind when assessing whether people are really asking for euthanasia. Even if they are, we need to be certain that this is not a way of asking some other question or of seeking reassurance and comfort. Some people worry, for example, about being unbearable burdens on caregivers or about being abandoned.

A striking example of different interpretations of what dying patients communicate has been the focus of considerable controversy. In an article published in the Journal of the American Medical Association, Dr. Herbert Hendin and his colleagues comment on a Dutch study of euthanasia carried out by Dr. Gerrit van der Wal and others (of which a summary account was published in the New England Journal of Medicine). Hendin and his co-authors point out that, in 1995, there were more than 1,500 Dutch cases of doctors administering lethal doses of opiates to patients with the intention of killing them. In the vast majority of these cases, “no request for death was made by the patient,” although some patients were mentally competent and could have made known their desires. In a press interview, van der Wal confirmed that “no request for death was made by the patient in these cases,” though he added that “doctors had received previous approval to administer opiates.” Requests to do whatever was necessary to ease pain had been made by the patients at some point. In short, the best reading of this situation, from the point of view of the physicians involved, was that they interpreted a request for pain-relief treatment as these patients’ consent to being killed. The alternative is that these physicians simply decided, despite the Dutch guidelines that applied at the time, that the patients’ consent to euthanasia was irrelevant.

Interpreting patients’ requests for pain-relief treatment as requests for euthanasia has a worrying flip-side that could augment one effect of the legalization of euthanasia: it can cause patients to refuse opiates they desperately need for the relief of pain because they are frightened of being killed. This outcome reportedly happened after the legalization of euthanasia in the Northern Territory of Australia. It could raise similar concerns for people who live in jurisdictions where euthanasia is still prohibited. Consequently, even those who are pro-euthanasia should oppose the use of pain-relief medication as a way of carrying out euthanasia because the latter can deliver a message that results in terminally ill people, who are frightened of being subjected to euthanasia or who are morally opposed to it, depriving themselves of essential pain-relief treatment.
Confusion in Association

Describing euthanasia as simply the “final stage of good palliative care,”20 and thereby associating it with this kind of care, can affect our impression of euthanasia and our reaction to it. Although not everyone agrees on all aspects of what constitutes the best palliative care, it would be surprising to find disagreement with its underlying objectives: the relief of pain and suffering and the provision of humane and compassionate care for dying people. If, then, as the pro-euthanasia argument goes, euthanasia is simply another example of good palliative care, why would anyone oppose it?

Proposing that euthanasia is just one part of good palliative care is an example of putting a “medical cloak” on euthanasia. Doing so makes euthanasia a medical issue concerning primarily individual patients, their families, and their physicians. We bury or ignore the fact that euthanasia is equally important as a philosophical and societal issue. One way to identify the effects of this medical-cloak confusion is to ask, as has been proposed, whether we should have a specially trained group of lawyers, rather than physicians, carry out euthanasia.21 This process would make us disconnect assumptions about euthanasia from those about physicians and the medical context. In general, we say that physicians seek to do no harm; medical treatment is involved when physicians intervene; and the medical context is an ethical and safe forum. These assumptions about physicians, when applied to physicians carrying out euthanasia, can make euthanasia seem acceptable. I have observed, anecdotally, that some of the same people who strongly object to describing euthanasia as killing also object to the suggestion that lawyers be authorized to administer euthanasia; it would be unacceptable, they argue, to permit lawyers to kill people. It could be that what we decide about euthanasia would be the same whether we make the decision within or beyond the medical context – as, primarily, a medical or a non-medical matter. The point is, however, that we cannot afford simply to assume that this result will be the case.

Confusion of association arises in some survey instruments in which the questions asked inextricably link euthanasia and the provision of adequate pain-relief treatment. People are asked whether they agree that a terminally ill person in great pain and suffering should be allowed to request a lethal injection. There are at least three problems here. First, respondents’ emotional responses to the thought of leaving people in pain can colour their responses to euthanasia and make them more favourable to it than they would otherwise be. Second, the only response provided for in some questionnaires is either to agree or to disagree with both euthanasia and pain-relief treatment that will shorten life. There is no way to record agreement with pain-relief treatment but to reject euthanasia; respondents must accept or reject “the package.” Third, this approach confuses euthanasia with pain-relief treatment that will shorten life; it can be an example of such treatment being defined as euthanasia.

Yet another source of confusion is the association between religion and opposition to euthanasia. An argument often used by those who are pro-euthanasia is that those who oppose it do so essentially on religious grounds. Although it is true that some people do oppose euthanasia because of their religious beliefs, there seems to be a reluctance to admit that there are good secular reasons to oppose euthanasia. Less frequently, confusion can also be caused by automatically associating being pro-euthanasia with being anti-religion. In some religious denominations, even members of the clergy are pro-euthanasia.22 I do not intend to deny that people’s religious stance can influence their views on euthanasia, but we should be careful before assuming so. Even more important, we should avoid devaluing or dismissing views just because they are associated with religious beliefs. We are usually sensitive, today, to religious bigotry, but we are not always as sensitive to anti-religious bigotry.

Still another confusion of association is that between individualism and a sense of personal identity. We could need a sense of personal identity most when we are dying. It would help to give us a sense that our lives have had meaning, which we probably need to die peacefully. Currently, many people seek a sense of personal identity through “intense individualism,” especially through its dominant feature of providing a sense of being in control. Euthanasia shares this feature with intense individualism; it is a very powerful expression of seeking control. Most people, however, probably cannot find a sense of personal identity in intense individualism. They need to find it in a structure of complex human relationships, including those that can be created only by feeling that one is a member of a community. As Isaiah Berlin says, “I am [at least in some important respects] what I see of myself reflected in the eyes of other people.”23 In short, paradoxically, we might be able to find full individual identity only by participating in communities – by immersing individuality in the greater whole. This need for community to be fully human individually brings us face to face with a major problem in many contemporary Western societies: the loss of a sense of community.

Loss of community might also be a causal factor in the emergence of the euthanasia debate. Death no longer occurs in the community. It is no longer surrounded by tradition, ritual, and ceremony. Dying people are often isolated, even to the extent that they can suffer intense
"pre-mortem loneliness," to repeat Jay Katz’s arresting description. Death is often sterilized, deritualized, and dehumanized. Euthanasia might be a complex response to this postmodern social reality. It accommodates an approach to death that is highly individualistic but, at the same time, surrounded by ritual explicitly associated with this way of dying.

**CONFUSION IN ETHICAL AND LEGAL ANALYSIS**

**Confusion of Means and Ends**

There is also confusion between the ethical and legal acceptability of some outcomes and of the means used to achieve them. The strongest version of the pro-euthanasia argument, in this respect, is the following: if death is inevitable and imminent for someone who wants and consents to euthanasia, then providing it is no different from withdrawing life-support treatment from someone who refuses it and dies as a result. In both cases, the argument goes, death is the outcome; the means used to achieve it are not morally distinguishable and should not be legally distinguished; it is inconsistent, they continue, to support the ethical and legal acceptability of some withdrawals of treatment that result in death, but not euthanasia by lethal injection. To summarize: there is no ethical or moral difference between death resulting from a refusal of treatment and death resulting from a lethal injection, and there ought to be no legal difference. Applied to physician-assisted suicide, properly so-called, this argument becomes the following: in refusing treatment that results in death, a person commits suicide; there is no moral or ethical reason to distinguish this process from physician-assisted suicide; therefore, these two situations should be treated in the same way by the law.

In contrast, those who are anti-euthanasia argue that there really is a moral and ethical difference between accepting refusals of treatment, even if doing so results in death, and giving lethal injections or assisting people in committing suicide; therefore, the legal difference between these situations should be maintained. They argue that the way in which death occurs is a morally relevant issue: the law should continue to reflect that some of these means are morally and ethically acceptable, but others – euthanasia and physician-assisted suicide – are not.

One example of the confusion of means and ends being used in support of euthanasia can be found in the article “Slow Euthanasia,” by physicians J.A. Billings and S.D. Block. They state that physicians frequently “hasten death slowly with a morphine drip,” which they describe as “slow euthanasia.” They argue that it would be better for everyone – patients, families, and physicians – and more honest to accept “rapid euthanasia.” To reach this conclusion, they downplay the relevance of intention in giving treatment that could or even would shorten life. For instance, they equate pain-relief treatment that could have this effect, but which is given with the primary intention of relieving pain, and injections given with the primary intention of killing. They do so by characterizing the means used in both situations as humane and ethical treatment of dying patients (that is, in such a way that they are the same) and point out that the same end – the deaths of patients – results in both situations. As part of this approach they define euthanasia to include necessary pain-relief treatment that will shorten life, and reject the doctrine of “double effect as an unconvincing justification for [this form of] euthanasia.”

This article elicited several responses. According to these comments, Billings and Block have failed to appreciate important ethical and legal distinctions that inform not only the law on euthanasia but also the law in general – especially the criminal law. For instance, if doctors hang morphine drips with the primary intention of killing patients, not with the primary intention of relieving their pain, this act would be euthanasia and it would be prohibited as such. But if the drips are needed to relieve pain and the primary intention is “to kill the patient,” the law would not regard it as euthanasia. Necessary pain relief treatment that shortens life would be justified under the doctrine of double effect. This legal doctrine requires, first, that the act resulting in a bad consequence, the shortening of life, is morally neutral. Providing pain-relief treatment would qualify. Second, the pain relief must not be achieved by shortening life – that is, through a bad consequence. Third, the bad consequence, the shortening of life, must not be primarily intended as either an end or a means; rather, the primary intent must be the legitimate aim of relieving pain. And, fourth, there must be no other reasonable way of achieving the pain relief without involving the undesired effect of shortening life; the proportionality of good and bad consequences required to justify the bad ones must be present. As Bernard Dickens says, Billings and Block “apply an outcome oriented test that simply links a physician’s use of medications with their inevitable effect regardless of immediate intent. However, intent is at the centre of ethical and legal judgments in this area, not a secondary or marginal concern unworthy of regard in ethical [or legal] analysis as the authors mildly acknowledge.”

To summarize, some of the confusion between euthanasia and pain-relief treatment or refusals of treatment that could or would shorten life is caused by focusing on the outcome, death, and arguing that if
someone is terminally ill, it is morally and ethically irrelevant — and should be legally irrelevant — how this outcome occurs. The central issue in the euthanasia debate is not the outcome — death; it is not if we will die, because we all eventually die, but how we die and whether some ways of dying — physician-assisted suicide and euthanasia — ought to remain legally prohibited. To respond, we must examine in greater detail the role that physicians’ intentions play in drawing the line between acceptable and unacceptable medical interventions that could or would shorten life.

Confusion of Intent

A fundamental principle in criminal law is that a crime requires both a criminal act, an actus reus — conduct that the definition of the crime requires to have occurred — and an accompanying criminal mind, a mens rea. In general, the latter is constituted by having an intention to cause the prohibited outcome. Classically, someone is held to have intended an outcome that results from his or her conduct in either of two situations: the outcome is a certain, or almost certain, result of the conduct in question, and the person knows this connection; or the outcome is less certain, but the person wants it to occur. In general, motive is irrelevant in deciding whether mens rea is present, though there are exceptions to this rule. Recently, some courts have taken a more straightforward approach. They have held that, in criminal law, intention bears its ordinary meaning of aim or purpose; foresight of even certain consequences is, at best, merely evidence from which purpose might — or might not — be inferred by the jury.

But even in jurisdictions in which courts use the more stringent, classical approach to intent, when the motive is to relieve pain and not to kill, a mens rea of intention to kill is not taken into account by the criminal law, even though it would otherwise be present in giving necessary pain-relief treatment that would shorten life. These cases fall within the exception to the classical rule that motive is irrelevant to intent. Because there is no motive to kill the patient, there is no criminal mens rea. Giving pain-relief treatment is not the actus reus of a culpable homicide, moreover, because it is not an unlawful act causing death, as required for that crime. Likewise, one way in which the law justifies the legality of withdrawing treatment that results in death, as compared with the illegality of physician-assisted suicide or euthanasia, is through a distinction with respect to intention. In physician-assisted suicide and euthanasia, the primary intent is to cause death. In withdrawing life-support treatment that patients have refused, the primary intent is not to cause death but to respect the right to inviolability, the right of patients not to be touched without their consent. That includes the right not to have treatment applied to them without their informed consent. Indeed, it would be a criminal assault to continue treatment that patients have refused.

But if life-support treatment were withdrawn from incompetent patients who had not previously refused it (or whose substitute decision-maker had not validly done so), there is a potential for criminal liability. Once again, intent would be relevant in deciding whether this liability would be imposed. If the treatment were withdrawn because it was medically futile, there would be no criminal liability; if it were not medically futile and was withdrawn with the primary intent of killing, this act would constitute the crime of homicide. And that, depending on the circumstances and the definition of euthanasia used, might or might not be classified also as euthanasia. In short, a primary intent to kill is never legally acceptable. An intent of allowing to die might or might not be legally acceptable, depending on all the circumstances.

Legal immunity for administering necessary pain-relief treatment, given with the primary intention of relieving pain but with the knowledge that it could or would shorten life, is implemented through the doctrine of double effect. One way of viewing this doctrine is that it allows motive or primary intent to negate a mens rea of intention to kill, which would otherwise be present. The doctrine of double effect could be regarded as functioning also as the law’s way of building into the requirements of the actus reus the absence of elements that otherwise could function as a defence of necessity. In the context of providing necessary pain-relief treatment that would shorten life, this defence can be articulated as follows: the necessity of using some means to relieve pain justifies the use of these means even though the undesired result of doing so would be the shortening of life. Transferred into the context of actus reus, the elements of this defence are as follows: the actus reus of a culpable homicide is absent if the act causing death was the administration of treatment necessary to relieve pain. This is a strained analysis. Why does the law not just apply necessity as a defence?

I can think of at least two reasons. First, there could be an important aim of not raising the spectre of criminal liability in the context of providing fully adequate pain-relief treatment; fear of attracting criminal liability could make physicians reluctant to treat pain. As a true defence, necessity operates by way of “confession and avoidance,” which means that it raises the possibility of criminal liability. The actor confesses to an act that attracts criminal liability and then avoids liability for it by proving all the essential elements for a defence of necessity. Second, there is probably concern not to open up the defence of
necessity in the context of medical treatment at the end of life for fear that it could be extended to apply to euthanasia. That can be achieved by using the absence of “necessity” as a necessary element of the actus reus of any crime associated with the giving of pain-relief treatment rather than by using necessity as a defence in these circumstances. Indeed, those who are pro-euthanasia do argue that a defence of necessity should apply to the provision of euthanasia, as the Dutch courts have held.

Responses to this proposition by those opposed to euthanasia are of two kinds. First, they argue that a defence of necessity has never been applied to allow the taking of human life except when that could be justified on the grounds that it was necessary to save one’s own life (that is, as self-defence) or to protect the lives of others. Second, they point out, difficult as it can be to accept, that we cannot eliminate all suffering, that we should not seek to eliminate it by inflicting death, and that euthanasia is unnecessary for the relief of pain. In extreme cases, pain relief can be achieved in ways that do not involve killing patients. Total sedation is one. This option makes it very unlikely that a court would hold that a defence of necessity would apply to justify euthanasia as a way of relieving pain.

The use of total sedation in the case of dying patients is yet another issue that raises complex moral, ethical, and legal problems. These issues cannot be explored here, but, as the Canadian Parliament’s Special Senate Committee on Euthanasia and Assisted Suicide recommended, they need a need for in-depth research. In a few rare cases, when patients are receiving good palliative care, but all other measures to relieve pain or other symptoms of unbearable physical suffering have failed, total sedation could be the treatment of choice — one that is ethically and legally acceptable. There should be serious concern, however, if the number of these cases in a given unit were more than a very few. It would be a strong indication that the treatment was, in fact, being used as a form of slow euthanasia, properly so-called. Moreover, as in other areas of the euthanasia debate, choice of language can have a profound effect on the way we view total sedation. Some people who are pro-euthanasia have decried their opponents’ willingness to approve of people dying in a state of “pharmacological stupor,” while being unwilling to permit lethal injections. Although we might not agree with the substance of the arguments that these criticisms reflect, they contain a valid warning of the need for all of us, including those who are anti-euthanasia, to question constantly the essential nature, moral and ethical integrity, and consistency of our actions, values, and beliefs concerning end-of-life decision-making.

Returning to intent, there is probably no mens rea of intention when pain-relief treatment that only might shorten life is given, because the outcome might not be certain enough to be intended and death is not a desired outcome. Alternatively, there might be a mens rea of recklessness — conscious, unjustified risk-taking — that would support a charge of manslaughter and even, in some circumstances in some jurisdictions, murder. But when the risk-taking with respect to shortening life is the only way to relieve pain, it is most unlikely to be considered unjustified; therefore, there would be no mens rea of recklessness.

Those who are pro-euthanasia argue that it is impossible in many cases to know whether the primary intent is to relieve pain or to kill patients — or, indeed, that both aims could be present concurrently. It might not seem possible to know in some cases. But keep in mind that juries in criminal trials are asked to make these determinations with respect to intent every day. Even if the task proves difficult in some cases, it does not lessen the importance of making a distinction between these different primary intents and recognising the impact beyond individual cases that changing this approach would have. The criminal law is an important value-forming, value-upholding institution. Changing it, therefore, would have important effects on values. The present legal approach to giving treatment that is necessary to relieve pain, but could or would shorten life, distinguishes a primary intent to relieve pain from a primary intent to kill and imposes criminal liability only when the latter is present. This means that society can maintain its most important fundamental norm — that we must not kill each other — while still allowing physicians to relieve pain. It is essential that we do both, which we could not do if we legalize euthanasia.

Confusion of Causation

Physicians often describe themselves as being deeply confused by the law’s approach to the presence or absence of causation with respect to death resulting from a withdrawal of life support treatment, for example, as compared with the administration of a lethal injection. This confusion is not surprising. Causation is a complex, technical, and nuanced area of legal theory. It can be confusing even for lawyers. The legal concept of causation and its application to decision-making at the end of life in a medical context is explored in this section.

Some confusion in understanding the law’s approach to causation when death occurs as a result of a refusal of treatment, as compared with a lethal injection, has been introduced by those in favour of euthanasia. They argue that distinctions made between these two situations are artificial with respect to causation. They contend that, in both
cases, the "but for" test – the law's test for causation-in-fact – shows that the physician's act was responsible for the patient's death. But for the withdrawal of treatment, the patient would not have died; therefore, withdrawal of treatment was the cause of death. But for the lethal injection, the patient would not have died; therefore, the lethal injection was the cause of death. This approach contains confusion of at least two kinds.

First, an analysis of causation becomes relevant in criminal law only when there is conduct that could constitute a crime, accompanied by the required mens rea. The question is, then, whether that conduct caused the prohibited outcome. In the case of a patient's refusal of treatment and the withdrawal of treatment after that refusal, there is no illegal act of which a causal link to the outcome must be established in order to impose criminal liability. But when a physician gives a lethal injection (which, in itself, constitutes the actus reus of a crime) and agrees that this action was accompanied by an intention to kill (the required mens rea), it is relevant to ask whether this lethal injection was the cause of death. But for the lethal injection, would the patient have died at that time? Only if it is proved beyond a reasonable doubt that the injection was the cause of death is the physician criminally liable. To find criminal liability, in other words, causation is an essential requirement that must be established as part of the actus reus and in addition to mens rea. It is not a factor that, standing alone, gives rise to liability. Hence the argument that a physician "caused" a patient's death either in turning off a respirator following the refusal of treatment or in giving a lethal injection – and, therefore, that both cases should be treated alike in terms of criminal responsibility – fails to understand or to apply some of the most basic tenets of criminal law.

The second confusion is that those who are pro-euthanasia assume that the "but for" test must always be applied. The law sometimes recognizes causal connections without this test being satisfied, however, and it ignores some connections that would be established under it. Moreover, in the case of a refusal of treatment that results in death, the "but for" test is complicated because there is not a sole cause of death. There are two causes: the patient's underlying condition and the removal of life support. If the "but for" question were framed simply in relation to the patient's condition that gives rise to the need for life support – “But for the underlying condition, would the patient have died when taken off the life support?” – and the answer is no (as it is when people are dependent on life support), then it is the patient's underlying condition (natural causes) that caused death, for the purposes of the law, not removal of the respirator. But when should the question be framed in this way?

When many causes are present, a value judgment is involved in choosing which formulation of the “but for” test predominates in establishing causation-in-fact, and which of the causal factors – one, more than one, or all of them (each of which could attract legal liability) – count in establishing criminal liability. When one has a duty not to continue treating patients with artificial life support, because they have refused it or because it is medically futile, then it is inappropriate to formulate the test of causation (even if it were relevant to assess causation itself, which it is not if the act of withdrawing treatment is legal) in terms of whether death was caused by the withdrawal of treatment. Physicians cannot have a legal obligation both to withdraw treatment and not to withdraw it. We must choose which of these duties predominates in each situation. If the former, then the relevant test for the cause of death is this: But for the underlying condition, would the patient have died? If the latter, it is this: But for turning off the respirator, would the patient have died?

Yet another approach is to recognize that the withdrawal of life-support treatment such as respirator support involves a situation of multiple causation in which one cause (respiratory failure) is, in itself, sufficient to cause death; the other cause (turning off the respirator) is not sufficient in the absence of respiratory failure. Although the courts could still hold the latter to be a cause for the purposes of the law (a contributing cause) – and would do so when turning off the respirator constitutes an illegal act – they do not do so when the act of turning it off is legal. Although causation is irrelevant in the latter circumstance, paradoxically, at first glance, the courts have often taken pains to justify their decisions not to impose criminal liability in these cases, from the point of view of causation; they hold that, from the law's perspective, turning off the respirator was not the cause of death. We could speculate on the psychological reasons that make judges feel compelled to offer this explanation. Most probably, however, the courts have found it necessary to rule that death results from natural causes in respirator cases for two reasons: to distinguish these cases from lethal-injection cases; and to avoid any possibility that they could be seen as setting a precedent to the effect that lethal injections would be legally acceptable.

It is clear in tort cases that cause-in-fact (the test for which in single-cause cases is most often “but for”) does not, by itself, establish causation for the purposes of legal liability. Cause-in-law, causus causans, is required as well. It is sometimes referred to as the "essential" cause or causes, if any, among the causes-in-fact, that will be regarded as the cause by the law. Although this second aspect of causation, "causation as a question of law," is relevant in criminal law, it is seldom openly
discussed in that context. When it is, the courts and commentators recognize the hesitancy and uncertainty that surround its definition and application. These difficulties are probably associated with fear that open use of the doctrine could give the impression that a finding of causation, and hence of criminal liability, is discretionary on the part of the judge. The same fear is absent, at least to the same degree, in imposing civil liability in tort cases; in this context, the concept is constantly identified and used. Indeed, on occasion, criminal law judges have turned to tort law cases to clarify and explain cause-in-law. Consequently, it is worth examining how this concept functions in that area.

In the law of civil responsibility—tort law—the tests for causation-in-law are of varying degrees of stringency. The test that most favours liability is that causation-in-law will be present for those consequences whose risk of occurrence would not be foreseeable to reasonable people in the same circumstances. The Privy Council described what constituted this kind of foreseeable risk as “one which would occur to the mind of a reasonable man in the [same] position ... which he would not brush aside as far-fetched.” A test that favours liability less is that causation-in-law will be present only for those consequences whose risk of occurrence a reasonable person in the same circumstances would have reasonably foreseen. The two tests can give different results because a risk that is not reasonably foreseeable (causation-in-law would be absent under the latter test) might not be unforeseeable (causation-in-law would be present under the former test). A causal test of directness, too—how directly the resulting harm is linked with the wrongful conduct—though no longer a sufficient test of causation-in-law, can play a role in assessing this element.

In the context of criminal law, the test of causation that most favours the accused would be used, as there is a presumption in the law against imposing criminal liability. Consequently, an accused person must have subjectively foreseen the outcome of the conduct that gives rise to criminal liability, or the risk of this occurring (though not the exact way in which this outcome results), in order to be held causally responsible for that outcome. Subjective foreseeability of the consequences, rather than objective foreseeability (as in civil law), is necessary because, as discussed previously, mens rea is an essential element in imposing criminal liability. Indeed, the requirements of mens rea mean that some elements necessary to establish causation overlap with those necessary for intention. Moreover, when the prohibited outcome results from crystallization of a risk, the likelihood of occurrence of that risk (in practice though not in theory) must probably be higher in criminal law than in civil law for it to be characterized as reasonably foreseeable within the context of proving causation. Again, this is because there is a presumption of innocence in favour of accused people, which means that all doubt must be resolved in their favour.

In the context of criminal law, Colvin summarizes the situation relating to causation as follows:

In the common law, two different general tests have been used in handling questions of causal responsibility. They will here be called the “substantial cause” test and the “reasonable foreseeability” test. The “substantial cause” test is a retrospective test. It involves looking backwards from a result in order to determine whether, in the light of all that happened, a particular causal factor has played a substantial role in bringing about that result. In contrast, the “reasonable foreseeability” test is a prospective test. It involves adopting the position of the person who was alleged to have caused the result and then looking forward from the conduct towards the result. The question is asked whether or not the conduct made the result a reasonably foreseeable consequence, in the sense that it was within the normal range of expected outcomes. Each of these tests carries a good deal of judicial support. In most instances they yield the same outcomes but divergences are possible. Unfortunately the courts have avoided confronting the differences between the tests. Cases are handled by reference to one or the other, with the alternative usually being ignored. If the alternative is recognized at all, the choice which has been made is usually not defended.

We can apply these tests of causal responsibility to death resulting either from the withdrawal of life-support treatment that the patient has refused or from the administration of a lethal injection. Death is a reasonably foreseeable result of withdrawing the treatment, but the courts have consistently held that consented-to withdrawals are not the substantial cause of death. Death is a reasonably foreseeable—in fact, certain—result of lethal injection, too. But one cannot imagine a court holding, when there is proof beyond a reasonable doubt that death resulted from the injection, that it was not the substantial cause of death.

In tort cases, in deciding whether causation-in-law is present, judges sometimes talk about needing to determine the proximity or remoteness of the damage from the cause. This requirement can be regarded simply as another way of expressing the foreseeability-of-consequences test of causation or as an additional test that must be fulfilled to establish causation-in-law. The words “proximity” or “remoteness” accurately connote that, to a greater or lesser extent, this test involves an exercise of judicial discretion in making a finding as to causation. The test can be regarded as a device that allows a judge to factor into the
decision-making a determination as to moral blameworthiness. It allows a judge to find that, even though causation-in-fact is established, causation is absent in a particular case if blameworthiness is low or absent. The words “proximity” and “remoteness” are seldom used by courts in ruling on causation in criminal-law cases.\(^{57}\) This judicial reservation is probably, again, due to these words – and any concepts they represent – strongly implying a discretionary component in the decision about causation: the identified exercise of discretion is much more carefully constrained in the context of criminal culpability than of civil liability.

It is important to note how the tests of remoteness or proximity interact with the causation-in-fact or “but for” test. “What is meant by ‘proximate’ is that because of convenience, of public policy, or a rough sense of justice, the law arbitrarily declines to trace a series of events beyond a certain point. This is not logic. It is practical politics.”\(^{58}\) In summary, even if “but for” the act the outcome would not have occurred, the court can still find that, in the eyes of the law, there is no causal link between that act and that outcome. We can speculate on whether the concepts of remoteness and proximity could help to explain the different findings on causation in relation to death resulting from the refusal of life support treatment and that resulting from a lethal injection. What role does the absence of moral blameworthiness play in finding that the withdrawal of life support does not cause death? Or does the presence of natural causes and the fact that death would not result in the absence of these causes make death from a refusal of treatment remote from, not proximate enough to, the withdrawal of that treatment? The same analysis would not apply to death from a lethal injection.

Public policy, another test that involves an exercise of discretion, may also be used in tort law to justify a finding that causation is absent, although judges have classically been reluctant to use it because of its perceived nature as “an unruly horse.”\(^{59}\) This test is sometimes articulated as an element in assessing cause-in-law or as a part of the test for proximity or remoteness, but it is best viewed as an additional test. It is used to find that, for reasons of public policy, causation is absent. But it is not used to find the contrary – that for reasons of public policy, causation is present. In other words, when called into play as an element of the doctrine of causation, public policy operates only to provide immunity from legal liability, not to impose it. Once again we can speculate whether there is an element of public policy at play in finding that causation is absent when death results from withdrawal of treatment following a patient’s request, but this same element is not operative when death results from a lethal injection.

It is worth noting here that, outside the context of causation, the notion of public policy plays a special role in criminal law when it is used to characterize acts to which the consent of those affected by them may or may not function as a defence. For instance, the intentional infliction of bodily harm, beyond a very limited degree, is held to be contrary to public policy. Therefore, in the common law, the consent of those suffering from that harm is not a defence.\(^{60}\) In contrast, consent to an act of minimal harm that is not deemed contrary to public policy protects the person inflicting the harm from a charge of criminal assault.

In this respect, we can compare an act of turning off a respirator on which someone depends for life support with that of giving a lethal injection. Turning off a respirator is not, in itself, contrary to public policy. Therefore, one way to justify it is with the patient’s consent at that time or in advance, or, if the patient is incompetent and has not left advance directives, with the consent of a legally valid substitute decision-maker. But giving a lethal injection is, in itself, contrary to public policy. Therefore, consent is irrelevant to criminal liability. This scenario raises the question of how necessary pain-relief treatment, given with the primary intention of relieving pain but with the possibility or expectation of shortening life, should be characterized from a public policy perspective. Just as the intent to relieve pain and not to kill justifies, through the doctrine of double effect, the administration of treatment, this same intent legitimates it from a public policy perspective. Therefore, it can be given with the patient’s consent. Indeed, not doing so should be considered contrary to public policy.

This discussion, as a whole, raises the sometimes vexed question of judicial discretion and the role it should play in determining legal liability. Views differ, depending on how the exercise of that discretion is characterized. There is a major difference between identifying it as an example of purely arbitrary decision-making on the part of the judge and characterizing it as the judge’s use not only of pure reason but also of additional “ways of knowing.” Judges in both the Supreme Court of Canada and United States Supreme Court, for example, found that a legislative ban on assisted suicide, which includes physician-assisted suicide, was not unconstitutional. To support their ruling, they looked to the history of their respective countries, including their legal and legislative histories – that is, to human memory as a “way of knowing.” Memory was used to balance a strictly reasoned argument that there was no moral, and ought to be no legal, difference “between letting a patient die and making that patient die,”\(^{61}\) allowing the courts to find that there were important, profound, and well-established differences.
Confusion of Case Law

I turn now to an article published in the *Lancet* – yet another argument, based on confusion, for the legalization of euthanasia. J.K. Mason and D. Mulligan propose that euthanasia be introduced by stages.\(^{59}\) It should be made available first, they say, for people suffering from specific conditions.\(^{55}\) The two conditions they suggest are permanent vegetative state and progressive neurological disease. In making this proposal, the two authors decry the fact that “the rhetoric of euthanasia is blurred,” and then proceed to add confusion. In this instance, the confusion resides in their interpretation of two Canadian judgments. They argue that the courts, in these cases, were moving towards support for euthanasia. One of these cases, *Nancy B*\(^{34}\) involved a refusal of treatment that resulted in death. In the other, *Rodriguez*,\(^{25}\) as discussed in previous chapters, the Supreme Court of Canada was faced with a claim that the Canadian Criminal Code’s prohibition of assisting a person to commit suicide,\(^{66}\) which includes physician-assisted suicide, contravenes constitutional rights to liberty and security of the person. In other words, this latter case involved the court adjudicating a claim that terminally ill people have a constitutionally protected right to the assistance of physicians in committing suicide.

Mason and Mulligan first recognize that medically futile treatment may be withheld or withdrawn from patients in a permanent vegetative state. I have already mentioned in passing the terms “medically futile treatment” and “futile treatment,” which are sometimes used interchangeably, are difficult to define, and whose identification often involves value judgments. There is no ethical or legal obligation to continue giving medically useless treatment. Indeed, at least in publicly funded health-care systems, there is an ethical obligation not to waste scarce health-care resources, which such treatment would involve. Therefore, we must not avoid the need to make decisions as to when treatment becomes medically futile.\(^{67}\) Provided that care is taken to limit strictly the definition of what constitutes medically futile treatment in any given case, most people who are anti-euthanasia would agree that treatment may be withdrawn. They would not agree, however, that this constitutes either euthanasia or, as Mason and Mulligan propose, a basis for its approval.

There is another way in which confusion between the withholding or withdrawal of treatment and euthanasia can arise. It involves cases in which either withholding or withdrawing treatment would constitute euthanasia. For instance, to withhold or withdraw life-support treatment from someone who has always been mentally incompetent, with the primary intention of inflicting death, rather than on the basis that any reasonable physician would agree that the treatment was medically futile, would be, at best, euthanasia.\(^{58}\) As this example demonstrates, and as I have already noted, it is not only what we do but also our reasons for doing so that are important in defining whether conduct constitutes euthanasia. Moreover, it is these reasons, and not simply the outcome of any given decision, that will set the precedents for what is legally allowed or prohibited.

Mason and Mulligan base their case for introducing “euthanasia by stages” on their finding “strong indications that courts and law enforcement authorities outside the United Kingdom are coming to accept the practice [of euthanasia and physician-assisted suicide].”\(^{50}\) As I have said, they cite as authority for this proposition two relatively recent Canadian cases, the decision of the Superior Court of Quebec in *Nancy B*\(^{20}\) and the Supreme Court of Canada in *Rodriguez.*\(^{77}\) Nancy B involved withdrawal of life support. It is important to understand the legal basis on which the court allowed withdrawal of medical treatment, therefore, in order to know whether the court was, as Mason and Mulligan assert, in fact tending towards support for euthanasia or, more accurately, physician-assisted suicide. *Rodriguez* involved a claim that prohibiting physician-assisted suicide contravenes individual rights protected under the Canadian Constitution. For the same reasons, it is important to understand the law on which this claim was founded, and that on which the judgments handed down in the Supreme Court of Canada were based.

*Nancy B* required the court to apply the Civil Code of Quebec (private law in Quebec is governed under a civil law regime, as in France). The Civil Code provides that “the human person is inviolable,” that is, not allowed to be touched without the person’s consent.\(^{74}\) The code expresses, in addition, that medical care or treatment must not be given to a competent person without that person’s free and informed consent.\(^{75}\) Nancy B had suffered irreversible respiratory paralysis as a result of Guillain-Barre syndrome and was dependent on a respirator. She asked for this life-support treatment to be discontinued. The court affirmed Nancy B’s right to refuse treatment, even though doing so would result in her death.

The court held that the duty to respect a refusal of treatment is almost absolute in the case of a competent adult person.\(^{74}\) It found that Nancy B wanted “the respiratory support treatment being given to her to cease so that nature can take its course.”\(^{75}\) It ruled that this “may properly be viewed as an attempt to commit suicide ... [because] [death] ... would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.”\(^{77}\) In particular, the court found that turning off the respirator would not offend any provisions of the
Canadian Criminal Code (which is based on the common law), because it would involve no act that would constitute homicide or assistance with suicide. The judge concluded "that homicide and suicide are not natural deaths whereas in the present case, if the plaintiff's [Nancy B's] death take place after the respiratory support treatment is stopped at her request, it would be the result of nature taking its course."

In Rodriguez, all judges of the Supreme Court of Canada strongly upheld the right to refuse treatment — in particular, on the basis of respect for the person's right to inviolability — but, just as strongly, a majority differentiated this ruling from any right to have assistance in committing suicide or access to euthanasia. The technical legal basis of the majority's judgment was that the prohibition on assisting in suicide in subsection 241(b) of the Criminal Code was constitutionally valid; assistance could be interdicted by Parliament through the criminal law. In coming to this conclusion, the majority analyzed the relevant sections of the Canadian Charter of Rights and Freedoms, that part of Canadian constitutional law that allows people to challenge the validity of legislation on the grounds that it contravenes the individual's constitutionally protected rights. To support their decision, though, the majority extensively explored the history of prohibitions on assisting in suicide, the approaches of other jurisdictions, and the common law governing medical decisions at the end of life.

Of the four dissenting judges in Rodriguez, who held that the prohibition on physician-assisted suicide was constitutionally invalid, the judgment of the chief justice of Canada was the most unprecedented. Chief Justice Lamer ruled that there is a "right to choose suicide," enshrined within Canadian constitutional law; a failure to provide assistance in committing suicide to patients who are physically unable to carry it out themselves contravenes constitutional rights against discrimination on the basis of physical handicap legislated in section 15 of the Canadian Charter of Rights and Freedoms. It was essential to Chief Justice Lamer's ruling that the prohibition of assisted suicide in the Criminal Code was unconstitutional. In order to find that, he had to find a right of the plaintiff with respect to having assistance to commit suicide; that this right was infringed as a result of discrimination; and that this discrimination flowed from the prohibition on assisting someone to commit suicide. The chief justice found that under the Charter and in the common law, the rights of the individual to self-determination and autonomy give rise to a "right to choose, in accordance with the law, how to conduct one's own life." Moreover, in view of the fact that Parliament had repealed the legislation making suicide a crime — which, the chief justice said, made suicide legal — he ruled that this right to choose extended to a right to choose suicide. There is no necessary reason to suppose that this "right to choose suicide" would be limited to people who are terminally ill, as Chief Justice Lamer himself recognises, or even to people who are ill. In fact, the contrary could be argued, since the chief justice based this right to choose suicide on the general rights of all individuals to self-determination and autonomy. This reasoning also raises the question of whether providing emergency medical care for patients who have attempted suicide and are unconscious or incompetent, or those who refuse medical treatment to ameliorate the consequences of their attempts (which raises difficult and complex ethical and legal questions), could contravene this right were a majority to recognize its existence.

This brief mention of some complex questions raised in the long judgment of the Supreme Court of Canada in Rodriguez can be contrasted with Mason and Mulligan's use of the case to support their proposal for legalizing physician-assisted suicide. They state that "the arguments [by which they seem to mean the reasons of the majority of the Supreme Court of Canada, in upholding the constitutional validity of the crime of assisted suicide] were ... based very largely on Canadian constitutional law and the dissenting opinions [which would have allowed physician-assisted suicide and included the judgment of the Chief Justice] were of more general application." If anything, the contrary is true. A "right to choose suicide" has never been articulated in common law, and I think it highly unlikely that it could be established except on a constitutional law foundation. Indeed, it was because the prohibition on assisted suicide in the Criminal Code breached Sue Rodriguez's rights to autonomy and self-determination, and because these rights were protected under her right to security of the person in section 7 of the Charter, that the Chief Justice held the prohibition unconstitutional and, therefore, ruled that it should be struck down. Interestingly, he did not rely on the section 7 right to liberty. Nor did he discuss the interaction of the section 7 right to life with the section 7 right to security of the person, when the rights to self-determination and autonomy, which this latter right encompasses, are used to choose suicide. Moreover, the ratio of his judgment is that the prohibition on assisted suicide in the Canadian Criminal Code constitutes prohibited discrimination within the anti-discrimination provisions of section 15(1) of the Charter. In other words, constitutional law was essential and central to the Chief Justice's finding that Rodriguez had a right to the assistance of a physician in committing suicide — that she had a right, in fact, to euthanasia.

In Rodriguez, one of the main arguments presented in support of physician-assisted suicide was one I outlined previously: that Canadian law recognizes patients' rights to refuse treatment even when this refusal
could or would result in death; that this is to recognize a right to die; and that it should make no difference legally whether this right is exercised through passive means (refusal of treatment) or active means (physician assistance in committing suicide or euthanasia). It is important, therefore, to understand the juridical basis of the right to refuse treatment. This basis can vary, and the extent to which a right to refuse treatment can be used to ground an argument for the legalization of euthanasia varies accordingly. This can be seen by comparing the situation in Canada with that in the United States.

In Canada, the right to refuse treatment has been consistently interpreted by the courts, with the exception of some dissenting judges in Rodrigue (who articulated a broader base for this right), as founded on the right to inviolability—that is, the right not to be touched without one's consent. This right is of only negative content and legally cannot be used to found a positive content right to assistance in committing suicide or of access to euthanasia. But in the United States, the courts have interpreted the penumbra right of privacy (which the United States Supreme Court has found surrounds that country's Constitution as including a right to personal autonomy. This right has been held to have both negative-content and positive-content limbs; it encompasses not only a right to refuse treatment but also a positive-content right to decide what happens to oneself. The latter includes rights to be free from state interference in the form of law in deciding what should happen to one's body. This right was interpreted by the United States Ninth Circuit Court of Appeals and the Second Circuit Court of Appeals as giving rise to a constitutional right not to be prevented from seeking physician assistance in committing suicide. These cases were appealed to the United States Supreme Court, which reserved the courts of appeal, ruling that state laws prohibiting assistance in suicide are constitutionally valid. But the constitutional validity of state laws that would allow euthanasia or physician-assisted suicide (in countries such as the United States and Australia, which have federal constitutions that give jurisdiction over criminal law to the states) remains an open question. This issue is very likely to be tested in the near future.

**CONCLUSION**

The euthanasia debate is a momentous one. As pointed out elsewhere, it involves our past (the norms and values we have inherited), our present (whether we will change these values), and our future (the impact that a decision, now, either for or against euthanasia, will have on our descendants both as individuals and a society). The outcome will set the “death tone” of the society in which we live and die. It will have a major impact on the societal and cultural paradigm—the shared story on which society will be based. Consequently, we need to engage in this debate not only with great honesty, integrity, and courage but also with clarity rather than confusion. This clarity must extend to recognizing that there are many important points relating to decision-making at the end of life on which we all agree, whether we are for or against euthanasia. We must then start from agreement, not disagreement. Doing so would change the debate’s tone. And that, in turn, could change its outcome.

Almost everyone agrees that competent people should be able to refuse treatment—when necessary through advance directives (living wills or durable powers of attorney) and that, when it is impossible to know someone’s wishes, there is no legal or moral obligation to continue medically futile treatment. Likewise, almost everyone agrees that people have the right to adequate pain-relief treatment, even if it could or would shorten life, if this is necessary to relieve pain. Where we disagree is whether physician-assisted suicide and euthanasia should be legalized. This decision must be faced head-on and not dealt with by confusing it, whether accidentally or intentionally, with rights to refuse treatment or the provision of adequate pain-relief treatment. To do so is to preempt the question that needs to be addressed—whether there ought to continue to be a legal difference between refusals of treatment and the provision of adequate pain-relief treatment on the one hand and physician-assisted suicide and euthanasia on the other.

In answering these questions, we should recognize the harm that can be done to the law, in general, by the facile use of legal concepts—whether those of intention, causation, or “precedent” in the form of case analysis. It should be a matter of serious concern, especially to lawyers, when those using these concepts to promote the legalization of euthanasia distort them, whether intentionally or because they have only a poor understanding of them from a legal point of view. Moreover, the question is not only a matter of our rightful, profound sympathy for people experiencing serious suffering, and whether, as Mason and Mulligan suggest, there are dreadful diseases or conditions for which we believe euthanasia is appropriate, but also whether allowing physicians to intervene with a primary intention of inflicting death is inherently acceptable as a foundational principle and basic value. We must not answer this question through confusion or in “stages.” Rather, we must answer it openly, honestly, directly, and— I hope—wisely.