PART I: DOUBTFUL ENDINGS

Chapter 1: “Birth After Death” [9]

An American Story [9]
Highland General in North Oakland:
Darious Marshall: born 3 August 1993
Dr. James Jackson: chairman of Maternal and Child Health Services at Highland Hospital

A German Story [12]
Marion Ploch: brain dead 5 October 1992
Miscarried: 16 November 1992
The Clinic’s legal advisor, Prof. Hans-Berhard Würmelung: “Respect for the dead body is not an absolute ethical demand, as the right to life is.”
Julius Hackethal: “The expression ‘brain death’ is a verbal construction that avoids the heart of the matter. In fact only the cerebrum of the patient does not function, but the rest of the brain works very well. She is alive.”

Our Choice [9]
Jackson compared bringing Darius Marshall to term to building the Bridge on the River Kwai, good for the morale of his “troops”. But that bridge actually served the enemy.
Issues:
1. If you are dead when you’re brain dead, when do you “die” if you never had a brain (like some babies)? May the organs be taken when the baby’s heart is still beating?
2. Can you remove feeding tubes from people in “persistent vegetative states”?
3. What should happen to fertilized embryos created in fertility clinics?
4. Baby Doe, born 1982 in Bloomington, IN, had Down syndrome and an intestinal blockage. Can the parents refuse to have the operation and allow the baby to starve to death?

Chapter 2: “How Death Was Redefined” [20]

Pink, supple…and dead [20]
“Isn’t it odd that for a human being to die requires a different concept of death from that which we apply to other living things?” [22] (What would Feldman say to this?)

“The burden is great”: The Harvard committee on the determination of death [22]
Two crucial medical developments:
1. 1950s: respirator invented: can keep alive people who earlier would have died. Initially polio sufferers, but also people who looked like they would never regain consciousness.
2. 1967: first heart transplant.
The first presented the spectre of permanently comatose patients filling up hospitals and draining resources. The second suggested a use for the live hearts of those patients. (Unlike kidneys, which can be taken from a subject whose heart has stopped beating, hearts must be kept beating until very shortly before donation, otherwise they will get damaged.)
Harvard Committee met quickly and published their report in 1968:
Our primary purpose is to define irreversible coma as a new criterion for death. There are two reasons why there is a need for a definition: (1) Improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured. Sometimes those efforts have only a partial success so that the result is an individual whose heart continues to beat but whose brain is irreversibly damaged. The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied by these comatose patients. (2) Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation. [25]

Two remarkable facts about this decision:
  a. Doesn’t claim that the patients are morally dead (just not legally) but instead uses the need for organs as a reason for redefining death.
  b. Refers to “irreversible coma as a result of permanent brain damage” is by no means identical to death of the whole brain. People in persistent vegetative states (PVS) meet the first standard but not the second. And even today, no legal system regards people in PVS as dead, despite the fact that all the reasons given for the criterion of death by the Harvard committee apply to them too.

Why did the Harvard committee limit its concern to those with no brain activity at all, rather than those with no consciousness?

A revolution without opposition [28]
How was this new standard implemented so quickly? Why no “pro-life” opposition?
1. The Harvard committee could quote the Pope’s 1957 speech that “it remains for the doctor…to give a clear and precise definition of ‘death’ and the ‘moment of death’ of a patient who passes away in a state of unconsciousness”
2. The new standard was popular, and the pro-life lobby worried that standing up to it might cause a wave to wash over into euthanasia. (In other words they were prepared to lose a battle so as not to lose the war – a tactical retreat.)

Japan is alone in the developed world in not accepting the new standard. They noticed that brain-dead patients can be kept alive by replicating the brain’s hormonal function. If the hormonal function of the brain is what matters, then why pick death of the brain as death rather than death of the heart or kidneys?
Answer: it’s consciousness that matters. (In which case, again, why aren’t people in PVS dead?)

Brain death: Who believes it? [32]
News article:
  A 17-year-old was pronounced brain dead after being accidentally shot in the head…[he is] being kept alive on life support

How can he be both? Also, what doctors say to families of brain-dead people:
  At this point in time, it doesn’t look like the patient is going to survive.
  The machine is basically what’s keeping him alive.

Why do people refuse to accept that brain death is really death?

An unstable compromise [35]
Problem: according to the Harvard committee, death occurs when all functions of the brain have irreversibly ceased. Tests have been developed to say when this has occurred. HOWEVER, there is evidence of brain function even in patients who meet this standard: for example, when brain-dead patients are cut open, their pulses quicken.

What should we do?
Two possibilities:
1. Get better tests to ensure that all brain functions have totally ceased.
2. Move to a definition of death as ceasing of higher brain functions (consciousness).

Option 1 would require expensive tests and keeping bodies on life-support for much longer as the tests are carried out, knowing all the time that nobody being tested would ever regain consciousness.

**Chapter 3: “Dr. Shann's Dilemma”** [38]

**Two Babies** [38]

**Anencephalic** babies are those born with a brain stem but no cerebral cortex. **Cortically dead** babies have irreparable damage to the cortex. Neither of these count as dead by the Harvard committee’s standard, because they still have functioning brain stems.

**Baby K** born anencephalic in 1992 in Falls Church Virginia could not be removed from life support according to the US Court of Appeals.

Dr. Shann’s dilemma: he could have saved the life of a baby with a damaged heart by transplanting the heart of a cortically dead infant, but the law prohibited it, so both babies died.

**Breathing but dead?** [42]

Dr. Shann:
I suggest that the organ that really matters in the cerebral cortex. If the cortex is dead, there is permanent loss of consciousness and there can be no person...If the cortex of the brain is dead, the person is dead. I suggest that it should be legal to use the organs from the body of the dead person for transplantation. [42]

Dr. Robert Truog:
Death is a process, and the moment of death cannot be discovered, but must be chosen. Truog’s choice: “death is the irreversible loss of the capacity for consciousness”.

Dr. Margaret de Campo (radiologist):
Thanks to new procedures (Three Vessel Angiography, etc.) we can tell in which sections of the brain blood is still flowing or not flowing. If blood is not flowing to the cortex then the patient is **cortically dead**. (This is a sufficient condition, but perhaps not necessary – it is possible that the patient could be cortically dead even if blood is flowing to her cortex)

Dr. Neil Campbell:
What we care about is the person rather than the body. And the person dies with the cortex, at which point, “there is no meaningful sense in which it can be claimed that decisions about life support or organ removal matter to him or her”

Dr. Steve Keeley:
Regarding anencephalic and cortically dead infants as dead would create “an ethical fiction” because it would suggest we should bury a child who can still breathe on its own.

**The case for a higher brain definition of death** [46]

Panel discussion:
Agreement on:
1. Description of the situation
   a. Death in intensive care is a **process** rather than a spontaneous event
   b. The acceptance of brain death has meant a shift in the traditional concept of death
If we use brain death, we have to decide between whole brain and cortex-only conceptions of death.

d. There is a shortage of organs that means that some savable children are lost

2. Appropriate medical care for anencephalic and cortically dead infants: attempts to sustain life are not obligatory

Disagreement on:
3. acceptability of removing organs from anencephalic and cortically dead infants.

Three positions:
   a. Redefine “dead” as meaning “death of the cerebral cortex” (Drs. Shann and Truog)
   b. Don’t redefine death that way, and don’t remove organs (Dr. Keeley)
   c. Don’t redefine death that way, but do allow removal of organs in tightly controlled situations (Singer)

Two medical reasons for position (a):
1. When the Harvard committee came up with the new standard, it was impossible to tell when the cortex died. Now it is possible (thanks to the methods outlined by de Campo)
2. We still can’t reliably tell when all brain functions cease, so if we leave the definition as it is, we face the dilemma of either killing people who still count as alive by the whole-brain criterion, or we have to institute expensive tests, and possibly lose the organs (see last chapter).

Against brain death [50]
People hold two conflicting views:
   1. People who are cortically dead are dead in every way that matters
   2. People who are still “pink and breathing” are still alive

The way to accommodate both intuitions is to deny that cortically dead patients are dead, but to allow organs to be taken. (Case of Laura Campo, who had her anencephalic baby delivered by C-Section so that the baby could donate organs, but wasn’t allowed to because of the current definition of death.)

A way forward? [54]
Separate questions:
· When does a human being die?
· When is it permissible to stop trying to keep a human being alive?
· When is it permissible to remove organs from a human being for the purpose of transplantation to another human being?

Chapter 4: “Tony Bland and the Sanctity of Human Life” [57]

Fine Phrases [57]
The notion of the “sanctity” of human life, that “all lives are intrinsically valuable” so that “it is always wrong intentionally to kill an innocent human being” is clearly noble and something we would like to adhere to. However, it disguises real decisions we need to make about people like anencephalic infants and Tony Bland.

Tony Bland’s Tragedy [57]
Tony Bland: in 1989 his lungs were crushed, depriving his brain of oxygen so that only the stem survived. He was “cortically dead”. He was “kept alive” in a persistent vegetative state (PVS) like between 10-25 thousand adults in America in 1994.
Compare Tony Bland with Nancy Cruzan: in Tony Bland’s case the relevant question was deemed to be “what is in the best interests of the patient?” rather than, as with Nancy Cruzan [60-62] and Joey Fiori [63], “what would they have wanted?” The latter question requires us to know the decision the patient would have made (in the case of Nancy Cruzan, friends and family suddenly “remembered” her saying she wouldn’t have liked to stay on life support, but because nobody said that for Joey Fiori, he was still being kept alive in 1994, 18 years after he entered a PVS), the latter can be made without such considerations.

Deciding on the basis of Quality of Life [65]
Each of the British Law Lords made it clear that “he did not value life that is human only in a biological sense” [65]. Lord Justice Hoffman said “the stark reality is that Anthony Bland is not living a life at all” [66] but clearly this is playing with words. He was living a biological life, so in saying that he wasn’t living “a life” Hoffman clearly meant “a life of sufficient quality”. Lord Mustill: withdrawing life-support was not only legally, but also ethically justified since the continued treatment of Anthony Bland can no longer serve to maintain that combination of manifold characteristics which we call a personality. [67]

Singer:
There can therefore be no doubt that, with the decision in the Bland case, British law abandoned the idea that life itself is a benefit to the person living it, irrespective of its quality…. The conclusion we can draw is that British law now holds that for life to be a benefit to the person living it, that person must, at a minimum, have some capacity for awareness or conscious experience. [67/8]

Lawfully Intending to End Innocent Life [68]
In the Tony Bland case, the intended purpose of ceasing treatment was to bring about Bland’s death. Previously, the most a doctor could do was bring about death as an unintended consequence of treatment, whose intended purpose was to alleviate pain (Mrs. Morrell, from the John Bodkin Adams trial of 1957 [69]). This is sometimes called the doctrine of double effect.

Discarding a Fig Leaf [70]
Karen Quinlan case:
Is ceasing treatment “turning on the gas chamber” [70] or ceasing “extraordinary” treatment?
Reasons why the “extraordinary/ordinary” distinction is a “fig leaf” covering the fact that real quality of life decisions are being made:
1. A respirator is only described as “extraordinary treatment” if a quality of life decision has already been made about the patient. If the patient will recover fine after being on the respirator then everyone would regard the treatment as “ordinary”.
2. The distinction is also intended to disguise the fact that Quinlan’s parents wanted her to die: it’s meant to look as if their intention is to “alleviate suffering” and so if death results, it’s because of the doctrine of double effect. But Quinlan could not suffer, because she was cortically dead.

Beyond the Sanctity of Human Life [73]
The principle of the sanctity of life states:

It is absolutely prohibited either intentionally to kill a patient or intentionally to let a patient die, and to base decisions relating to the prolongation or shortening of human life on considerations of its quality or kind.

Clearly this is not intended to be outweighed by other factors, but that’s what happened in the Tony Bland case. This means that, in effect, the Law Lords were discarding it as stated.

Acts and Omissions [75]
Were the Law Lords in effect sanctioning euthanasia in the Tony Bland case by allowing a doctor to intentionally end his life? They didn’t think so: they relied on a distinction between acting to end someone’s life and allowing someone’s life to end. In terminating treatment to Bland, the doctor was allowing him to die by “natural causes” – the doctor was not administering a lethal dose. But none of the Law Lords denied that this distinction between action and omission was anything but a stopgap compromise.

Lord Browne-Wilkinson:

How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? [78]

Lord Mustill:

The acute unease which I feel about adopting this way through the legal and ethical maze [i.e., allowing passive euthanasia but not active] is I believe due in an important part to the sensation that however much the terminologies may differ the ethical status of the two courses of action is for all relevant purposes indistinguishable. [79]

This suggests that we need a new legal framework to avoid being forced to make such bogus distinctions. That is, although the decision in the Tony Bland case made a revolutionary step in allowing quality of life decisions, it still didn’t go far enough, as it should have carried through and allowed active euthanasia in certain cases.

**PART II: CRUMBLING AT THE EDGES**

**Chapter 5: “Uncertain Beginnings” [83]**

**Peggy Stinson’s Puzzle [83]**

Peggy Stinson wanted an abortion because her life and that of her baby were threatened. However, she went into labor unexpectedly and gave birth prematurely. The baby was very likely to be handicapped and brain-damaged and the Stinsons asked that “no heroic measures” be taken to save his life, but the doctors threatened to take them to court and put the baby on a respirator. Peggy wrote:

A woman can terminate a perfectly healthy pregnancy by abortion at 24 ½ weeks and that is legal. Nature can terminate a problem pregnancy by miscarriage at 24 ½ weeks and the baby must be saved at all costs; anything less is illegal and immoral.

Why should birth make all the difference? Shouldn’t we treat fetuses of the same age the same whether inside the womb or out?

**The unavoidable issue [85]**

It is misleading to call the pro-abortion-rights movement “pro-choice” because you cannot get around the issue of whether or not the fetus has a right to life simply by focusing on the right of the mother to choose abortion.

Similarly, it is misleading to call the anti-legal-abortion movement “pro-life” because they’re not typically vegetarians and they’re often (unless Catholic) pro-capital punishment.

Anti-abortion comparatively new for religions:

Judaism has never taught that abortion is equivalent to murder. Jesus never mentioned abortion (and if it is so bad, you would think he would’ve).

Aquinas held that abortion was okay until “the quickening” which happened at 40 days after conception for males, 80 for females (according to him).

Why did Catholics switch to opposing abortion from conception? Because advances in biology suggested that the embryo was *not* “inert” for 40 days, but alive from day 1. (That is, they accepted...
Aquinas’s claim that abortion was wrong after “quickening” but thought that that happened at conception.)

In the 19th century in England (and, soon after, the English-speaking world) it became illegal to perform any abortions. Why the change in the law?

1. “real” doctors supported the change in the Hippocratic Oath to distinguish them from “irregular” purveyors of medicine (like Midwives)
2. scientifically trained doctors took the quickening to occur at conception
3. The AMA crusaded to outlaw abortion

This change took hold until in the 1950s it was pretty much set in stone. All abortions were illegal.

The era of legal abortion [90]

What changed?

1. **Thalidomide**, a pain-killer given to pregnant women in most commonwealth countries (although not the USA) that caused birth defects – specifically, children born without limbs.
   
   Once it was discovered that thalidomide was the cause, women pregnant with thalidomide babies sought to abort them (including Sherri Finkb, who had to go to Sweden to get an abortion).

2. The number of women injured or killed in illegal abortions

By the time of Roe v. *Wade*, 18 states (including CA and NY), home to (or within 100 miles of) 2/3 of the population of the US had allowed some abortions to be legal.

Now (i.e., 1994, when the book was published) about 1.5 million legal abortions are carried out a year, the majority on women in their 20s and 30s.

Abortion on the grounds of defects evident thanks to ultrasounds is legal in countries as diverse as Australia, India, Israel, Japan, Turkey and the US.

Between 1972 and 1987 this question was asked of a national sample 13 times:

> Please tell me whether or not you think it should be possible for a pregnant woman to obtain a legal abortion if there is a strong chance of a serious defect in the baby.

The answer has always been between 75-78% “yes”. This shows a majority prepared to make quality of life decisions.

New reproductive technology and the abortion debate [93]

Is the early embryo, before implantation, a human individual?

Catholic Theologian, Father Norman Ford, Master of Melbourne’s Catholic Theological College was troubled by **identical twinning**, which is where the early embryo splits and two separate individuals develop.

Two puzzles for the claim that human life begins at conception:

1. **TWINNING**: call the fertilized egg Marion. If the embryo that results from Marion splits into twins, what happened to Marion? (Compare this case to Feldman’s Alvin the Amoeba.) Either:
   
   a. Marion is one, and a new person (Ruth) is the other.
   b. Marion disappears and there are two new people (Ruth and Esther).

   In case (a), which one gets to be Marion? Why not the other?

   In case (b), should we have a funeral for Marion?

2. **SYNGAMY**: conception does not occur *all at once*. Once a sperm enters the egg, the outer layer of the egg “locks up” so no other sperm can enter. BUT the genetic material of the egg and sperm are separate and do not merge until about 22 hours later (syngamy). So does conception occur when the sperm enters the egg or 22 hours later?

Wood and Trounson’s experiments: the law of the Australian state they were in forbade the creation of embryos for research UNLESS those embryos were later brought to term. Wood and Trounson didn’t want to implant their embryos because of possibilities of birth defects, so their suggested compromise was to observe embryos up to but not including syngamy. Is an egg in the *process* of fertilization an embryo? [96]
Objections to regarding the potential of the fetus as sufficient reason for preserving its life:
1. Population concerns: we don’t believe that contraception or abstinence is bad, even though both of these prevent potential people. In fact, we think them almost required.
2. Sperm and egg have potential too, perhaps comparable with an early embryo, because:
   a. modern technology teaches us that spontaneous miscarriage of embryos occurs more often than we (including Noonan) thought, and before the embryo implants in the uterus, the probability of it surviving to birth is about 30%. Immediately following implantation, it is still less than 60%. It reaches 80% about 6 weeks after conception.
   b. modern technology (microinjection) raises the chance of single sperm, combined with an egg, surviving up almost parallel with the embryo. (In fact, fertilizing eggs is the easy part of IVF.)

This means that, if potential is the reason not to destroy a fertilized egg, then it should also make destruction of sperm just as immoral.

Unlocking the abortion deadlock [100]
The argument against abortion:
1. It is wrong to take innocent human life
2. From conception onwards, the embryo or fetus is innocent, human and alive
3. It is wrong to take the life of the embryo or fetus

Attacks on this argument usually target premise 2. Roe v. Wade decided that viability was the cut-off point at which abortion was impermissible (i.e. the start of human life)

BUT:
1. as medical technology improves, viability moves earlier and earlier, and when artificial wombs (allowing ectogenesis) are perfected, it will move back to conception
2. viability is a function of where you are: if you’re near a good hospital the fetus is viable much earlier than if you’re stuck in the middle of nowhere

Alternative suggestion: the brain life criterion (Hans-Martin Sass [103])
This brings back all the issues of brain death: do we mean life of the cortex (starts after 10 weeks) or the brain stem (activity has been observed from 54 days)?
Also: are we really saying that the fetus “becomes alive” when the brain starts working? If so, this is the same “convenient fiction” as claiming a body is dead when the brain stops working. It’s clearly not true. Singer thinks the better way to take this proposal is that we are allowed to terminate human life before the brain starts working (just as he thinks we should be allowed to remove organs from living humans with dead cortices). Understood this way, the brain-life criterion is an attack on premise 1: it is okay to take some innocent human life – that is, the life of those who do not have active cortices.

Chapter 6: “Making Quality of Life Judgments” [106]

How the Reagan administration chose a quality of life ethic [106]
“Baby Doe” was a Downs Syndrome baby, born in 1982 with an intestinal blockage. The Parents supported Dr. Walter Owens (the obstetrician who had delivered the baby) in his suggestion that the blockage not be removed and the baby be given drugs to ensure that he be free from pain.
2 weeks later, Reagan ordered that all providers of health care receiving federal funds should be notified that they must not discriminate against the handicapped. 6800 hospitals received new guidelines, including that posters must be put up saying that “DISCRIMINATORY FAILURE TO FEED AND CARE FOR HANDICAPPED INFANTS IN THIS FACILITY IS PROHIBITED BY FEDERAL LAW.” If such failure was spotted, a hotline should be called and “Baby Doe” squads would roll into action to investigate.
Most health-care professionals affected were opposed to the new “Baby Doe Guidelines”. Several organizations including the American Academy of Pediatrics sued to have the regulations struck down. The academy argued that some conditions were “simply not treatable” including anencephaly, a brain haemorrhage leading to cortical death, and absence of a major part of the digestive tract.

At the trial, the Reagan administration was represented by C. Everett Koop, who was supposedly in favor of a “sanctity of life” ethic agreed that children without intestines should not be kept alive on drips. In effect, the difference between him and Owens was not that one had a quality of life ethic and the other didn’t, but rather what quality mattered. Koop had a quality of life ethic, but thought Downs syndrome children of sufficient quality, but (e.g.) anencephalic children not.

The Baby Doe guidelines were struck down, and the size of the poster reduced. This statement was released:

> the law does not require the imposition of futile therapies which merely temporarily prolong the process of dying of an infant born terminally ill, such as a child born with anencephaly or intra-cranial bleeding. [111]

The terms in bold reveal a quality of life ethic. Why is an anencephalic terminally ill, while a child with diabetes, who also needs constant care, not? Because of their differing “qualities of life”.

The Linares case [114]: in 1989, the only way that Rudy Linares could get doctors to take his brain-dead child Samuel off a respirator was at gunpoint. The grand jury refused to indict him for homicide, and even his misdemeanor charge of unlawful use of a weapon was given a suspended sentence.

**Chapter 7: “Asking for Death”**

**The problem** [132]

It is, after all, the patient’s life, and as long as the patient is capable of reaching an informed decision, then who better to decide whether life is worth living? Doesn’t the patient have a right to ask for [assistance in ending her life] and, if a doctor is willing to give it, why should the law stand in the way? [132]
Michigan, 1990
Janet Adkins, 54, Alzheimer’s patient from Oregon. Kevorkian’s machine which, when operated by Adkins, administers potassium chloride. (Judge ruled assisted suicide, which was not against the law. It became against the law in 1992, but that law was overturned by Judge Richard Kaufman on the grounds that it was an “unnecessary intrusion” upon personal decisions.)

Michigan, 1993
Thomas Hyde, suffering from Lou Gehrig’s disease. Supplied carbon monoxide and a mask by Kevorkian. Kevorkian’s (successful) defense: he was intending to end suffering, not cause death.

Rochester, NY, 1990
Diane, 45, leukemia. Dr. Timothy Quill prescribes enough barbiturates to kill her and told her how to use them. She did. Quill published a paper describing what he’d done, and the local DA tried to prosecute under the NY law against assisted suicide (sentence: 15 years), but a grand jury decided not to indict him.

Sydney, 1979
Rex Mortimer, 53, brain tumor. His wife helped him overdose on sleeping pills.

British Columbia, 1993
Sue Rodriguez, 41, Lou Gehrig’s disease. Argued that it was discrimination against the disabled not to allow assisted suicide. Narrowly lost in the Canadian Supreme Court, 5-4. Did it anyway.

Winchester, England, 1991
Lillian Boyes, 70, arthritis so agonizing she “howled like a dog” if touched. Dr. Nigel Cox injected 2 ampoules of potassium chloride. A Catholic nurse reported him, and he was found guilty, and given… a 12 month suspended sentence. The General Medical Council, while concluding that it was “wholly outside” a doctor’s duty to alleviate suffering “to shorten life” to do so, decided to be merciful and did not take away his license to practice.

The solution? [141]

Delft, Holland, 1990
Carla’s tumor. She asked for euthanasia: this has to be agreed to by a team of 2 doctors, a nurse, and a “pastoral care-giver” (Roman Catholic, Protestant or Humanist). Carla was Catholic, and her chaplain was sympathetic (!? Does the Pope know?) Dr. Admiraal gave her a lethal injection.

How voluntary euthanasia became possible in the Netherlands [143]
One in 50 deaths in the Netherlands is the result of voluntary euthanasia – about 2300 cases every year. Plus 400 cases of assisted suicide. How did this come about? Answer, in 1971, Dr Geertruida Postma helped her mother to die with an injection of morphine. A later case in 1984 was of a 95 year old woman who begged her doctor to end her suffering. He did, and defended his actions by arguing that he had a “conflict of duties” between his duty as a physician to relieve suffering, and his legal duty not to kill.

By the time this case was decided (conviction with no punishment), the Royal Dutch Medical Association proposed that euthanasia should be permissible under the following conditions:
- Only carried out by a medical practitioner
- Have an explicit request from the patient
- The patient’s decision must be well-informed, free and persistent
- The patient must be in a situation of unbearable suffering with no hope of improvement
- There must be no other measures available to make the suffering bearable
- The doctor must seek a second opinion from an independent doctor

The Dutch parliament approved in 1993.

The coming struggle for the right to die [147]
The day after Kevorkian’s acquittal in the Hyde case, in Washington state, US District Judge Barbara Rothstein declared unconstitutional a state law preventing doctors from helping terminally ill patients to commit suicide [on the grounds that it] violated the liberty of terminally ill patients. She also found that
to permit the refusal of life-support systems for terminally ill people, but not to allow a doctor to help a patient to commit suicide, is a violation of rights to equal protection granted by the Fourteenth Amendment. [148]

In November 1994, Oregon voters decided in a referendum to allow doctors to prescribe drugs that can cause a (painless) death. (Previous initiatives in 1991 in WA and 1992 in CA had only managed 46% of the vote in each case.)

**Sliding down a slippery slope?** [150]

In the Canadian Supreme Court decision about Sue Rodriguez, the judge delivering the majority decision charged that

Critics of the Dutch approach point to evidence suggesting that **involuntary active euthanasia** (which is not permitted by the guidelines) is being practiced to an increasing degree. [150]

Is this true? A study done in the Netherlands in 1990 found that, a total of 48,700 “end of life medical decisions” broke down as follows:

- 22,500 were associated with decisions to withdraw or withhold treatment
- 22,500 with decisions to alleviate pain by giving drugs known to be likely to hasten death
- 2,300 were active **voluntary** euthanasia
- 400 were assisted suicides
- 1,000 were cases in which a doctor supplied, prescribed or administered a drug with the explicit purpose of hastening the end of life, but **without an explicit request from the patient**

Is this last category “involuntary active euthanasia”? Well, all the 1,000 were patients who “were near death and clearly suffering grievously”, the drug was usually morphine, in 600 cases there had already been some patient involvement in discussions about ending life (of course, that’s consistent with the involvement being “NOOOOO!!!”) and in all but 2 cases where there had been no discussion, the patient was incapable of doing so (and the 2 cases were from the early 80s where doctors would’ve been very loath to discuss it openly). Nobody was put to death “against her will”. Furthermore, we can’t say that these figures show that legalizing euthanasia has led to an “increased practice” of anything, because there aren’t any other figures to compare.

pp. 154-4: studies showing that euthanasia is not uncommon even when illegal – for example 29% of doctors in Victoria who treated terminally ill patients admitted to taking active steps to bring about the death of a patient who’d requested it.

What about the 22,500 cases of withdrawing treatment? Withdrawing treatment is common everywhere – quite possibly the legalizing of euthanasia reduces the number of such cases (for example, if euthanasia was permitted in the case of Tony Bland, he would’ve been given it, and not starved to death).

**Breaking the commandment** [157]

Voluntary euthanasia has (at the time of Singer’s book writing, i.e., 1994) the support of 80% of the Dutch population. What effect will this have outside of Holland?

When Dutch doctors can directly, intentionally and openly kill their patients – and the heavens have not fallen – drawing subtle distinctions between acts and omissions begins to seem like splitting hairs. [157]

**Chapter 8: Beyond the Discontinuous Mind**

**An unusual institution** [159]

A group of “persons” is described in such a way as to make you think they are mentally handicapped humans. In fact, they are chimpanzees. Given that all the facts about their behavior remain the same, should you change your view of their moral status when you find out they are not human?

In what way are they “persons”? Answer, they fit John Locke’s definition:
A thinking intelligent being that has reason and reflection and can consider itself as itself, the same thinking thing, in different times and places. [162]

The “curious fact” about pro-lifers – they oppose killing human fetuses but are quite happy to support the killing of calves, pigs and chickens. Is this position, of favoring humans over comparable non-humans, just because of their species, justified?

Whose organs may we take? [163]
As the cases of Baby Teresa and Baby Valentina [pp. 53-4] illustrated,

The traditional sanctity of life ethic forbids us to kill and take the organs of a human being who is not, and never can be, even minimally conscious; and it maintains this refusal even when the parents of the infant favor the donation of the organs.

But, as the cases of Drs. James Hardy (1964, Mississippi – chimp heart), Leonard Bailey (1984, CA – baboon heart), and Thomas Starzl (1992, Pittsburgh – baboon liver) show:

At the same time, this ethic accepts without question that we may rear baboons and chimpanzees in order to kill them and use their organs. [165]

How can we justify this?

In God’s image and at the centre of the universe [165]
The western tradition is unusual in its emphasis of the sanctity of every human life (no infanticide), but only human life (other life is there for the plunderin’).

Sources:
· Genesis: man in God’s image, and having dominion over all other life
· Jesus: cursing the fig tree, casting devils into a herd of pigs which make like lemmings
· Augustine: interprets the two Jesus incidents to justify dominion
· Aquinas: combines Aristotle with Christianity
· Aristotle:
  (1) everything exists for a purpose
  (2) the purpose of the less rational is to serve the more rational
· (BUT: Pythagoras was much more egalitarian about animals)
· Pope Pius IX: wouldn’t allow a (mid-19th century) Rome Society for the Prevention of Cruelty to Animals, because that would imply that humans have duties to animals
· Marsilio Ficino (Renaissance Italian): humans as “the centre of nature, the middle of the universe, the chain of the world.”
· Descartes: non-humans are just biological machines – they lack a soul
· Kant: humans are ends-in-themselves. Animals are means to the ends of man.

The western tradition under attack [169]
Thinkers who rejected the man-as-center-of-the-universe view:
· Giordano Bruno (post Copernicus, pre-Galileo): “man is no more than an ant in the presence of the infinite” – burned at the stake.
· Galileo: argued for the Copernican view that Earth is not the centre of the universe – forced to recant, but later his view was accepted, but humans are still “in God’s image”
· Carl Linnaeus (1788): “show me a generic character…by which to distinguish between Man and Ape. I myself most assuredly know of none”
· Lord Monboddo (1792): “it appears certain that [Ouran Outangs] are of our species”
· Darwin (1838): “Man in his arrogance thinks himself a great work, worthy of the interposition of a deity. More humble, and, I believe, true to consider himself created from animals”

Evolution shows us that the difference between humans and non-humans is one of degree not kind.

Who is Homo? [172]
Shocks that forced the post-Darwinian western view finally to accept his conclusions:

1. The ecological movement, which saw us as part of nature rather than above it.
2. The animal rights movement, and the notion of “speciesism.” [What Singer perhaps modestly, perhaps tactically neglects to mention is that he is probably the major figure in that movement, with his seminal ‘70s work *Animal Liberation*]
3. Growing knowledge of the great apes, from Jane Goodall and Diane Fossey, in particular. We now know that apes use tools, make tools, and use language [175]
4. Genetics: we share 98.4% of our DNA with chimps. We are closer to chimps than chimps are to gorillas (97.7%), and chimps, gorillas and humans are more closely related than all are to orang-utans.

Aren’t we a distinct species though?
Well, that notion itself is dubious – it’s now argued that species are not found in nature, but are merely projected on to nature by us, for classification purposes. Even the old definition of distinct species as groups that cannot interbreed is put into question by the phenomenon of ring species – illustrated by the herring gull and lesser black-backed gull, which cannot interbreed, but which have intermediary “species” which can. The only difference between those two cases and us and chimps is that our intermediary “species” have died out. (We do have different numbers of Chromosomes – chimps 48, humans 46, but siamangs (50) and lar gibbons (44) have successfully interbred.)

Who is a person? [180]
Although we use “person” as being synonymous with “human”, that was not its origin. The sixth century philosopher Boethius defined “person” as “an individual substance of rational nature”. Locke, as we saw, defined a person as a being that has reason and a sense of self-identity. By both these definitions, Koko the gorilla, with her vocabulary of over 1000 words [181] appears to qualify. On the other hand, many humans (for example, Tony Bland, post-accident) do not qualify.

Why should we treat the life of an anencephalic human child as sacrosanct, and feel free to kill healthy baboons in order to take their organs? [183]

The traditional sanctity of life view is speciesist.

**Chapter 9: “In Place of the Old Ethic”** [187]

**The Structure of Ethical Revolutions** [187]
Comparison between current crisis in Ethics and crisis in Ptolemaic astronomy: just as epicycles on epicycles had to be added to orbits of the planets to make their motion “fit” with a cosmology that had the earth at the centre of the universe, so the “Sanctity of life” ethic (that has humans at the centre of the ethical universe) has to make the following “patches”:

a. Death redefined so that breathing humans are “dead”

b. Distinction between “ordinary” and “extraordinary” treatment invented

c. Euthanasia permitted if the intention is to relieve pain (doctrine of double effect)

d. “Non-treatment” permitted for disabled infants

e. Denying that humans exist before birth/viability

f. Taboo made on comparisons between disabled humans and non-humans of any kind

**Rewriting the Commandments** [189]

OLD COMMANDMENTS:

1. *Treat all human life as of equal worth* [190]
   Leads to absurdities like Joey Fiori and anencephalic Baby K being kept on respirators

2. *Never intentionally take innocent human life* [192]
   Examples
a. Not allowed to cause the death of a baby even to save the mother’s life
b. Not allowed to cause the death of Tony Bland-like cases

3. **Never take your own life and always try to prevent others taking theirs** [196]

4. **Be fruitful and multiply** [198]
   Story of Onan (joke: why did Granny call her pet parrot “Onan”? Because he always spilled his seed on the ground)

5. **Treat all human life as always more precious than any nonhuman life** [201]

NEW COMMANDMENTS:

1. **Recognize that the worth of human life varies** [190]
   Factors affecting worth:
   a. Consciousness
   b. Capacity for physical, social and mental interaction with other beings
   c. Having conscious preferences for continued life
   d. Having enjoyable experiences
   e. Others’ attitude towards your life (family members, etc.)
   f. Finite medical resources [192]
   In none of these cases is defining death the important issue.

2. **Take responsibility for the consequences of your decisions** [195]
   Inaction that causes death is, in general, just the same as actively causing death
   (Difference: society that doesn’t help others can survive, whereas society with constant murder cannot, hence the priority of a commandment against active killing.)

3. **Respect a person’s desire to live or die** [197]
   Killing a person against her or his will is a much more serious wrong than killing a being that is not a person.

4. **Bring children into the world only if they are wanted** [200]

5. **Do not discriminate on the basis of species** [202]
   Opposing speciesism doesn’t mean that you can’t say that killing the person who rings your doorbell is much more wrong than uprooting a cabbage. It just means that killing the human who rings your doorbell is no more wrong than killing ET if he rang your bell.
   There are four possible reasons that would make it wrong to kill a person:
   a. She has conscious preferences for continuing to live
   b. She’s capable of enjoyable experiences
   c. Doing so would bring grief to her relatives
   d. Doing so would cause alarm to others in similar circumstances.

Some Answers [206]

1. **Brain death, anencephaly, cortical death and the persistent vegetative state** [206]
   The new commandments settle Dr. Shann’s dilemma and the cases of Babies Theresa and Valentina (cortically dead, whom their parents wanted to be organ donors, but the courts intervened – chapter 3, 53-4). They aren’t as clear cut in cases where the parents aren’t yet ready to part from their children: they allow that the parents have the right not to donate organs, which is right.

2. **Abortion and the brain-dead pregnant woman** [208]
   What the commandments say: commandment 1 allows that some or possibly all fetuses don’t have the right to life. Commandment 5 demands that whatever rights we ascribe to fetuses, we must also do so for non-humans with comparable cognitive capacities. When the fetus can feel pain (possibly from ten weeks) abortions that are painless are more likely to be permissible. In these cases causing death to the fetus will not be as bad as causing it pain, because the fetus doesn’t have plans for its future, but it does have desires not to feel pain.
   What about the cases of Tricia Marshall and Marion Ploch (chapter 1)? Here we are not morally
required to keep their bodies alive to bring the fetuses to term, although this is certainly permissible, particularly if the father really wants this.

3. **Infants** [210]

If we allow late abortions, does that mean we must also allow infanticide, given that the capacities are the same (particularly for premature infants)? **Birth** is the only difference – that might be relevant in two ways:

a. The mother’s right to control her body is no longer relevant

b. There may be other people who want the baby (this only applies in affluent countries, and [another difficulty] it may apply most to healthy, white, male babies. Does this mean that non-white babies have, in effect, less of a right to live simply because there’s a lower demand for them?)

Whether or not the child continues to live should be up to the **parents** (not a judge), as they are charged with its care, and its continued life will affect them (and their prospective future children) the most.

What about **Downs** infants, like John Pearson, rejected by his mother?

Singer argues that the desires of a parent for the kind of life involving “normal” child are enormously important. They have the right not to choose the life of someone who has to care for a handicapped child. **Also** this may effect future children – Peggy Stinson noted that delay on decision on her premature and handicapped child might take away the possibility of another child. In *Should the Baby Live?* Singer and Helga Kuhse suggest that after 28 days the baby should be granted the same rights as an adult.

1. **People** [218]

Commandment 3 says that every **person** has the right to life. Persons should (mostly) therefore be beings who can fear their own death because otherwise they do not have much need for the right. (This applies even to those who can fear but don’t – we don’t want to say it’s not murder to kill Epicureans.) **BUT**: one can choose to waive one’s rights, so someone who really wants to die should have that right.

The Basis of the New Approach to life and death [219]

The two central assumptions of the old ethic that Singer rejects (because they are untenable, he claims, in the light of the various examples discussed):

1. we are responsible for what we intentionally **do** in a way that we are not for what we deliberately fail to prevent (distinction between acts and omissions)

2. the lives of **all** and **only** members of our species are more worthy of protecting than any other being.