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A case for justified non-voluntary active euthanasia: exploring the ethics of the Groningen Protocol

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One of the most recent controversies to arise in the field of bioethics concerns the ethics for the Groningen Protocol: the guidelines proposed by the Groningen Academic Hospital in The Netherlands, which would permit doctors to actively euthanise terminally ill infants who are suffering. The Groningen Protocol has been met with an intense amount of criticism, some even calling it a relapse into a Hitleresque style of eugenics, where people with disabilities are killed solely because of their handicaps. The purpose of this paper is threefold. First, the paper will attempt to disabuse readers of this erroneous understanding of the Groningen Protocol by showing how such a policy does not aim at making quality-of-life judgements, given that it restricts euthanasia to suffering and terminally ill infants. Second, the paper illustrates that what the Groningen Protocol proposes to do is both ethical and also the most humane alternative for these suffering and dying infants. Lastly, responses are given to some of the worries expressed by ethicists on the practice of any type of non-voluntary active euthanasia.

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It is a rather disturbing trend when the general public fails to take the time to educate itself about a certain controversial issue before criticising or condemning it. This does a disservice to all by conveying a faulty view of the actual issue, thereby precluding the possibility of discussing its ethical implications intelligently or accurately. In my opinion, this has been the prevailing trend when it comes to the debate about the Groningen Protocol, the guidelines proposed in December 2004 by the Groningen Academic Hospital in Amsterdam, The Netherlands, which permits doctors to actively euthanise terminally ill infants who are deemed to be in a state of unbearable pain.[1] Given that infants cannot consent to their deaths, approval of the protocol would establish a legal framework permitting non-voluntary active euthanasia (not involuntary active euthanasia, as I have heard some describe it, for the infants are not requesting to be spared from death, but are put to death nevertheless). The protocol was officially introduced across The Netherlands in July 2005.

This request on behalf of the doctors from the University Medical Center Groningen has met with a considerable amount of backlash. The protocol has been labelled by some to be a Hitleresque type of eugenics programme.

> This chilling, horrific development is as appalling a story as occurs but also not surprising. So complete is the devaluing of life and the idea of soul that we have come in 60 swift years back to the gates of Auschwitz.[2]

> Were he attempting to escape allied justice today, Dr. Joseph Mengele, the Nazi ''Angel of Death,'' would not have to make his way to the jungles of Brazil; the Netherlands would probably welcome him with open arms … Hey, if we can get rid of society's ''deadwood,'' why let niceties of law or morality get in the way? I have no doubt that if the Groningen Protocol becomes official, parents who don't want to contend with raising a disabled child will have their baby or young child euthanized, even if the baby has a fighting chance at a meaningful life.[3]

Such straw man arguments detract from discussing the actual proposed protocol, which is not in any way an attempt to kill infants because they are ''inconvenient'', ''disabled'' or considered to be ''deadwood''. The Groningen Protocol, if adopted, would not entail the killing of infants because they are disabled; indeed, the protocol makes no mention of justifying the deaths of infants owing to any cognitive disabilities per se. Most infants who would be killed under the guidelines will be disabled—indeed terminally disabled—but it is their terminal prognosis that grounds their eligibility for active euthanasia. Consequently, the protocol would probably not lead to a slippery slope that would entail the deaths of infants simply because they have some minor defect—for example, if they are missing a limb—because such defects are not usually terminal in nature. We will return to the slippery slope concern later in the paper.

Nevertheless, if the Groningen Protocol is adopted, it would indeed change the face of active euthanasia in The Netherlands and it may lead to other countries adopting similar practices. Thus, it is necessary to explore what exactly the Groningen Protocol entails and whether what it purports to do is ethical.

UNDERSTANDING THE GRONINGEN PROTOCOL

To morally assess the protocol as accurately and fairly as possible, it is imperative to look at exactly what its guidelines are proposing. An infant must meet the following five criteria to be eligible for active euthanasia under the protocol[1]:

1. The suffering must be so severe that the infant has no prospects for a future.
2. There is no possibility that the infant can be cured or alleviated of her affliction with medication or surgery.
3. The parents must give their consent.
4. A second opinion must be provided by an independent doctor who has not been involved with the child's treatment.
5. The deliberate ending of life must be meticulously carried out with the emphasis on aftercare.

Notice what the first condition does not say. It does not say that the infants must have such a severe affliction that they have no prospects of enjoying a future of a certain kind—that is, the condition does not make a quality-of-life judgement pertaining to the future of these children. Instead, what the first condition states is that the infants must be so severely afflicted that they face no future at all—that is, the infants must be terminally ill. The second condition reaffirms this requirement and the fourth condition mandates that the infant's prognosis be evaluated by a doctor who has had no previous exposure to the neonate, to ensure that the bleak prognosis is accurately diagnosed. Moreover, according to the third condition, parental consent is required, so that there will never be a case in which the parents are opposed to euthanasia, but the child would nevertheless be euthanised. For example, parents are often opposed to active (although not passive) euthanasia as a result of religious convictions, and the third condition will serve as a guarantee that a child's life will never be taken without a parent's explicit consent. Again, the protocol is not advising that all infants who are disabled be euthanised. The infants who will be eligible for euthanasia if the protocol is approved will most likely be disabled, but what grounds their killing is that the disability has made them terminally ill; it is their terminal prognosis that makes them candidates for active euthanasia. If a child was born disabled, but not terminally ill (eg, with Down's syndrome), then he or she would not be considered a candidate for active euthanasia under the Groningen Protocol.

Now that I hope to have clarified some of the misunderstandings surrounding the protocol, I will analyse the guideline itself and argue that, as it stands, what the Groningen Protocol is advocating is not unethical. Indeed, I will argue that it is the most humane course of action that can be taken, given the prognosis of these infants and the fact that any life that they face will be one of intense pain, with not even a single moment of respite from their suffering lest they be terminally sedated. A possible objection against the practice of actively euthanising these terminally ill infants who are suffering is that, rather than giving a lethal injection, it would perhaps be better to terminally sedate them. In the case of terminal sedation, the subject is deliberately rendered unconscious with an overdose of analgesics and sedative drugs to relieve intractable physical pain or mental suffering. An essential aspect of terminal sedation is the cessation of all forms of treatment, nourishment and hydration to hasten death. In other words, terminal sedation is a method of painless passive euthanasia; the practice essentially drugs the patients into unconsciousness until they finally die, rather than giving a lethal injection that would kill them relatively instantly. I have no objections to this procedure being used if the infants are indeed completely unaware of their suffering and the slow process of dehydration and starvation that they are then exposed to. My only problem with this option is that it is often presented as a morally acceptable alternative to active euthanasia, because whereas in active euthanasia the doctor directly hastens death, terminal sedation is an attempt to relieve pain, with death occurring as a foreseen, but unintentional, consequence. In this paper, I will not deal with the famous doctrine of double effect that this distinction appeals to, but I will say that such a distinction, at least in the case of terminal sedation, seems rather implausible, given that an essential aspect of the procedure is the withdrawal of even basic treatment and sustenance. These actions do indeed strike me as a blatant attempt to hasten death; indeed, why else would they be undertaken? If the appeal to terminal sedation is thought to be morally superior to active euthanasia, it is only because of its passive rather than active nature, because it means ''letting die'' and not actively killing. No morally relevant difference exists between the two forms of euthanasia, however, and doctors are equally causally and morally culpable in both instances of euthanasia. If parents prefer the terminal sedation of their infants to active euthanasia that is, of course, their prerogative; it is morally acceptable as long as the infant does not suffer. I, however, reject the notion that terminal sedation is morally superior to active euthanasia, given that it is based on the passive/active distinction, a distinction that strikes me as being morally untenable. As the protocol does indeed widen the door concerning who may be euthanised by allowing for a form of non-voluntary active euthanasia, I will argue that careful steps need to be taken to ensure that the protocol does not lead to abuse and the death of others who may have lived to see valuable futures or to the betrayal of the wishes of people who may not have wanted euthanasia as a way of ending their lives, but who can no longer express such a sentiment.

WHEN DEATH MAY CONSTITUTE A BENEFIT

To avoid controversy, I will confine my arguments to considering the best interests of the infant who would be euthanised. I want to show that if properly construed and regulated, the Groningen Protocol can serve the best interests of a terminally ill infant. In arguing for this, it is necessary to first understand what an interest is and then consider whether prolonged existence is in the best interests of an infant who would be eligible for euthanasia under the protocol.

I will appeal mainly to the conception of interests as defined by Joel Feinberg in his book *Harm to others* and how he subsequently relates it to a proper understanding of harm and benefit. According to Feinberg,[4] to have an interest in x is to have a stake in x's well-being, and a person has a stake in x ''when he stands to gain or lose depending on the nature or the condition of x''. A person's collection of interests ''consists in all of those things in which one has a stake … what promotes them is to his advantage or *in his interest*; what thwarts them is to his detriment or *against his interest*''.[4] When a person's interest in x is advanced or promoted, this constitutes a benefit for that person; subsequently, when an interest is thwarted, this constitutes a harm. An interest in continued existence is, of course, the most fundamental interest a person can possess, for if we are deprived of continued existence, we are deprived of all other interests life has to offer. Given its primacy, Feinberg[4] refers to the interest in continued existence as the most basic welfare interest a person can have, and welfare interests ''cry out for protection, for without their fulfillment, a person is lost … an invasion of a welfare interest is the most serious … harm a person can sustain''.

Whereas the interest in continued existence is usually the most fundamental interest a person can possess, there are instances in which it is actually death itself that serves a person's best interests. It is not that any type of life, even a life consisting of nothing more than intense pain, is better than no life at all. Indeed, because of the strong conviction that there are times when death is preferable to life, many

people choose to cease life-sustaining treatment either for themselves or as a proxy for someone else. For the purposes of this paper, I will concentrate on the selective non-treatment of certain newborns and whether doing so in certain situations is ethical. I will compare two cases: one in which an infant was not treated for a certain affliction that was terminal if left untreated, and thus was passively euthanised, and another in which an infant was treated rather aggressively, against her parents' request, only to die shortly thereafter.

In April 1982, a baby boy with Down's syndrome, dubbed Baby Doe, was born in Bloomington, Indiana, USA, with trachea-oesophageal fistula—a condition that prevented the infant from being nourished as no food reached his stomach. The affliction, if left untreated, was of course terminal, but it could have easily been rectified by a routine operation. But because the infant was also afflicted with Down's syndrome, the parents issued a directive that the operation correcting the trachea-oesophageal fistula should not be performed. The Indiana Supreme Court let this decision stand, although many families offered to adopt Baby Doe, and he died of pneumonia, starvation and dehydration on 15 April 1982.[5] Although Baby Doe could have had his affliction rectified, and although he could have gone on to live a fruitful life with adoptive parents who would have wanted him and loved him, he was instead passively euthanised. It is imperative to note that Baby Doe would not be considered a proper candidate for active euthanasia under the Groningen Protocol because he did not meet the second condition. His trachea-oesophageal fistula was treatable by surgery and after a successful surgery he would no longer be terminally ill and so would not have met the first criterion, although he was disabled.

The second case is that of a baby girl who was born with a variety of congenital defects, including

> meningomyelocele (spina bifida), hydrocephalus, and paralysis and deformities of her legs. *No satisfactory treatment exists for this set of conditions* … even with costly and repeated surgery, more than half of these infants would be expected to die. Crippling disabilities, retardation, and shortened lifespan were common among the survivors. The mother, supported by the father, refused to consent to surgery, but a court order was secured for a series of operations … the child's brain was damaged [the infant died at 10 months of age][6] (emphasis mine).

It seems as though the respective decisions on proper treatment were inverted in these two situations. Clearly, Baby Doe ought not to have been allowed to die, especially given that many families offered to adopt this little boy in full knowledge of his disability. To allow Baby Doe to die was morally wrong, a flagrant expression of chauvinism for a certain type of cognitive existence. Many people with Down's syndrome, depending on the severity of the affliction, go on to lead fruitful lives that are of great worth to them and to the loved ones who surround them. Baby Doe could have continued to live a normal span of human years and although his cognitive abilities were impaired, they probably were not impaired enough to preclude a worthwhile existence. Continued existence would have thus benefited Baby Doe and hence the operation would have been in his best interests. In other words, in the Baby Doe case ''treatment [would have been a] benefit and, thus, since the physician has an obligation to benefit the patient, that obligation here entails the obligation to secure life''.[6] In passively euthanising Baby Doe, the medical staff violated his most basic welfare interest and one of the primary moral tenants of medicine: to do no harm.

I am doubtful that the same could be said about the baby girl in the second case. Her condition was very close to being terminal in nature and the short existence that she did experience was one fraught with invasive procedures and extreme pain and suffering. Interestingly, although death seems to have been in this girl's best interests, she would nevertheless still not have been eligible for active euthanasia under the Groningen Protocol. Although the infant's prognosis was very bleak and she was close to being terminally ill, she did have a small chance at survival, and thus did not meet the Protocol's second condition. In her situation, ''the prognosis was poor and the interventions burdensome''. In this case, the odds were strongly against the possibility that she would have survived the invasive procedures and any prolongation of her life contained nothing but pain and suffering; nothing positive was added to her life. Continued existence for her was pointless, not because she would have been disabled if she had survived, but because she probably would not have survived at all and whatever time she was given was full of nothing but suffering. My thesis thus is less ambitious than that promoted by Kipnis and Williamson.[6] They do, eventually, make an assertion on quality of life in their article (although they also admit that letting Baby Doe die was morally wrong because Baby Doe's life could indeed have had some ''subjective value'' to him). In the end, they conclude: ''Where life-sustaining treatment and the resulting burdensome existence can be expected to have negative value to the patient, there is an obligation to withhold or discontinue the treatment''.[6] I do not disagree with them on this point. I think that there can be some forms of human existence that are so impaired as to make life not worth living. But this is a controversial statement, and one that entails delineating the necessary and sufficient conditions for when a person has crossed the threshold into a comparatively valueless state of existence, which I admit is difficult, given that it is hard to assess the subjective experiences of others (but so is the problem of other minds). My main interest in this article is defending the Groningen Protocol and, despite what some have argued, the protocol does not make judgements on quality of life but is rather very clear that the infant in question must be terminally ill—that is, the infant must have no prospects, not an impaired prospect, for a valuable future life. In this situation, the pain that the infant went through added injury to her already bleak diagnosis. Continued existence arguably constituted a harm for her.[6]

But isn't any life better than no life at all? Couldn't someone argue that despite being in an intense amount of pain, the possibility of being given a few more days to share with loved ones is worth the pain and suffering that we may endure? The answer to this question, of course, depends on each patient's priorities. Some patients may be willing to endure days of extreme agony to experience some goods—for example, the good of kissing a spouse or child for the last time, saying goodbye to loved ones, watching one last sunrise and sunset, and reading excerpts from a favourite book over again. Indeed, the very act of looking forward to these prospects may make enduring the pain worthwhile. But infants are not these sorts of creatures. All infants lack the cognitive ability to look forward to anything, to anticipate a future activity, to take comfort in the fact that tomorrow they will be able to see their loved ones and spend more time with them. Infants are the types of beings that are locked in a perpetual state of present emotions and desires. The life of an infant in agony is nothing but perpetual existence in that agony. For infants who are suffering and terminally ill, extending their lives is nothing but extending their agony. It is hard to see how this can fail to constitute a harm for them. Their interests lie not in continued existence but, rather, in

death. Given that infants eligible for active euthanasia under the Groningen Protocol face a similar diagnosis, continued existence constitutes a harm for them as well.

This is why not all cases of withholding or withdrawing life-sustaining treatment from infants are morally problematic. It is imperative that medical decisions are made, first and foremost, with the best interests of the patient in mind. Continued existence is usually in a patient's best interests; indeed, as stated earlier, it is usually the most important and basic interest any person can possess. But when patients are terminally ill, and when the remainder of their lives will be spent in a chronic state of nothing but pain and suffering, then it is hard to see how continued existence constitutes a benefit for them, given that prolonging their lives means just prolonging their suffering. In these cases, the basic moral imperative to do no harm may entail that terminally ill infants not be treated, that their pain not be needlessly prolonged.

FROM PASSIVE TO ACTIVE EUTHANASIA

The above section shows that passively euthanising terminally ill infants who are suffering is a better way to ensure that the best interests of the infants are honoured than fruitlessly prolonging their lives. I will assume that this is a rather uncontroversial claim. The controversy ensues when we make the transition from passive to passive euthanasia. Although neither voluntary nor non-voluntary passive euthanasia is without its critics, these are generally accepted practices. Yet, if death is beneficial to the patient rather than harmful, then active euthanasia brings about a beneficial state of affairs sooner; it is more advantageous for the patient than passive euthanasia. Indeed, by allowing terminally ill infants who are in pain to die passively, we do not add to their suffering by artificially prolonging their life, but we do add to their suffering by allowing the dying process to be prolonged naturally. It may take days, even weeks, for an infant to die by passive means, and the infant experiences those days or weeks in an agonising and atrocious manner. It seems, then, that it would be more humane to actively euthanise terminally ill infants who are suffering and bring their suffering to an end rather than to allow that suffering to be prolonged for the days or weeks it may take them to die. In this, I must agree wholeheartedly with James Rachels[7]: ''The doctrine that says that a baby may be allowed to dehydrate and wither, but may not be given an injection that would end its life without suffering, seems so patently cruel as to require no further refutation.''

And yet, there remains refutation. So much so that the doctors at the Groningen Hospital are referred to as Nazis or murderers for bringing the life of terminally ill, suffering infants to an end. I am sure that this would not be the general public's reaction if these infants were either aggressively treated to prolong their inevitably doomed lives for a few short days or allowed to die owing to convulsions, dehydration or starvation. It is this that puzzles me the most: how can the two options that are ultimately the cruellest for the infant (although passive euthanasia is less cruel than prolonging the infant's life, and subsequent suffering, artificially) be deemed the most moral and most in the infant's interest?

I can offer very little new material in this area, for this is simply rehashing the old ethical question on whether there is a major moral difference between active and passive euthanasia. However, I want to reiterate a point that has been emphasised before by previous ethicists but which nevertheless often remains ignored when discussing this controversial issue: the fact that doctors do indeed have a causal role in passive euthanasia in addition to active euthanasia, and thus that passive euthanasia may very well be considered an instance of killing rather than merely ''allowing to die''.

In her book *The Sanctity-of-Life Doctrine in Medicine*, Helga Kuhse uses John Mackie's analysis of an inus condition, defined by Mackie as ''an insufficient but non-redundant part of an unnecessary but sufficient condition'',[8] to argue that the causal role of a doctor in both passive and active euthanasia is causally, and therefore morally, equivalent. When discussing the issue of selective non-treatment of infants affected with spina bifida, Kuhse argues that a doctor who fails to treat the afflicted infant is causally responsible for the infant's death, particularly because the doctor's omission classifies as an inus condition towards the death. That is, the doctor's failure to treat the infant is an insufficient condition towards the infant's death in so far as other factors also contribute to the death (eg, being afflicted with spina bifida or contracting a case of pneumonia that doctors deliberately fail to treat). The doctor's failure to treat was also a non-redundant condition, however, for without this omission the infant would not have died. As the omission, the failure to treat, is an inus condition, it ''is a cause in the correct sense of the word''[9] and thus the failure to treat the infant can well be viewed as an integral causal factor leading to the infant's death.

> If it can be shown that what differentiates those situations in which death occurs (or would have occurred) from other situations in which death does not occur (or would not have occurred) is the doctor's failure to treat, then the doctor's omission is the causal factor that allows us to distinguish those situations in which death occurs from those in which it does not, and the doctor's failure to treat is identified as the causal factor that made, or would have made, the difference between an infant's dying or not dying. Hence, the doctor's failure to treat is the cause of death.[9]

Kuhse argues that killing a patient by lethal injection also classifies as an inus condition towards the death of the patient, thus bringing about the death of a patient by either passive or active means ''cannot be distinguished in terms of causal efficacy or in terms of causal agency … [b]oth killing and letting die are *inus* conditions in two different minimally sufficient conditions for death''.[9] Kuhse also maintains that a doctor who brings about death by passive means (such as deliberately refraining from treating a patient) is ''just as accountable or morally responsible as she would be had she brought it about by a deliberate positive action''.[9]

The following example offered by Brock[11] illustrates this last point excellently.

> Consider the case of a patient terminally ill with ALS [amyotrophic lateral sclerosis] disease. She is completely respirator dependent with no hope of ever being weaned. She is unquestionably competent but finds her condition intolerable and persistently requests to be removed from the respirator and allowed to die. Most people and physicians should respect the patient's wishes and remove her from the respirator, though this will certainly cause the patient's death … suppose the patient has a greedy and hostile son who mistakenly believes that his mother will never decide to stop her life-sustaining treatment and that even if she did her physician would not remove the respirator. Afraid that his inheritance will be dissipated by a long and expensive hospitalization, he enters his mother's room while she is sedated, extubates her, and she dies. Shortly thereafter the medical staff discovers

> what he has done and confronts the son. He replies, ''I didn't kill her, I merely allowed her to die. It was the ALS [amyotrophic lateral sclerosis] disease that caused her death.'' I think this would rightly be dismissed as transparent sophistry—the son went into his mother's room and deliberately killed her. But, of course, the son performed just the same physical actions, did just the same thing, that the physician would have done.

As this example shows, removing life-sustaining treatment can indeed be considered a form of killing that is morally impermissible—that is, it can be considered a form of murder. The patient's greedy son is just as guilty in the death of his mother as he would have been had he given her a lethal injection. Yet, I suspect that few of us would argue that the mother's doctor would have committed murder had he taken the same physical action the greedy son did. This means that the same physical action of removing life-sustaining treatment may be considered morally justifiable in some cases and morally impermissible in other cases. The following example really drives this point home.

> Samuel Linares, an infant, swallowed a small object that stuck in his windpipe, causing a loss of oxygen to the brain. [Particularly, Samuel asphyxiated on a blue latex balloon at a birthday party on August 2, 1988.] He was admitted to a Chicago hospital in a coma and placed on a respirator. Eight months later he was still comatose, still on the respirator, and the hospital was planning to move Samuel to a long-term care unit. Shortly before the move, Samuel's parents visited him in the hospital. His mother left the room, while his father produced a pistol and told the nurse to keep away. He then disconnected Samuel from the respirator, and cradled the baby in his arms until he died. When he was sure Samuel was dead, he gave up his pistol and surrendered to police. He was charged with murder, but the grand jury refused to issue a homicide indictment, and he subsequently received a suspended sentence on a minor charge arising from the use of the pistol.[12]

Samuel's father took exactly the same physical action that the greedy son did: he removed his baby's life-sustaining treatment and allowed him to die. If the greedy son's action constituted killing his mother, then Samuel's father killed his son as well (as did the doctor in the earlier example). In all these examples, the removal of life-sustaining treatment classified as an inus condition: the respective deaths would not have occurred without the removal of the treatment, although the removals were not, in themselves, sufficient for causing the deaths. All three people, the greedy son, the doctor and Samuel's father, were causally, and morally, responsible for the deaths that resulted from their removal of treatment. The reason most of us, I think, would only impugn the greedy son as performing a morally unjustifiable act is because of his murderous, selfish and callous intent. Samuel's father and the doctor, however, did not have these morally appalling intentions, and so their respective instances of killing may indeed be justifiable ones. What all this drives at is that passive euthanasia is indeed a form of killing, which may or may not be morally permissible, and hence may or may not be considered an instance of murder. One thing seems rather clear, however: in all the examples cited, there is certainly some degree of causal agency that can be attributed to each of the people who removed life-sustaining treatment.

Therefore, in any instance of passive euthanasia, the doctor does indeed have a direct causal role in the death of the patient. The doctor initiates a state of affairs that directly leads to the patient's death: withholding or withdrawing life-sustaining treatment that, had it been given, would have resulted in a patient's continued existence. The doctor has a causal role in the patient's death by withholding or withdrawing treatment, and the passivity comes only after this initial action. The doctor takes active measures to withhold or withdraw life-sustaining treatment and then passively stands by and allows the patient to die. Indeed, it is precisely because of this initial active and causal role in his mother's death that the greedy son cannot justify his actions by arguing ''I didn't kill her, the underlying ALS [amyotrophic lateral sclerosis] killed her, I simply stood by and let it happen''.

Yet, as unacceptable as this defence would be for the greedy son, it is exactly this logic that is used to exonerate doctors of their causal role when they participate in passive euthanasia. The American Medical Association's[13] official stance on the ethics of euthanasia incorporates this very defence:

> When a life-sustaining treatment is declined, the patient dies because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide however [or any instance of active euthanasia], death is hastened by the taking of a lethal drug or other agent.

Some philosophers also incorporate this distinction. For example, Fiona Randall,[14] a consultant in palliative care with a background in philosophy and medical ethics, argues that in cases of patients in a persistent vegetative state who die as a result of the withdrawal of treatment,

> … surely the patient's death is caused by the underlying severe pathological condition of the PVS [persistent vegetative state], which renders the patient incapable of survival without constant life-prolonging treatment, including artificial hydration and nutrition. The fundamental cause of death is the patient's condition, not the withdrawal of treatment, which should be regarded as incidental.

As Kuhse's argument shows, however, the withdrawal of treatment, or refraining from treatment by a physician, is not merely incidental, but is rather a non-redundant condition for the patient's death; the patient would not have otherwise died at that time had it not been for the withdrawal of or refraining from treatment. If the argument proposed by the American Medical Association and Randall were a sound one, then the greedy son would be exonerated for his actions, given that he can argue that he merely withdrew treatment, that his action was incidental, and thus that he merely ''let his mother die''. Yet every single moral fibre in our body prevents us from accepting this consequence. The mother's death at the hands of her greedy son (and Baby Doe's death) was an unjustifiable instance of killing by withdrawing or withholding some kind of life support, and there were people who played causal roles in these deaths, who may be morally impugned for their actions. On the other hand, Samuel's death, or the death of the mother at the hands of the doctor, were justifiable instances of killing by removing life support, as would have been the death of the baby girl born with the congenital defects or the death of any terminally ill infant who is suffering intolerably.

But does it matter how a person is killed? If the killing of a patient is sometimes morally permissible, can the method of

killing be morally problematic? I am hard pressed to see why there is a major moral difference between the causal role a doctor has when removing life support and the role the doctor has when injecting a patient with a lethal chemical that causes death (indeed, according to Kuhse, there is no such moral difference, for both are inus conditions and thus causes of death in the proper sense). If the greedy son cannot take refuge in passivity, then a doctor cannot do so either. In passive euthanasia, the doctor takes steps to ensure a patient's death (either by removing existing life support or by declining to initiate any type of life support), and then stands by while the patient dies, when the patient otherwise would have continued to live, as a result of the lack of life-sustaining treatment. In active euthanasia, the doctor injects the patient with a chemical that leads to the patient's death. In both cases, the doctor takes the first step in a causal chain that leads to the patient's death. If the death is unjustifiable, then the doctor, being the initiator of such a causal chain, would be equally guilty of murder, whether by active or passive means. For instance, if a doctor were to refrain from giving a simple drug to an infant who has a mild case of pneumonia, resulting in the infant's untimely death, the doctor is causally, and morally, responsible for the infant's death, as responsible as he or she would have been had he given the infant a lethal injection. As Kuhse[10] argues, ''[I]f a doctor deliberately refrained from preventing an infant's death, we would say that it is the doctor's failure to treat that was the cause of that infant's death.'' The doctor would most likely be brought up on murder charges, although his actions constituted passive, not active, euthanasia. Indeed, those people who called the death of Terri Schiavo a form of murder, although her death was an instance of passive, not active, euthanasia, illustrated this very point in their moral condemnation of Michael Schiavo and those doctors who removed Terri's feeding tube. Not one single person who thought the death of Terri Schiavo was unjustified argued that it was not a form of killing, but merely ''allowing to die'', because it was an instance of passive euthanasia, or ''allowing nature to take its course''. For those who thought the death was unjustifiable, it was murder no matter what method of euthanasia, active or passive, was used. An unjustifiable death is unjustifiable, no matter how the death occurs.

It should follow, then, that a justifiable death is justifiable, no matter how the death occurs. If the death of a particular infant is justifiable, then the doctor should be equally exonerated in instances of either active or passive euthanasia, just as he should be equally impugned if the death is unjustifiable. In both cases, the doctor remains causally and morally responsible for the death of the patient, but if the death has already been deemed justifiable, then the doctor should be absolved of any wrongdoing when performing active or passive euthanasia. Therefore, if doctors from the Groningen Medical Center are not to be morally impugned for passively euthanising an infant who is terminally ill and suffering, given that continued existence is not in the infant's best interests, they ought not to be morally impugned for actively bringing about this beneficial state of affairs sooner rather than later by active euthanasia, especially when letting the infant die passively only adds to the infant's suffering.

Nevertheless, many ethicists argue with just as much conviction that there is a moral difference between these two methods of killing. I would now like to consider some pressing concerns that have led them to the conclusion that killing actively is worse than killing passively.

RESPONDING TO SOME WORRIES

In his article "'Aid-in-dying': the social dimensions", Daniel Callahan[15] argues that allowing for voluntary active euthanasia results in an inequality of power by putting the life and death of one person, the patient, completely in the hands of another, the doctor, resulting in a violation of human dignity:

> To allow another person to kill us is the most radical relinquishment of sovereignty imaginable, not just one more way of exercising it. Our life belongs no longer to us, but to the person into whose power we give it. No person should have that kind of power over another, freely gained or not.

I am not sure why Callahan thinks that this instance of relinquishing control over a person's life to a doctor is more problematic than relinquishing such control when a doctor is asked to perform passive euthanasia by removing or withholding life-sustaining treatment. In both voluntary passive and active euthanasia, the life of the patient is handed over to the doctor; the patient has the final and decisive word on whether the patient lives or dies, but the doctor has a causal role that leads to the patient's death. It seems that the control handed over to the doctor in both instances of euthanasia is equally strong, and if such control is not deemed sufficiently morally problematic in instances of passive euthanasia and prevents its practice, I do not see why it should be sufficiently morally problematic in instances of passive euthanasia to prevent its practice.

Callahan[15] also makes another noteworthy argument against active euthanasia:

> Traditionally, only three circumstances have been acceptable for the taking of life: killing in self-defense or to protect another life, killing in the course of just war, and, in the case of capital punishment, killing by agents of the state … the proposal for ''aid-in-dying'' is nothing less than a proposal to add a new category of acceptable killing to those already socially accepted. To do so would be to reverse the long-developing trend to limit the occasions of legally sanctioned killing.

I agree with Callahan that as a society we should implement strict conditions detailing when it is acceptable to kill other human beings, and that we should sincerely ask ourselves whether a particular instance of killing another human being should be advocated on moral grounds. Killing in self-defence seems to me the least morally problematic of the above three cases to justify. Killing as a form of punishment or societal vengeance for wrongful killings is more problematic, as is killing in the course of a just war, which claims the lives of soldiers and innocent civilians in the name of ''collateral damage''. Indeed, the justification given in defence of the latter two instances of permissible killing seems more morally dubious to me than the reasons the doctors from the Groningen Medical Center have given for allowing terminally ill and suffering infants to be killed. They advocate the premature killing of these infants, who will die soon no matter what actions they undertake, in the name of mercy; in the name of sparing, primarily, the infants' atrocious pain and suffering and, secondarily, ending the resulting parental suffering upon seeing their terminally ill children in such a state.

> It's time to be honest about the unbearable suffering endured by newborns *with no hope of a future* … A lot of disquiet has arisen around this issue, especially when the Vatican expressed concern. But these children face a life of agonizing pain. For example, we're talking about newborns with hydrocephalus and no brain. Another example may be a child with spina bifida with a sack of brain fluid

> attached where all the nerves are floating around. This child is barely able to breathe, and would have to undergo at least sixty operations in the course of a year to temporarily alleviate its problems. These operations would not ease the pain. Moreover, the child would suffer such unbearable pain that it has to be constantly anaesthetized. The parents watch this in tears and beg the doctor to bring an end to such suffering.[16] [My emphasis to highlight that the infants in question are indeed terminally ill, and thus to reaffirm that the Groningen Protocol is not making quality-of-life judgements when it comes to these infants.]

Such a justification strikes me as being much less morally problematic than the reasons we, as a society, allow for the death penalty (which fails to serve as a deterrent to prevent future murders, which is a justification that I would find less morally problematic if it were true): killing for punishment or revenge. Such a focus on mercy is also morally less problematic than killing in the name of collateral damage in war; perhaps it is indeed true that it is necessary to bomb a whole village to kill a few terrorists, yet I find it dubious whether such a consideration justifies the death of innocent people, including infants and children, who, unlike the infants of the Groningen Protocol, are not terminally ill.

In other words, we should pay close attention to what types of killing we permit in society, but I am at a loss about why we sanction the above instances of killing, for morally dubious reasons, but do not sanction killing for what seems to be an altruistic interest in preventing suffering for terminally ill infants and their families. Unless we want to be rid of all instances of approved killing in a society, we ought only to allow for those instances of killing that ground its basis on morally sound reasons for doing so. The justification for killing offered in the Groningen Protocol does not validate the death of these infants to rid their families of children who are mentally disabled, despite what some critics maintain (the Baby Doe case, on the other hand, did justify the death of the infant, ultimately, on such grounds and, ironically enough, this harmful death did not take place in The Netherlands, but in the US). Rather, it justifies the premature death of these terminal infants in the interest of sparing them pain and suffering throughout their short, inevitably doomed, lives. I can think of few other morally sound reasons for killing than this one.

Perhaps the strongest objection against the Groningen Protocol pertains to the ethics of non-voluntary euthanasia in general and whether establishing a legal framework for its practice on any occasion may lead to the killing of people who cannot give their consent for euthanasia, but who ought not to have been killed because they would have objected to it had they been able. Given this possibility, it is not advisable to make such acts of killing into a general rule, even if certain individual acts of killing may be morally justified. This concern is voiced by Beauchamp and Childress[17] when they write, ''although particular *acts* of killing may be humane or compassionate, a *policy* or *practice* that authorizes killing in medicine—in even a few cases—might create a grave risk of harm in many cases and a risk that we find it unjustified to assume''. Brock,[11] an advocate of voluntary active euthanasia, expresses similar worries:

> Making nonvoluntary active euthanasia legally permissible, however, would greatly enlarge the number of patients on whom it might be performed and substantially enlarge the potential for misuse and abuse. As noted above, frail and debilitated elderly people, often unable to defend and assert their own interests, may be especially vulnerable to unwanted euthanasia.

These concerns are perhaps reflective of what most people fear may happen if non-voluntary active euthanasia is made legal—that is, it would result in a type of involuntary euthanasia, where people who do not want to be killed, but who cannot express such a desire, are nevertheless killed. One thing to note right away, however, is that this is not a problem confined to non-voluntary active euthanasia; this problem also applies to non-voluntary passive euthanasia, and so I caution readers against unfairly impugning active euthanasia with a whole host of problems that apply equally strongly to passive euthanasia, but do not lead to its moral or legal proscription. If a person does not want to die, but is too incompetent to express such a wish (eg, being in a temporary coma), killing the patient by active or passive means violates the patient's wishes equally.

The worry may remain, however, that even if the Groningen Protocol itself does not allow for this type of misuse, permitting any general guidelines that allow for non-voluntary euthanasia would establish a precedence that would make it easier to kill other people who may not have wanted to die. Certainly we do not want patients being terrified that if they slip into temporary unconsciousness they may be euthanised by the consent of a proxy. Although the Groningen Protocol itself does not leave room for such a possibility, could this not be construed as the first step in a terrifying slippery slope? If so, as Beauchamp and Childress argue, no matter how heart-breaking the particular cases of terminal and suffering infants may be, we simply cannot afford to start down this road, and so we cannot, as a rule, allow for non-voluntary active euthanasia in any situation.

Two ways of responding to this genuine and serious concern exist. One is to point out, once again, that this danger lies also in permitting non-voluntary passive euthanasia, which the US itself pervasively practises and which was unjustly practised in the Baby Doe case. As mentioned earlier, an unjustifiable death remains unjustifiable, and a harm to the patient, whether it occurs by passive or active means. It seems simply unfair for this concern to count decisively against non-voluntary active euthanasia when it does not do so for non-voluntary passive euthanasia. It is a concern, and it is a concern that must be guarded against. But surely, if we allow for non-voluntary passive euthanasia despite these concerns, there is no reason not to allow for non-voluntary active euthanasia as well, as long as we are mindful not to perform any type of euthanasia, active or passive, if we have the least bit of an indication that the patient may not have wanted to be euthanised.

The second is to try as much as possible to safeguard against these concerns by making any protocol specific to certain types of cases to prevent abuse (which I believe the Groningen Protocol successfully achieves, given its five criteria). Indeed, in all the cases that morality and the law allow for killing, there is the possibility of abuse that can lead to the unjustifiable deaths of innocent people. McMahan[18] responds to this concern quite aptly when it comes to the sanctioning of killing in self-defence:

> Our acceptance of the permissibility of killing in self-defense offers significant opportunities for people to perpetrate wrongful killings under the guise of self-defense—for example, by provoking a person to violence and claiming that killing him was necessary to save oneself, or by killing, in a secluded spot, a person with a known history of violent aggression and then claiming that one killed in self-defense. Although we are aware of these possibilities of abuse, we do not respond by forbidding killing in self-defense. Instead we erect safeguards against the abuse.

Similarly, there are questions on the danger of executing innocent people who were unjustly convicted to death row, yet this worry alone has not been sufficient for eradicating the death penalty (although some have argued that it should be). There will always be dangers, and we should always remain vigilant about these dangers. But, when it comes to the issue at hand, providing a careful analysis on which infants are eligible for euthanasia under the Groningen Protocol can safeguard against these dangers. Indeed, bringing the euthanasia of these infants out in the open and under the watchful eye of the government of The Netherlands and public will aid in creating these safeguards and help prevent another Baby Doe from dying needlessly. Indeed, there has been an increase in the reporting of euthanasia in The Netherlands by doctors. In 1999, 2216 cases of euthanasia were reported, which was a clear increase from the 1466 cases reported in 1994.[19] As of this writing, a doctor in The Netherlands must report any death that results from active euthanasia to the municipal corner in adherence to the relevant procedural requirements in the Burial and Cremation Act.

Is there a certain amount of unwarranted optimism on my behalf? Is such a slippery slope inevitable even with strict guidelines legally in place? Keown would certainly think so. Indeed, he would perhaps argue that the very fact that the doctors in The Netherlands are proposing these guidelines, and that I am writing a paper defending these guidelines, is evidence that the slippery slope has already occurred. In various publications, Keown expresses worry that the Dutch guidelines allowing for voluntary active euthanasia have already resulted in illicit instances of non-voluntary active euthanasia despite the strict guidelines delineated by several Dutch lower courts, which require that a patient's euthanasia request ''must come only from the patient and must be entirely free and voluntary … [in addition] the patient's request must be well-considered, durable, and persistent''.[19 20] According to Keown, however, the empirical evidence suggests that many instances of euthanasia in The Netherlands do not adhere to these two very pivotal rules, and it is adherence to these rules that renders a particular act of euthanasia truly voluntary, rather than non-voluntary or involuntary. Using the Remmelink Commission Report and the van der Maas survey as evidence, Keown[20] concludes that ''non-voluntary euthanasia is in fact more common than voluntarily euthanasia'' (p 278) in The Netherlands, and he defends his claim by citing the number of instances where doctors in The Netherlands have performed passive or active euthanasia, with the precise intention of ending a patient's life, without the patient's explicit consent. His conclusion is that ''cardinal safeguards—requiring a request which is free and voluntary; well-informed; and durable and persistent—have been widely disregarded'' (p 278). As a result, the slide from voluntary to non-voluntary active euthanasia is rather evident in The Netherlands and ''[t]here is little sense in which it can be said, in any of its forms, to be under control''.[21]

As mentioned earlier, the concern with permitting any legalisation of non-voluntary active euthanasia is that it will result in a slide towards involuntary euthanasia. The concern is not that people will be euthanised ''for their own good'' while actively begging not to be killed. (I cannot begin to imagine that this is even a viable possibility.) Rather, the concern is that people will be killed ''for their own good'' when they are too incompetent to express their wishes: wishes that would have revealed their desire not to be euthanised. This is a very important concern, but one that I do not think the Groningen Protocol is in danger of resulting in, given that the subjects of euthanasia in this case—infants—possess no will to be defied (this concern would be an issue, however, if the Protocol were ever expanded to include people who do have wills and preferences on the matter—for example, older children, adults and elderly people). A more realistic danger, as I see it, is that, over time, the first two conditions of the Groningen Protocol, requiring that the infants in question be terminally ill with no prospects for a future, would be relaxed to include infants who may not survive or to infants who would survive, but whose prospects for a valuable future would be severely impaired.

I will admit that this possibility worries me. Although there are cases where it is uncontested that a child's life would be so devastating and full of suffering that it is not worth living, these assessments reach a grey area rather quickly and as a result there may be more Baby Does who will fall through the cracks, infants who may have survived and would perhaps have led fruitful lives. I have argued that the Groningen Protocol does not make quality-of-life judgements, and it is because of this very important requirement that the protocol strikes me as humane and morally permissible, for it seems utterly vicious to extend the life of a suffering infant with no prospects for a future. If the infant did have a possible future ahead, I would be more hesitant to condone a legal practice that begins to make quality-of-life judgements, for such judgements can be, and have been, subject to error. Consider, for example, the case of the Danville conjoined twins. Jeff and Scott Mueller were born on 5 May 1981 at Lakeview Hospital in Danville, Illinois, USA. The brothers were joined at the waist and the spine and shared a lower digestive system, bowels and a leg. At first, the twins were not expected to live through the night, but the next day they were still very much alive. After a battle with the courts on whether the decision to deprive the infants of nourishment and hydration was attempted murder, the parents of the Mueller twins were allowed to take them home. Despite preliminary assessments, the brothers had reached a healthy year when they underwent separation surgery on 15 July 1981. Scott died in 1985, having lived four more years than originally expected. Jeff is still alive and is a testament to the error that can occur when doctors engage in quality-of-life judgements. Perhaps we ought to restrict all instances of both passive and active non-voluntary euthanasia to patients with no prospects for a future—for example, people in confirmed persistent vegetative states or infants who would currently be eligible for euthanasia under the Groningen Protocol. Therefore, I am willing to defend the protocol only in so far as it strictly adheres to the first two conditions. A marked difference exists between guidelines that make quality-of-life judgements, which entails doctors ''playing the odds'' with the life of an infant despite the medical profession's reputation for miscalculating those odds, and those guidelines that do not engage in these types of judgements, as the Groningen Protocol carefully seems to avoid doing. Therefore, the first two conditions of the protocol are of pivotal importance in assessing its moral and legal permissibility, and to ensure that they are strictly enforced, I suggest that in addition to having another doctor offer a second opinion on the infant's diagnoses (according to the fourth requirement), ethics boards should be formed with the adoption of the Groningen Protocol, which will extensively review each case before the infant is euthanised to ensure that each infant is in fact terminally ill and that the infant's prospects for a future are truly naught.

CONCLUSION

In this paper, I have argued that the current debate on the Groningen Protocol is highly misdirected and deserves fair and unbiased attention. The doctors at the Groningen Medical Center are not Nazis. They are not advocating a

type of eugenics programme for ridding The Netherlands of infants with disability and they certainly are not making quality-of-life decisions about who is worthy of continued existence. These infants are terminally ill; modern medicine can do nothing to save them. The remainder of their short lives will be fraught with intense pain and suffering—the simple act of breathing may fill an infant with nothing but agony. These infants cannot take psychological refuge the way adults can by remembering a pleasurable past experience or by looking forward to a desirable experience in the future. The life of these infants consists of nothing more than perpetual suffering. Continued existence is of no benefit to them; rather, death is often looked upon as a much prayed for blessing. In these tragic cases, death is what constitutes the best interests of the infant and it is on the basis of this realisation that we recognise that passive euthanasia is what the primary moral principle of medicine—to do no harm—calls for. Needlessly prolonging the lives of these infants counts against their interests, and so we concede to their deaths and allow them to occur. Yet, when the time it takes the infant to die is also full of suffering, inducing death by active euthanasia does nothing but bring about a beneficial state of affairs sooner, and this works more for the interests of the infant than killing him by passive means. In these cases, the duty to do no harm may entail the positive duty of hastening death. As such, the Groningen Protocol, as it stands, is morally permissible. The five criteria the hospital has offered, strictly enforced, will serve to safeguard against the possibility of abuse and ensure that the best interests of the infant are never compromised.

As a society, we must be careful not to wantonly allow for the killing of innocent people, infants included. We must respect life and build medicine around the ethics of preserving life as much as possible. Yet, when a fatal tragedy befalls infants, if we truly care about their best interests, we will deliver them from their suffering sooner rather than later. This strikes me as being much more morally justifiable than tucking them away into the corner of a hospital while they slowly die in agony, as was done with Baby Doe, which seems to me to add insult to his already tragic injury.

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