(7) See, for example Rachels J. Active and passive euthanasia. *The New England journal of medicine* 1975 January 9; 292: 78–80, and critique by Steinbock B. The intentional termination of life. See reference (2): 69–77.
(8) See reference (5): 6.
(9) Chief Rabbi Jakobovits I, as cited by John, Cardinal Heenan, Archbishop of Westminster. A fascinating story. In: Lack S, Lamerton R, Chapman G, eds. *The hour of our death:* a record of the conference on the care of the dying held in London 1973. London, 1974; 7.
(10) *Declaration on euthanasia.* See reference (5): 7.
(11) Karnofsky D A. Why prolong the life of a patient with advanced cancer? *Cancer journal for clinicians* 1960 Jan–Feb, X: 9, as cited by Wilson J B. *Death by decision.* Philadelphia: The Westminster Press, 1975; 118.
(12) Cameron C S *The truth about cancer.* Prentice Hall, 1976: 115–116, as cited by Wilson J B. See reference (11).
(13) See *New York Times* 1974 June 16: Part IV: 7, as cited by Singer P. *Practical ethics.* Cambridge: Cambridge University Press, 1979; 149 and 229.
(14) See Rachels J. Euthanasia, killing and letting die. In: *Ethical issues relating to life and death.* New York and Oxford: Oxford University Press, 1979; 150, on the practice of 'no coding'.
(15) See *Melbourne Herald* 1979 November 29, reporting on the death of a squash champion who had suffered severe brain damage following cardiac arrests. 'The machine, in the Royal Adelaide Hospital's intensive care unit, was switched off just after midnight and Torsam Khan, 27, was dead within 10 minutes'.
(16) See reference (5): 11.
(17) See reference (9): 6 – italics in original.
(18) Beauchamp T L, Childress J F. *Principles in biomedical ethics.* New York: Oxford University Press, 1979; 117–126.
(19) Pius XII, AAS 49. 1957; 1031–1032.
(20) Kelly S J G. *Medico-moral problems.* St Louis, The Catholic Hospital Association, 1958; 129.
(21) See reference (5): 10.
(22) See reference (2): 72.
(23) *In the matter of Karen Quinlan.* Opinion in the Supreme Court of New Jersey 1976 March 31. 355 A. 2d 647, p 659.
(24) McCormick R. The quality of life, the sanctity of life. *Hastings Center Report* 1978; 8/1: 30.
(25) See reference (5): 6.
(26) See for example Shaw A. Dilemmas of 'informed consent' in children. *The New England journal of medicine* 1973; 289: 885–890. Also Duff R S, Campbell A G M. Moral and ethical dilemmas in the special care nursery. *The New England journal of medicine* 1973; 289: 890–894.
(27) Crane D. *The sanctity of social life: physicians' treatment of critically ill patients.* New York: Russell Sage Foundation, 1975.
(28) See also Reich W T. Quality of life. In: *Encyclopaedia of Bioethics Volume 2* New York and London: MacMillan and The Free Press, 1978; 831.
(29) McCormick R A. See reference (24): 35.
(30) See reference (2): 73–74.
(31) See for example, Gustafson J M. Mongolism, parental desires and the right to life. *Perspectives in biology and medicine* 1973; 16: 529–557.
(32) Colen B D. *Karen Ann Quinlan: living and dying in the age of eternal life.* Los Angeles: Nash, 1976; 115, as cited by Steinbock B. See reference (2); 73.
(33) Duff R S, Campbell A G M. Moral and ethical dilemmas in the special care nursery. See reference (26): 890 (italics added).
(34) Case study 14. In: Beauchamp T L, Childress J F. *Principles of biomedical ethics.* See reference (18): 263–264.
(35) See reference (5): 11.
(36) Morison R S. Death- process or event? *Science* 1971 August 20; 173: 697.
(37) I owe this example to Beauchamp T L, Childress J F. See reference (18): 121.

Commentary

Gerard Hughes SJ *Heythrop College, University of London*

It would be difficult to read Helga Kuhse's paper and remain convinced that all was well with the arguments in medical ethics about the preservation of life, or that the guidelines for medical practice were perfectly clear. Her case for saying that there are both philosophical difficulties and practical uncertainties is surely unanswerable. Upon closer inspection, however, it becomes less obvious precisely which points she has established, which a more traditional moralist would be concerned to dispute. Ms Kuhse makes several points: one is that there is a serious inconsistency in the traditional view of the sanctity of life; the second is that the distinction between actions and omissions has no application in the traditional view; and the third concerns a more positive proposal to replace the traditional doctrine about the sanctity of life by a fully explicit appeal to the quality of life. I should like to reply, as it were on behalf of the traditional position, on each of these points, and to make some remarks on precisely how they are connected to one another.

Helga Kuhse argues that it is inconsistent to hold both the 'sanctity of life doctrine' and the view that there is an important distinction to be drawn between ordinary and extraordinary means of preserving life. Now, it certainly is inconsistent to hold both:

a) that one must never intentionally kill, shorten life, or allow someone to die, and
b) that one is not obliged to take extraordinary means to preserve someone's life,
c) just if it is also held that the prohibition on allowing someone to die obliges one to take all possible means to keep him alive.

The charge of inconsistency crucially depends on showing that the 'sanctity of life doctrine' must

understand the prohibition on letting die in this strong sense. But does the traditional view take this extreme position?

Ms Kuhse offers, I believe, two very different types of consideration to establish that such indeed is the traditional view. I think it is important to take these separately, though they appear as interwoven in her argument. The first type of consideration consists in quoting writers who have understood the 'sanctity of life doctrine' in this strong sense, by arguing, for instance, that human life is of infinite value, and therefore must be preserved in no matter what form and at no matter what cost. Such incautious remarks do indeed give rise to inconsistency when they are combined with the view that extraordinary means are not obligatory, and Ms Kuhse is right to castigate them on this score. Emotive rhetoric does little to clarify philosophical discussion or medical practice. However, those moralists who engage in lengthy discussions about where to distinguish between ordinary and extraordinary means would surely be astonished to have imputed to them the view that life must be preserved by whatever means are possible. At least *they* do not understand the 'sanctity of life' in this sense, and if they are inconsistent, it is not because they have indulged in excessive rhetoric alone. However, Helga Kuhse's paper contains arguments which are aimed against these more sophisticated moralists as well, along the following lines. Not to take a possible means to preserve life must be equated with intentionally killing (1) because the distinction between actions and omissions is held to have no relevance so far as medical practice is concerned, and (2) because doctors have stricter duties towards their patients than do ordinary citizens towards others whose life may be in danger. These two reasons require some further examination.

It seems to me that the supporters of the traditional view have never in fact accepted (1). Perhaps some difficulties in the traditional view do arise just here, and I shall return to these briefly later. But the difficulties are not quite the ones which Ms Kuhse seems to allege. Part of the problem, I think, is that 'omission' can have two quite different senses: it can mean simple inactivity, or it can mean failure to do what one ought to do. On the traditional view, it is indeed not in itself an excuse against the charge of letting someone die if one pleads simple inactivity; in this sense of 'omission', to do nothing might well be just as reprehensible as positively acting to shorten someone's life, just as Helga Kuhse says. However, on the traditional view, it is an excuse to plead that one did nothing if there was nothing which one had a duty to do. If, on independent grounds, it can be shown that, for example, one did not have a duty to take extraordinary means to preserve someone's life, then to omit to take those means *has* traditionally been considered quite different from intentionally shortening a life, and this kind of omission is morally distinct from a positive action. *Pace* Ms Kuhse, this position does not depend on drawing the distinction between ordinary and extraordinary means in any particular place, or on any particular grounds (whether on the quality of life or anything else); it presupposes merely that not all possible means of prolonging life are obligatory. It follows, I think, that no intelligent doctrine about the sanctity of life is inconsistent just for the reason given in (1) alone. But perhaps Ms Kuhse suggests that the force of (2) is to show that, at least for the doctor if not for the ordinary citizen, any means which is possible is also obligatory, and that the extraordinary/ordinary distinction collapses on this account? But she admits that medical practice does not take this line, and it certainly is not how traditional moralists have argued, despite their occasionally incautious bursts of rhetoric. I would therefore respectfully suggest that the charge of inconsistency as Helga Kuhse presents it succeeds only against a version of the sanctity of life doctrine which is not that which most moralists have in fact held.

I believe that the real difficulty for the traditional position arises at a slightly different point, and is only obliquely touched upon in Helga Kuhse's paper. Assuming that some distinction between ordinary and extraordinary means can be made (and, as I have said, this is a separate issue), the traditional moralist still has to claim that there is a significant moral difference between intending to kill someone (or intending that person's death) and deliberately refraining from using extraordinary means to prolong his or her life. Moreover, he will be concerned to draw this distinction in such a way as not to allow in by the back door cases of what he would regard as wrongful active euthanasia. So he will have to frame his doctrine of intention in such a way that refusing to employ or to continue to employ a life support system could be shown to be different from, say, administering a lethal injection to save a patient from further suffering. I do not think that the normal ways of defining 'intention' in terms of desires, foreseeability, and the agent's description of his action) will suffice to make the distinction the traditionalist needs here. Nor can the job be done without circularity by invoking the distinction between an action and its consequences and saying that only the action in itself need be intended, since the line between the action and its consequences cannot be independently established. What Ms Kuhse, to my mind, needed to show was that there is no way in which the traditional moralist *could* frame a doctrine of intention which would be coherent and still give him the answers he is intent on defending. Instead of doing this, she seems to me to rely on the exaggeratedly absolutist versions of the sanctity of life doctrine to make her point, whereas the difficulty, if I am right about it, remains even when the traditional position is not held in its

exaggerated form: *is* refraining from using a possible means to prolong life different from intending a death?

Now, the difficulty could be removed at a stroke were one willing to say that there is nothing wrong with intentionally killing, or intending a death, once life has fallen below a certain quality. This the traditional moralist has always been careful to deny. Does Ms Kuhse wish to argue that this is the point at which we should be prepared to abandon the traditional view? I found her paper unclear on this issue. She does say that the physician must 'shoulder responsibility for the death of the patient' and even that he 'is responsible for the death of the patient'. If this simply means that the physician must accept responsibility for deciding when not to use extraordinary means (or, for deciding what are to count in this case as extraordinary means), and that, if the patient dies, the physician should expect to be held accountable for the decision he made, then what she says is true and is hardly controversial. But does she wish to be taken as saying in addition that in such cases the physician intentionally causes the death, and may (at least sometimes) do so legitimately? If she is willing to go so far (and, as I say, it is not clear to me whether or not she is) the traditional moralist would press her to say whether there is to be, in her view, no difference between intending a death by withholding extraordinary treatment, and intending a death by administering a lethal injection. It is *this* distinction which is at the heart of the traditional position, and the difficulty with the traditional position is to discover a philosophical means to support it. I am not at all clear whether Ms Kuhse would see this as a problem at all, or whether she would simply adopt the more radical solution to it and accept active as well as passive euthanasia.

At any rate, this central issue seems to me to be independent of the problems about how to draw the distinction between ordinary and extraordinary means of treatment. Helga Kuhse is perfectly right to insist that this distinction is not merely a technological one, and to insist that it involves considerations about the quality of life which are inconsistent with a totally absolutist view about the sanctity of life. On the other hand, I am not convinced that this distinction can simply be replaced by an explicit and overt reliance on the concept of the quality of life, valuable as this notion is. The sources quoted by her make it clear that they consider as relevant such factors as cost, the availability of resources and the risk involved, none of which is simply a matter of the quality of life to be attained. And it seems to me that the possibility of recovery is more important in this connection than Ms Kuhse seems willing to allow. Her counter examples (insulin for diabetics and iron lungs for the paralysed) seem to me to show no more than that recovery need not be complete in order to be important. After all, both patients are better off with this treatment than they would be without. I would have thought that insulin treatment was clearly 'ordinary' for most patients, on the traditional doctrine, and the iron lung 'ordinary' for very many. While the quality of life is one of the criteria used in arriving at such judgments, it is not the only one, and not in every case the most important one. Ms Kuhse is surely right to bring out the fact that, whether on traditional grounds or on any others, clear guidelines for difficult cases are going to be hard to come by, and philosophical articulations of these guidelines are going to be even more difficult. To my mind, this is hardly surprising, given the extremely rapid development of medical expertise. But that in itself is not a reason to seek to reduce all the complexities of the issue to one single criterion such as the quality of life, and still less to advocate as a philosophical principle that one may intentionally shorten or terminate a life just because its quality is below a certain standard.

In short, I am not convinced that the more sophisticated versions of the sanctity of life doctrine have been shown to be inconsistent. Moreover, to continue to speak of the sanctity of life (or of respect for life, if a more secular variant is preferred) has at least the advantage that it expresses a healthy presumption in favour of trying to preserve it. To speak of extraordinary means is to recognise that this presumption can be defeated, and to endeavour to spell out carefully the conditions under which it is defeated. There are philosophical and practical problems in this position which certainly need further development; but I still believe that the traditionalist can maintain that his is a good starting point from which that further development can take place.

Response

Helga Kuhse *Department of Philosophy, Monash University, Clayton, Victoria, Australia*

Let me but briefly reply to Gerard J Hughes's thoughtful discussion of my article, and of a most complex moral issue. More could be said but space sets the limit.

Hughes agrees that what he calls the 'strong version' of the 'sanctity-of-life' doctrine is incompatible with the optionality of extraordinary means. If it is not only absolutely forbidden to kill but also to let die, then any possible means of prolonging life becomes an obligatory one. But, Hughes points out, the 'sanctity-of-life' doctrine has not always been held in this strong form. Rather, the traditional view is that life must not always be preserved indefinitely, or at any cost: if one does not have a duty to take extraordinary means, then to omit to take those means is not the intentional termination of life.

This position does, according to Hughes, 'not depend on drawing the distinction between ordinary