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EUTHANASIA AND COUNTERFACTUAL CONSENT

A Dissertation Presented

by

DEBORAH R. BARNBAUM

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements of the degree of

DOCTOR OF PHILOSOPHY

MAY 1996

Department of Philosophy

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DEBORAH R. BARNBAUM

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ABSTRACT

EUTHANASIA AND COUNTERFACTUAL CONSENT

MAY 1996

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Counterfactuals about what a patient would consent to, if he were able to consent, are often cited as justifications, or partial justifications, for acts of euthanasia. In virtue of this fact, they deserve special scrutiny by moral philosophers.

In Chapter I, I examine terminology that is essential to further understanding the relationship between euthanasia and counterfactual consent. I propose a definition of 'euthanasia', an analysis of 'consent', and I present a brief description of counterfactuals.

In Chapter II, I consider two questions. The first is, "When it is appropriate to invoke counterfactual consent in an attempt to justify an act of euthanasia?" By making use of an improved version of the voluntary, nonvoluntary, and involuntary distinction among acts of euthanasia, I am able to determine when it is appropriate to cite counterfactuals about consent in an

attempt to justify an act of euthanasia. The second is, "to what end is counterfactual consent used?" I contend that counterfactual consent does morally justify some acts of euthanasia, and defend an argument for this claim. Finally, I look at the role of counterfactual consent as a possible legal justification for acts of euthanasia.

In Chapter III, I use possible world semantics to analyze counterfactual consent. Traditional counterfactuals are determined to be true if in the closest world at which their antecedent is true, their consequent is also true. Counterfactuals about consent have a less straightforward reading. I consider and reject several possible ways of reading counterfactuals about consent, before settling on the correct reading of counterfactuals about consent.

In Chapter IV, I consider evidence for the truth of claims about counterfactual consent. I consider and reject the claim that no counterfactual is either true or false. I examine both Living Wills and the practice of surrogacy, neither of which offers sufficient evidence for the truth of claims about counterfactual consent.

In Chapter V, I contrast counterfactual consent with actual consent. I review and refute the arguments for the claim that actual consent is preferable to counterfactual consent. I conclude by presenting a principle about the relationship between actual and counterfactual consent.

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INTRODUCTION

A tragic car accident sends John to the hospital. John lies in a coma in a hospital room. The doctors tell John's family that he has no hope for recovery. The family is forced to make the following decision: do they let John linger in the hospital room, for days, months, or perhaps years? Or, do they ask the doctors to shut off John's life support machines? Several considerations seem to weigh in favor of terminating life support. "John was always so athletic - it seems such a shame to see him like this." "There is absolutely no hope for his recovery." "He feels nothing right now, so turning off the machines would not deprive him of anything he is currently experiencing." Finally, John's wife says "I know John very well - if he could tell us, he would say it's okay to turn off the machines." The rest of the family nods in agreement.

Some people have this to say about cases of euthanasia: "He would have wanted it this way", or "Could she know the state that she is in right now, she would just want us to turn these machines off". Our intuitions are strong here. Something is added to the act of euthanasia by the consent of the patient. But in many cases of euthanasia, consent of the person who is being killed is not available at the time of his death. In Jack's case, his wife stated what Jack would have consented to had he been able to, even though he was not able. Her statement was a counterfactual about consent; counter-to-the-facts about Jack's inability to consent, this is what he would have consented to if he were able to consent.

Had Jack not consented to being killed, had he protested and screamed and begged to live, then killing him may not have been an act of euthanasia at all. Consent may be a necessary condition for an act to be an act of euthanasia. If this is true, then the fact that an agent would have counterfactually *not* consented may be important. Or, perhaps while the patients who screamed and begged to live *were* euthanized, it was nonetheless morally impermissible to kill them without their consent. In this case, consent is a necessary condition on an act of euthanasia being morally permissible. The statement "If he were able to consent, then he would consent to our killing him" appears to be either true or false, but what are the truth conditions for such a statement? Some people compose Living Wills, "an advance declaration of your wish not to be connected to life support equipment if it is adjudged that you are hopelessly or terminally ill"[1]. Effectively the Living Will is saying "If I were to be in the state of being hopelessly or terminally ill, then I would like you to pull the plug." Other people sign Durable Powers of Attorney - giving permission for a friend or relative to make life-and-death decisions for them. The patient, in signing a Durable Power of Attorney, is giving consent for another individual to make his decisions for him. But are either of these sufficient to demonstrate the truth of a counterfactual about consent? Is counterfactual consent only a poor cousin of actual consent, never

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[1]Final Exit, Derek Humphry, The Hemlock Society, 1991, p. 21.

as reliable or desirable as actual consent? All of these are interesting issues that deserve further consideration.

Why Are These Important Questions?

It might be argued that questions about consent, and counterfactual consent, are irrelevant in making health-care decisions. If a patient is dying, or in immense pain with no hope that the pain will ease, then the physician, not the patient, will be the best judge of what would be best for the patient. If that is true, then the physician would be doing what is best for the patient by taking steps to euthanize the patient based on her knowledge alone, and not based on any consent on the part of the patient. Why should consent, or counterfactual consent, be a factor when making these decisions?

First, in considering if a patient would give consent, were he asked for consent, the physician may more likely perform that action that will be best for her patient[2]. What will be best differs from patient to patient. There are some patients who will be willing to live with far more pain than others. By considering what a patient would counterfactually consent to, the physician will be less likely to make broad judgments that do not take into consideration each patient's individual beliefs and preferences.

Second, in considering what the patient would consent to, were he able to consent, the physician demonstrates respect for

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[2]Dan W. Brock, Life and Death: Philosophical Essays in Biomedical Ethics, Cambridge University Press, 1993, pp. 24-28.

the patient. Without considering what the patient would consent to, were he able to consent, the physician would be behaving in a paternalistic and authoritarian manner. Dan Brock observes that consent can be valued for many reasons:

> ...such as the avoidance of frustration involved in interfering with a person's liberty of action, the development of individual judgment (especially since people often learn best from their mistakes), the satisfaction people often get from making decisions about their life for themselves, and so forth.[3]

Brock makes the claim that giving people the opportunity to consent to treatment is extrinsically good, for it ultimately results in a better state of affairs for the patient, and those around him.

Finally, statements of counterfactual consent are *actually used* to justify acts of euthanasia. Since it is a regular practice to cite statements of counterfactual consent when justifying a morally problematic act, it seems only appropriate to ask what these statements mean, when it is appropriate that they are used, and to what ends they are used. As an actual practice, counterfactual consent's philosophical implications deserve further scrutiny.

There may be a further question, however. It is clear that counterfactual consent is interesting for philosophers to think about. However, why have I restricted my discussion of counterfactual consent to questions pertaining to euthanasia?

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[3]Brock, p. 32.

Counterfactual consent is philosophically interesting in many contexts - not only in cases of euthanasia.

I agree. Many of the points I make about counterfactual consent are not interesting only to those who are interested in philosophical questions about euthanasia. Counterfactual consent is a concept that has relevance in the philosophy of law, social contract theory, all forms of medical paternalism, and many other areas. However, there are three reasons why counterfactual consent has special relevance to questions of euthanasia. First, acts of euthanasia are unique in that they are permanent and unrectifiable. Once an act of euthanasia is performed, it is not possible to alter states of affairs so as to approximate the circumstances before the act of euthanasia takes place. If I take a pen off your desk without your consent, you may be upset, but I can always return the pen. With a case of euthanasia, the damage cannot be undone.

Second, cases of euthanasia deal with something far more valuable than pens. Human lives are at stake. Some philosophers have gone so far as to say that human lives bear intrinsic value. Others claim that we have a right to life. Certainly, if we are no longer alive, numerous experiences are denied us. Taking a human life is a significant moral act, and the circumstances that surround the taking of a human life should be carefully considered. Thus, while counterfactual consent is philosophically important in its own right, counterfactual consent's implications for cases of euthanasia seems to be especially significant.

Finally, owing to the permanent and unrectifiable nature of acts of euthanasia, counterfactual consent about acts of euthanasia is able to illustrate important factors about counterfactual consent that statements of counterfactual consent for other acts cannot demonstrate. In Chapter III, I use possible world semantics to demonstrate precisely what is meant by a statement of counterfactual consent. Most statements of counterfactual consent do not have the special features that the statements of counterfactual consent about euthanasia have. For example, statements of counterfactual consent require us to consider the patient in very different circumstances than he is when the act of euthanasia is about to be performed. Are we asked to consider the patient's response in circumstances that are so different from the patient's actual circumstances that the question of performing an act of euthanasia is no longer relevant? These questions shed light on counterfactual consent, not only counterfactual consent in cases of euthanasia.

Two Tools in My Discussion

I am not presupposing any moral normative theory in my discussion. I recognize that this may seem problematic, but I have limited my discussion to relatively clear cases, and hope to make do with consulting my moral intuitions in determining what is right in these cases. I recognize the difficulty in this strategy - those who believe that acts of euthanasia are always wrong will not agree with my conclusions. However, there is an advantage in taking this strategy. I have not limited my discussion of

counterfactual consent by chaining my conclusions to a single moral normative theory. Hopefully, I have demonstrated some interesting points about counterfactual consent which are relevant regardless of the moral normative theory that the reader believes is true.

Finally, I have assumed that if there are any benefits or harms that come to the victim being euthanized or not euthanized, those are benefits or harms that come to a person while he or she is alive. I have not taken into account the benefits or harms that may come to the victim after that individual is dead. For example, when I define 'euthanasia' in Chapter I, I will limit my discussion of the cessation of suffering that results from an act of euthanasia to the suffering that a person experiences when he or she is still living, not the suffering he or she may experience in an afterlife. The rare examples that make reference to benefits or harms after an individual is dead will be mentioned when the time comes.

CHAPTER I

INTRODUCING SOME TERMINOLOGY

Pollyanna is confronted by a mugger on her first trip to New York City. When she refuses to hand over her wallet, she is shot to death by the mugger. At the trial, the mugger's attorney does not argue that his client did not kill Pollyanna - the evidence of this fact is overwhelming. Furthermore, the attorney does not argue that his client did not intend to kill her - the motive to kill is not in dispute. Rather, the attorney takes out a copy of Beneficent Euthanasia, edited by Marvin Kohl. The attorney also has a copy of Biomedical Ethics, edited by Thomas A Mappes and Jane S. Zembaty. Each is determined by the court to be a reputable collection of philosophical essays. The attorney reads a definition of 'euthanasia' presented by Tristram Engelhardt Jr:

> I will use the term euthanasia in a broad sense to indicate a deliberately chosen course of action or inaction that is known at the time of decision to be such as will expedite death.[1]

The attorney then proceeds to argue that his client ought to be given the lightest possible sentence. While the mugger did deliberately kill Pollyanna, he did not perform an act of murder. Rather, he performed an act of euthanasia, as defined by Engelhardt. Other individuals who have performed acts of

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[1]Tristram Engelhardt Jr., "Aiding in the Death of Young Children", Beneficent Euthanasia, ed. Marvin Kohl, p. 189-190. Also reprinted in Biomedical Ethics, ed. Thomas A. Mappes and Jane S. Zembaty, McGraw Hill, Inc., 1991, p. 413.

euthanasia have been acquitted[2] - at the very least his client should receive a light sentence.

There are some bad definitions of 'euthanasia' in the philosophical literature, and armed with one of these bad definitions, one can prove almost anything. Before euthanasia can be discussed appropriately, and the relevance of counterfactual consent to cases of euthanasia can be discussed appropriately, I first must explain what I mean by 'euthanasia' and 'counterfactual consent'.

A Few Poor Definitions of 'Euthanasia'

A surprising number of philosophical articles about euthanasia do not even give a definition of 'euthanasia'[3]. Among the articles that do include definitions of 'euthanasia', many of these definitions are quite different. Often an act that will be picked out as an act of euthanasia according to one definition, fails to be an act of euthanasia based according to another definition.

One definition of 'euthanasia' is proposed by Arthur J. Dyck, in "An Alternative to the Ethic of Euthanasia":

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[2]For a concise summary of both United States and International legal cases in which individuals who performed acts of euthanasia were acquitted, or never brought to trial, see Fred Rosner, "Euthanasia", Contemporary Jewish Ethics and Morality, ed. Elliot N. Dorff and Louis E. Newman, Oxford University Press, 1995, pp. 350-353.

[3]See, for example, "Should There be a Legal Right to Die?" by Robert F. Drinan, and "Justifying the Final Solution" by Helge Hilding Mansson, all reprinted in Ethical Issues in Death and Dying, ed. Robert F. Weir, Columbia University Press, 1977.

> The term "euthanasia" is used here, exactly as in the Voluntary Euthanasia Act of 1969, to mean "the painless inducement of death"[4].

A similar definition is mentioned by Marvin Kohl, in The Encyclopedia of Ethics. Kohl proposes three definitions of 'euthanasia'. The first is:

> It ('euthanasia') is often defined as "the act or method of painlessly inducing the death of a nonfetal sentient being"[5].

Dyck elaborates on his definition. He rejects definitions of 'euthanasia' that do not make a reference to the fact that a death by euthanasia is one which is induced. Rather than a definition that fails to make this important distinction, he considers the Webster's New World Dictionary, 1962 edition, definition of 'euthanasia':

> an act or method of causing death painlessly so as to end suffering[6].

Kohl's second definition of 'euthanasia' seems to capture the spirit of Dyck's second definition. Kohl writes:

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[4]Arthur J. Dyck, "An Alternative to the Ethic of Euthanasia", reprinted in Ethical Issues in Death and Dying, ed. Robert F. Weir, Columbia University Press, 1977.

[5]Marvin Kohl, "Euthanasia", The Encyclopedia of Ethics, ed. Lawrence C. Becker, Garland Publishing, Inc., New York and London, 1992, p. 335.

[6]Daniel Maguire, in "Deciding for Yourself: The Objections", uses this same definition of 'euthanasia' (also reprinted in the Weir volume).

> 'Euthanasia' is sometimes defined as "the act or method of directly causing or allowing the painless and quick death of a nonfetal being, so as to end suffering or an undesirable existence"[7].

Of course, what is meant by an "undesirable existence" is very vague[8]. Perhaps the most interesting question when determining what an "undesirable existence" is, is "Undesirable for whom?" Is this an existence that is undesirable for the family of the patient, because the patient's continued care is costing a great deal of money? Is it undesirable for the doctors who are spending a great deal of time on a patient when they could be doing other things? Perhaps Kohl believes that an "undesirable existence" refers to the degree of the desirability of the patient's existence for the patient, not the degree of desirability of the patient's existence for those surrounding the patient.

Finally, Marcia Angell mentions a definition that is very similar to both Dyck's and Kohl's definitions:

> Euthanasia means purposely terminating the life of a patient to prevent further suffering[9].

What do Dyck, Kohl and Angell mean by these definitions? I would like to propose a condensed version of Dyck's and Kohl's definitions of ' an act of euthanasia', which I will refer to as E1:

> E1: a is an act of euthanasia =df 1) a is the painless inducement of death of a non-fetal sentient being,

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[7]Kohl, p. 336.
[8]Kohl considers what he calls "Conservative", "Moderate" and "Libertarian" views on the notion of an undesirable existence.
[9]Marcia Angell, "Euthanasia", Biomedical Ethics, ed. Thomas Mappes and Jane S. Zembaty, McGraw Hill, 1991, p. 382.

> and 2) a is performed so as to end suffering or an undesirable existence of the being that is killed[10]

Phillipa Foot in her article, "Euthanasia", introduces but does not endorse, the following definition:

> Let us insist, then, that when we talk about euthanasia, we are talking about a death understood as a good or happy event for the one who dies....For if we say that the death must be supposed to be a good to the subject we can also specify that it shall be for his sake that an act of euthanasia is performed[11].

This definition of 'euthanasia' may be taken literally to mean a special type of act of dying. However, it is charitable to mean by 'euthanasia' an act that causes a death, rather than the death itself. Foot makes this clear later in her paper, when she poses the question "If one man kills another, or allows him to die, thinking that he is in the last stages of a terrible disease, though in fact he could have been cured, is this an act of euthanasia or not?"[12] The action that is being questioned is the action of the killer that caused the death of the other man - his mistaken beliefs may have some bearing on whether this was euthanasia or not. The action of the killed man (ie: dying) is the same,

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[10]While Dyck does not say this, I believe that he meant that acts of euthanasia are performed "so as to end (the) suffering of the person who dies". Were a doctor to be involved in a long, drawn-out malpractice lawsuit, but realized that were he to painlessly kill his former patient that his (the doctor's) suffering would end, such a killing would not be euthanasia. I believe Dyck would endorse this modification of his definition.

[11]Phillipa Foot, "Euthanasia", Virtues and Vices and Other Essays in Moral Philosophy, University of California Press, 1978, p. 34.

[12]Ibid, p. 35.

regardless of the beliefs of the killer. I will consider this definition of 'euthanasia' as E2:

> E2: a is an act of euthanasia =df a the act of causing a death which is 1) a good or happy event for the person who dies and 2) a is performed for the sake of the person who dies

Finally, I would like to consider a third definition proposed by Kohl. He mentions a third, more substantial definition of 'euthanasia':

> They [philosophers who find problems with Kohl's earlier definitions] define 'euthanasia' as "the act or method of inducing as painless a death as possible, where the organism is acutely suffering or in an undesirable state, where the relief of the latter condition is the only primary motive and where there is convincing evidence that the resulting death is a greater good or lesser evil for the recipient than the failure to actively intervene."[13]

This definition may be adopted, almost verbatim, into a third definition of 'euthanasia' which I will refer to as E3:

> E3: a is an act of euthanasia =df a is 1) an act or method of inducing as painless a death as possible, 2) the one who is killed is acutely suffering or in an undesirable state, 3) the relief of the latter condition is the only primary motive, and 4) there is convincing evidence that the resulting death is a greater good or lesser evil for the recipient than the failure to actively intervene

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[13]Kohl, p. 336.

Of course, what constitutes an "undesirable state" or an "undesirable existence" differs from person to person. It may be pointed out that E3 offers the patient a greater number of options than E1 does. If you are leading an undesirable existence, the only immediate option appears to be to cease existing. However, if you are in an undesirable state, you presumably have the option to change states, and not merely change whether you exist or not.

I would now like to demonstrate that no two of these definitions pick out exactly the same acts as acts of euthanasia. Each of the definitions also picks out certain acts as acts of euthanasia that are clearly not acts of euthanasia. I will demonstrate this by considering several cases.

The Case of Joe. Joe is a patient in a hospital. He is suffering from a terminal and very painful illness. Joe requests that his doctor assist him in killing himself. Joe's doctor agrees to help kill Joe, but the only method of killing Joe available to the doctor is fatal injection using a hypodermic syringe. There will be a very small amount of pain when the injection is administered, but shortly after that Joe will fall into a deep, comfortable sleep, and die. All of Joe's suffering will be over.

According to E1, this is not an act of euthanasia. Although Joe's case did fulfill the second conjunct in E1 (the killing of Joe was performed to end Joe's suffering), it did not fulfill the first conjunct. This was not a painless inducement of death. Joe did feel a small amount of pain when his death was induced - the pin-prick of the hypodermic syringe.

According to E2, this may have been an act of euthanasia. The act was "performed for the sake of" Joe. Also, the death may have been a "good", if not "happy", event for Joe. Perhaps what would have been best for Joe was for his suffering to be over, even if that meant his death. In this sense, a 'good' is understood to be better than any alternative, even if it is not a happy alternative. The death of Joe may not have been a happy event for him. It is unlikely that Joe was happy at the time of his death. Relieved, perhaps, comforted in the thought that his suffering would soon be over, likely, but "happy"? Probably not. The badness of his death may have been outweighed by the goodness of the end of his suffering. In that case, his death would have been a good event for him, albeit not a happy one.

However, using Foot's own analysis of what makes an event a "good" one for an individual, Joe's euthanasia fails to be a "good" event for him. In saying that euthanasia is a "good or happy event for the one who dies", one must elaborate on what is meant by a "good or happy event". While Foot does not say much about about what makes an event happy, she does discuss in detail what makes something good for a human being:

> The idea we need seems to be that life which is ordinary human life in the following respect - that it contains a minimum of basic human goods. What is ordinary in human life - even in very hard lives - is that a man is not driven to work far beyond his capacity; that he has the support of a family or community; that he can more or less satisfy his hunger; that he has hopes for the future; that he can lie down to rest at night...

> ...It is not the mere state of being alive that can determine, or itself count as, a good, but rather life coming to some standard or normality. It was argued that it is as part of ordinary life that the elements of good that a man may have are relevant to the question of whether saving his life counts as benefiting him. Ordinary human lives, even very hard lives, contain a minimum of basic goods, but when they are absent the idea of life is no longer linked to that of good.[14]

Using Foot's conception of what it means for something to be "good" for a person, then there are no acts of euthanasia which are good for anyone! Acts of euthanasia are performed to end the life of individuals who are suffering, or who will be suffering, or who are in a state in which they experience nothing at all (ie: they are comatose, or in a persistent vegetative state). But after they are killed, they will no longer be experiencing the "minimum of basic human goods". They will be experiencing nothing at all! Thus this is not a case of euthanasia according to E2, for it is not the case that this is a "happy" event for Joe, and using Foot's own conception of human good, it is not a "good" event either.

According to E3, this was an act of euthanasia, for this was the only method of killing Joe (thus it was the method that induced the least painful death possible), Joe is in an "undesirable state", the hope of getting Joe out of the "undesirable state" is the motive for the action, and Joe at least believes that his death is a greater good or lesser evil than his failure to die.

The Case of Doctor Lechter's Patient. Doctor Lechter accidentally administers a fatal dose of aspirin to a young and

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[14]Foot, pp. 42-43.

happy patient, in an attempt to stop a migraine. The administering of the aspirin was entirely painless, but ended the patient's happy life. Certainly this would not be considered a form of euthanasia!

In this case, the first conjunct in E1 is satisfied - this was a painless inducement of death. The second conjunct is also satisfied - the doctor performed the action in an attempt to stop the suffering of his patient. The case of Doctor Lechter is a case of euthanasia according to E1! Of course, this is not an act of euthanasia according to E2 - having his life cut short is not a good or a happy event for Doctor Lechter's patient. Nor is this an act of euthanasia according to E3. It is true that Doctor Lechter's patient was acutely suffering and in a "undesirable state". Her current state was one in which she was in great pain due to her migraine. However, the final condition in E3 - that the "resulting death is a greater good or a lesser evil for the recipient than the failure to intervene" - is not satisfied in the Doctor Lechter case. Had Doctor Lechter failed to intervene, the patient would have continued to live in great pain for a short time. However, she would have recovered from her migraine. Every reasonable expectation indicates that she would have lived an enjoyable life. His failure to intervene would have cost her a few days pain from a migraine. In intervening, he cost her her life. The resulting death is certainly a greater evil than his failure to intervene. The final condition of E3 is not satisfied. This is not a case of euthanasia according to E3.

The Case of Mary. Mary was on her deathbed, at the end of a long illness. She asked her doctor to kill her, so that she might end her suffering sooner. Her doctor had two possible methods by which to kill her: sleeping pills, or lethal injection. He chose the lethal injection, because another patient might need the sleeping pills later. Mary felt a slight pin-prick, and died.

In many ways, the Case of Mary is very similar to the Case of Joe. As with the Case of Joe, the Case of Mary fails to be a case of euthanasia according to E1. Since Mary felt a small amount of pain when her doctor gave her the lethal injection, this was not a "painless inducement of death". Thus, E1 fails to pick out the Case of Mary as a case of euthanasia.

Similarly, E2 has problems in picking out the Case of Mary as a case of euthanasia. Mary was probably not happy that she was dying. As with the Case of Joe, Foot will also concede that the Case of Mary was not a good event for Mary either, for it did not enable her to enjoy the "minimum of basic human goods".

However, unlike the Case of Joe, the Case of Mary fails to be a case of euthanasia according to E3. Mary's doctor did not perform an act that was the "method of inducing as painless a death as possible". Giving Mary sleeping pills would have been less painful for her than experiencing the pin-prick of the lethal injection.

In summary, the Case of Joe illustrates that in some cases E1 does pick out the same acts as acts of euthanasia as E2; while both E1 and E2 failed to pick out the act of causing death in the Case of Joe as an act of euthanasia. The Case of Joe demonstrated that E1

and E2 pick out different acts as acts of euthanasia than E3. While the case of Joe illustrated an act of euthanasia according to both E1 and E2, it did illustrate an act of euthanasia according to E3. Thus, the Case of Joe illustrated that E1 and E2 are not equivalent to E3.

Additionally, E2 has been demonstrated to be deeply flawed. E2 contends that acts of euthanasia result in deaths which are "good or happy event(s) for the person who dies" - but this is odd. It is unlikely that any deaths are happy events for the persons who die. They may be events which are a relief, or a comfort. The person's death may be the best possible option for him, under his circumstances. It is odd to claim that such deaths are happy events for the person who dies. Furthermore, using Foot's own conception of "good", none of these events is good either, for none of them allow the persons who die to then experience the "minimum of basic human goods". In virtue of this fact, no euthanasias are ever good *or* happy.

Furthermore, we intuitively recognize that the Case of Joe *is* a case of euthanasia. But E3 was the only definition that picked out the case of Joe as a case of euthanasia. Thus, E3 is the only definition that may be correct, thus far.

In the Case of Doctor Lechter, E1 did pick out Doctor Lechter's act of killing his patient as an act of euthanasia. Our intuitions lead us to believe that the Case of Doctor Lechter was not a case of euthanasia, demonstrating that E1 is flawed. However, this was not an act of euthanasia according to either E2

or E3. Thus, the Case of Doctor Lechter demonstrated that E1 is not equivalent to E2 nor E3.

Finally, the Case of Mary was not a case of euthanasia according to E1, E2, nor E3. Many people would claim that the Case of Mary certainly *was* a case of euthanasia. And yet not one of these definitions picked it out as such. None of the definitions offered so far has adequately captured our notion of what is meant by 'euthanasia'.

The following chart summarizes the conclusions drawn from the cases of Joe, Doctor Lechter and Mary:

Table 1.1: Cases of Euthanasia According to E1, E2, E3, and Intuitively Speaking

	E1	E2	E3	Intuitions
Case of Joe	no	no	yes	yes
Case of Doctor Lechter	yes	no	no	no
Case of Mary	no	no	no	yes

Unless it is understood what is meant by 'euthanasia', further discussion of the topic would be quite difficult.

Better Definitions of 'Euthanasia'

I would like now to turn my attention to definitions of 'euthanasia' that do not suffer from the over-simplicity that resulted in the flaws of E1, E2, and E3.

Michael Wreen, in his "The Definition of Euthanasia", considers a definition of 'euthanasia'[15]. His definition is in seven parts (where A is a person, but it is not determined what B is). I will refer to this definition as 'E4':

> E4: Person A performed an act of euthanasia if and only if 1) A killed B or let her die, 2) A intended to kill B, 3) the intention specified in (2) was at least partial cause of the action specified in (1), 4) the causal journey from the intention specified in (2) to the action specified in (1) is more or less in accordance with A's plan of action, 5) A's killing B is a voluntary action, 6) the motive for the action specified in (1), the motive standing behind the intention specified in (2), is the good of the person killed, and 7) the good specified in (6) is, or at least includes, the avoidance of evil.

There are several interesting points that I would like to discuss in Wreen's definition. First, in part 1 Wreen says that an act is an act of euthanasia if and only if 'A killed B or let her die'. But in part 2 Wreen considers only that 'A intended to kill B'. Why didn't Wreen say that 'A intended to kill B or let B die?' Shutting off life support machines may result in death, but the doctor who shuts off such a machine may only intend to let his patient die, and not intend to *kill* the patient. Wreen's definition is weakened by his failure to include the intent to let the patient die in part 2, and focus only on the intent to kill the patient[16].

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[15]Michael Wreen, "The Definition of Euthanasia", Philosophy and Phenomenological Research, vol. 48, no. 4, June 1988, pp. 637-653.

[16]James Rachels, in his famous "Active and Passive Euthanasia" (reprinted in Biomedical Ethics, ed. Thomas A. Mappes and Jane S. Zembaty, McGraw-Hill, 1991, 367-370) has argued that the distinction between the two is an impertinent distinction. Rachels's claim is that there is no *morally*

Wreen's claim in part 7, that the good that results from the act of euthanasia "is, or at least includes, the avoidance of evil" is also problematic. As stated in part 6, Wreen means to be discussing the good and avoidance of evil of the person who is killed, and not his doctors, family or friends. There are many people who request to be euthanized if they fall into irreversible comas in the future[17]. For some of these people, living in a coma is a life that is neutral, neither good nor bad. There is nothing evil in their lives - there is nothing good in them either. Yet, Wreen in claiming that acts of euthanasia "at least include[s], the avoidance of evil" would be forced to rule out the terminating the life of such an individual from being an act of euthanasia, because the good that results from that person's being killed does not include the avoidance of evil[18].

Finally, according to Wreen, some suicides, some acts of abortion, and some martyrdoms are acts of euthanasia. Some of these acts are occasionally voluntary, for the good of the person involved, and in some cases the good that resulted from the performance of the act involved the avoidance of evil. When Joan of Arc was burnt at the stake, her death was voluntary, intentional, and it may have even been good for Joan of Arc to have been burnt at the stake; she subsequently achieved

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relevant distinction between the two, not that there is no conceptual distinction between the two.

[17]See Chapter IV for the distinction between these options and their possible application as evidence for the truth of a statement of counterfactual consent.

[18]For a discussion of a case of a man who is in an irreversible coma, and his desire to be euthanized if he were in such a case, see Chapter III.

Sainthood[19]. But burning an otherwise healthy 14 year old girl at the stake is certainly not an act of euthanasia.

Wreen proposed his definition of 'euthanasia' in contrast to another definition. That definition was proposed by Tom Beauchamp and Arnold Davidson, in their "The Definition of Euthanasia"[20]. I will refer to Beauchamp and Davidson's definition as 'E5':

> E5: the death of a human being, A, is an instance of euthanasia if and only if 1) A's death is intended by at least one other human being, B, where B is either the cause of death or a causally relevant feature of the event resulting in death (whether by action or by omission); 2) there is either sufficient current evidence related to A's present condition such that one or more known causal laws supports B's belief that A will be in a condition of acute suffering or irreversible comatoseness; 3) (a) B's primary reason for intending A's death is cessation of A's (actual or predicted) suffering or irreversible comatoseness, where B does not intend A's death for a different primary reason, though there may be other relevant reasons, and (b) there is sufficient current evidence for either A or B that causal means to A's death will not produce any more suffering than would be produced for A if B were not to intervene; 4) the causal means to the event of A's death are

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[19]The claim that Joan of Arc's posthumous achievement of Sainthood was good for her is only true if it is the case that things can be good or bad for you even after you no longer exist. This notion was first discussed by Aristotle in his Nicomachean Ethics (1101a23-1101b9). Aristotle believes that the lives of the dead are affected to some degree by what happens even after they are dead. For further discussion of this question, see Fred Feldman's Confrontations with the Reaper, Oxford University Press 1992, and Thomas Nagel's "Death", Mortal Questions, Cambridge University Press, 1979.

[20]Tom Beauchamp and Arnold Davidson, "The Definition of Euthanasia", The Journal of Medicine and Philosophy, vol. 4, 1979, p. 294-312. The definition is reprinted in Wreen, p. 640.

> chosen by A or B to be as painless as possible, unless either A or B has an overriding reason for a more painful causal means, where the reason for choosing the latter causal means does not conflict with the evidence in (3b); 5) A is a nonfetal organism.

There are a few problems with this definition, also. Wreen finds a problem with part 1 - the causal chain from B's intent to cause the death of A has not been sufficiently established. "It is killing and letting die, not merely causing of death, which figure in the definition of euthanasia (sic)", says Wreen[21]. It is not clear that Wreen has argued sufficiently that there is a distinction between "causing" a death and "killing (or) letting die", however. If an agent's action is sufficient to cause a death, then is there anything that that agent did in causing that death that would not have fallen under the description of either "killing" or "letting die"? Wreen offers this example: "If I were to walk into my house one night and flip on the light switch, for example, a man tied to an electric chair in the middle of my living room, hooked up to my light switch, might meet his fate, and I would cause his death, perhaps, but certainly not kill him."[22] The example is not at all persuasive. Wreen killed the man in his example. It may have been an unintended killing, it may be one that he is not morally responsible for, but certainly Wreen killed the man in the electric chair in his living room. Wreen may disagree; he may claim that didn't kill the man in the electric chair, for the person who

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[21]Wreen, p. 641.
[22]Wreen, p. 641.

contrived this sadistic death-trap was a least partly responsible. I answer that the efforts of both Wreen and the person who placed the electric chair in the living room were jointly sufficient to have killed someone. Certainly a killing took place. Wreen may reply that since his efforts alone were not responsible for the killing, he did not perform an act of killing. I would then ask him if acts that looked like killing that he didn't perform *alone* , such as murders with guns, knives and grenades, weren't acts of killing? They are acts of killing, and Wreen is forced to concede that it is not important that an agent alone be the sufficient cause of death to have performed an act of killing. Wreen may reply that he needed to be the sole *agent* involved to perform an act of killing; non-living tools like guns and grenades don't count. Does that mean that soldiers on the battlefield aren't killing, since without their commanding officers they wouldn't be there, I ask. You can't suggest that an act is an act of killing only if you alone intended it as such! The mafia assassin who was following the Godfather's orders is still a killer. Wreen's claim that the flick of his lightswitch isn't an act of killing is impossible to defend.

Beauchamp and Davidson's mention of irreversible comatoseness in part 2 eliminates the problem that Wreen encountered in part 7 of his definition - the problem of the euthanasia having to eliminate evil for the patient, and not merely be a good. However, there are other problems with E5. What is meant by the claim in part 3b that "there is sufficient current evidence for either A or B that causal means to A's death will not produce any more suffering than would be produced for A if B

were not to intervene"? Does this mean that the act of euthanasia will cause less suffering than the act of failing to euthanize the patient? Or, does it mean that the act of euthanasia will cause no suffering at all? If A is already comatose, then A is not suffering at all. However, euthanizing a comatose patient by giving a hypodermic injection may result in some pain, where the comatose A was previously not feeling any pain at. According to 3b, the hypodermic injection of a comatose patient that results in his death is not an act of euthanasia if it causes the patient even slightly more suffering than he was feeling before the injection. But this is a mistake - of course this would be considered an act of euthanasia.

E5 eliminates the possibility that an agent can die of euthanasia by his own hand. Is every case of euthanasia one in which an agent kills someone else? Derek Humphry talks extensively about killing yourself in case you are diagnosed with a terminal, debilitating illness, before you are unable to perform the act of killing yourself. Humphry calls himself an advocate for the legalization of euthanasia - be it "suicide" or a case of "assisted suicide"[23]. According to Humphry, euthanasia includes acts of killing in which an agent kills himself. Beauchamp and Davidson's definition would eliminate such acts from being acts of euthanasia. This is too strict a prohibition, however. Wreen agrees with this point; "I can see no reason for insisting that A and B be distinct persons".[24]

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[23]Derek Humphry, Final Exit, The Hemlock Society, 1991, p. 149.
[24]Wreen, p. 641.

A final problem with E5 is the conspicuous defining of euthanasia for human beings only. It is the case that animals can be euthanized. Beauchamp's and Davidson's definition defines euthanasia only for human beings, and not for animals. This raises the question why it is that they end their definition by mentioning "non-fetal *organisms* (italics mine)", when they are so clearly discussing only non-fetal human beings.

While E5 does have some problems, on the whole E5 is the best of the definitions of 'euthanasia' thus far discussed. With a few modifications, Beauchamp's and Davidson's definition of 'euthanasia' will be adopted.

A New Definition of 'Euthanasia'

Beauchamp and Davidson's definition of 'euthanasia' was a fair one, with only minor problems. I will adopt a modified version of their definition of 'euthanasia', that I call 'E6':

> E6: the death of A is an instance of euthanasia if and only if 1) A's death is intended by at least one human being, B, where an action of B's is either the cause of death or a causally relevant feature of the event resulting in death (whether by action or by omission); 2) there is sufficient current evidence related to A's present condition such that either one or more known causal laws supports B's belief that A will be in a condition of acute suffering or irreversible comatoseness; 3) (a) B's primary reason for intending A's death is cessation of A's (actual or predicted) suffering or irreversible comatoseness, where B does not intend A's death for a different primary reason, though there may be other

> relevant reasons, and (b) there is sufficient current evidence for either A or B that causal means to A's death will not produce any more suffering than would be produced for A if B were not to intervene; 4) the causal means to the event of A's death are chosen by A or B to be as painless as possible, unless either A or B has an overriding reason for a more painful causal means, where the reason for choosing the latter causal means does not conflict with the evidence in (3b); 5) A is a nonfetal organism.

I have made two more slight modifications to E5. I have changed the definition so as to allow that human beings can die of euthanasia by their own hands. While I will not be discussing such cases in detail, it is important that any correct definition of euthanasia include such a modification. Finally, I have removed the claim that this is a definition of euthanasia for people. It is the case that animals can be euthanized, and E6 does describe euthanasia of animals as accurately as it describes euthanasia of people. It may be noted that while a human being can die by his own hand and such an act may still be called an act of euthanasia according to E6, it is not the case that an animal can die of its own hand and such an act be called an act of euthanasia, for at least one of the parties (ie: the person doing the killing or letting, and the individual who is killed or let die) must be a human being according to part 1 of E6.

It should be pointed out that some people will take issue with E6. They will single out 3b - the claim that there is sufficient current evidence for either the patient or person performing the act of euthanasia that the euthanasia will not produce any more

suffering than would be produced if the euthanasia did not take place. Some people will say that there is never sufficient current evidence for this claim. For example, if you believe that all acts of euthanasia will be punished by endless suffering in hell for the person who is killed, then it is certainly better not to intervene, no matter the amount of suffering the patient is undergoing. They will say that this is not a problem for my definition, it is merely evidence for the claim that there are no morally permissible acts of euthanasia.[25] I disagree. I did not wish to advance a definition of 'euthanasia' in which all acts of euthanasia are by definition morally right. I do not believe that all acts of euthanasia are by definition morally right. By the same token, I do not believe that by definition all acts of euthanasia are morally wrong. Regrettably, I cannot see a way of altering E6 so as to accommodate those who disagree with it on these grounds.

Consent and Informed Consent

While the term 'informed consent' refers to a more complex concept than mere 'consent', when I refer to 'consent' I will mean 'informed consent'. What is the difference between 'consent' and 'informed consent', and why is the later preferred over the former?

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[25]The importance of this objection is evident in Chapter II. Without the claim in 3b, the argument presented in Chapter II, that counterfactual consent can be used to morally justify acts of euthanasia, is not sound.

Seemingly, any time a patient says "yes" when asked if he is willing to undergo a treatment, that patient has consented to that treatment. Yet, merely saying "yes" seems too weak a sufficient condition for consent to that treatment. Imagine a delirious patient, mumbling "yes" for a hour before being asked to undergo a treatment. In that case, it was mere coincidence that the patient said "yes" when asked if he would be willing to undergo a treatment. Perhaps the patient was asked if he wished to undergo a treatment, and said "yes". But even that statement of assent, or "affirmative agreement"[26] is not sufficient for consent.

Perhaps the patient felt undue pressure from his family, or his doctors, to undergo a treatment that he would under other circumstances refuse. In this case, the consent is not voluntary[27]. The notion of 'consent' must be improved upon so as to eliminate these cases in which a patient's mere utterance of the word 'yes', or uninformed assent, or an unfree seeming assent, should not count as true consent.

So as to eliminate these obviously false cases of giving consent, I will now introduce a complete analysis of consent, which I will call 'IC', for 'informed consent':

> IC: A patient, S, gives informed consent to treatment x for condition y iff 1) S assents to treatment x for y, 2) S is given sufficient information about x and y and the effect x would have on y, 3) S comprehends

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[26]Ruth Macklin, "Autonomy, Beneficence and Child Development: An Ethical Analysis", Social Research on Children and Adolescents: Ethical Issues, ed. Barbara Stanley and Joan E. Sieber, Sage Publications, 1992, p. 90.

[27]Foot observes that persuading a patient to consent to euthanasia against their will is a possible abuse resulting from the possible legalizing of euthanasia (p. 59).

> the information given to him about both x and y, and 4) the assent given by S for an agent to perform treatment x for y is given freely and voluntarily[28]

There are several terms that require further analysis before IC can be properly understood.

Sufficient information. How much must S know about both his condition and the treatment for his condition before S has sufficient information about his condition? It is important that S not only know the details about the effect of x on y, but it must also be the case that S know enough about y so as to know what the possible alternative treatments are. If all that S knows is that he has y, and that x is one possible treatment, but S is unaware of other possible treatments, then S does not have enough information so as to make an informed decision about treatment x[29]. It is important that the patient not have too little information on which to base his decision.

However, does the patient have to be aware of every alternative? This would be prohibitive! The alternatives may be too numerous to even name, let alone be described in any detail[30].

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[28]This analysis of 'informed consent' is based upon an analysis advanced by the Office for Protection from Research Risks, National Institutes of Health, Protecting Human Research Subjects, United States Department of Health and Human Services, 1993, p. xxii. See also Dan W. Brock, Life and Death: Philosophical Essays in Biomedical Ethics, Cambridge University Press, 1993, p. 22. This analysis would also be endorsed by Joel Feinberg, who claims that an agent can consent to relinquish any right as long as his choice is fully informed, well considered, and uncoerced. See Joel Feinberg, Harm to Others, Oxford University Press, 1984, pp 274-275.

[29]Brock, p. 22.

[30]The Hastings Center appears to have overlooked this fact when they claimed on page 21 that the patient or his surrogate should be careful to consider all possible outcomes the patient might experience. The Hastings

There is a point at which it is no longer reasonable to keep naming alternative treatments. At what point is this? It is nearly impossible to say. Suffice it to say that each of the reasonable alternatives must be known to the patient for him to make an informed decision that treatment x is the one to which he is willing to consent.

Given that the patient knows that there are alternatives to treatment x, how much more does he have to know? The doctor would be irresponsible in merely naming the possible reasonable treatments, without explaining what is involved in each of them. Just knowing that there are numerous treatments, without knowing what is involved in each is not sufficient for the patient to make an informed choice. However, there is a limit to the amount of information that is necessary for a patient to know what is involved in each treatment. Another problem may arise if a patient has too much information. It is possible that a patient is told the details of his alternative treatments and possible side effects in such detail that he will be paralyzed by fear at what is involved. In this case, the patient may be *too* informed, and will fail to chose an otherwise preferred treatment, out of fear[31].

Against this view, Humphry suggests that an agent is not ready to die if he is questioning if dying his best alternative[32]. This seems misguided. The agent who is both rational and informed enough about his alternatives so as to question those

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Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying, The Hastings Center, 1987.

[31]Brock, p. 49.

[32]Humphry, p. 104.

alternatives seems best able to actualize the correct alternative. If you failed to be both rational and informed about your alternatives, it is possible that you would not be able to actualize your best alternative, for you might not have the faculties to actualize it, let alone recognize it! Just because an agent questions if an alternative is his best does not eliminate that alternative from being his best[33].

Brock recommends that the patient be told what a reasonable person would want to know, and then have the opportunity to ask for additional information that he might find important to making his decision[34]. However, this raises an interesting dilemma: how will the patient know what the important additional information is that he needs to make his informed decision unless he already has that information? It may not occur to the patient to ask what the effects on his eyesight will be if his leg is amputated, but that is not to say that there will not be any effects on his eyesight. Putting the responsibility on the patient to ask all the right questions, so that he might make an informed decision, will not solve the problem of determining how much information is enough. It is nearly impossible to say when the patient knows enough so as to be properly informed.

Able to comprehend the information. This is not as complex a notion as the notion of 'sufficient information'. For S to be able to comprehend the information that has been given to him, it is

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[33]See Chapter IV for a discussion and rejection of a related view - that the best alternative is defined as the one an agent chooses for himself.
[34]Brock, p. 50.

important that the information be stated in a way that S can understand it. S's circumstances and mental abilities must be taken into consideration when determining if the information is presented in such a way that S can in fact understand the information[35]. It is important to realize, however, that not every patient has the ability to comprehend information given to him. For example, infants or young children, as well as severely retarded individuals, may have limited capacity to understand anything at all. It makes very little sense to say that such patients "consented" to anything, for it is reasonable to assume that they can not understand that treatment to which they give their "consent"[36].

It is essential that the patient is rational to be able to give informed consent to any treatment. Dan Brock considers a thought experiment which illustrates the importance of rationality in informed consent. Suppose that you are concerned for your own well-being, and at the same time you value your ability to make your own decisions. When would you want your own decisions to be used to determine your fate, and when would you want others to accept responsibility for determining your fate? Brock claims that in those cases in which your own decision-making abilities are severely limited by irrationality, and thus you are unable to make rational decisions, on your own behalf,

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[35]Office for Protection from Research Risks, p. xxii.

[36]However, while these agents never actually consent to anything, it may nonetheless make sense to attribute true statements of counterfactual consent to them, using either a "best interests" standard or a "rational agent" standard, both of which are discussed in Chapter IV.

you would want others to make decisions on your behalf[37]. Were you irrational, you may consent to a treatment that would not conform to your preferences.

A patient who is able to make a rational decision about his treatments is one who is able to communicate and understand what the treatment and the alternatives are, is able to deliberate about those treatments, and is able to come to a decision about those treatments which is in accord with his beliefs and preferences[38]. It is not enough for the patient to merely have a preference; rather, the patient must be able to connect that preference to an alternative and understand how that alternative best accords with his preference. It is important to note that it is sufficient for the patient to make a rational choice if the choice is in accord with his own preferences - it need not be in accord with other people's preferences. The doctor may believe that what the patient is choosing is wrong, for it is not the choice that the doctor would have made were she in the patient's circumstances. However, a choice is not irrational if another rational agent would not have chosen the same thing. The choice is irrational if it does not follow from the beliefs and preferences of the agent who is doing the choosing. If the doctor believes that what the patient is choosing is wrong, for what the patient is choosing does not follow from the patient's own preferences, then the doctor can reasonably assume that the patient is unable to make a rational decision.

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[37]Brock, p. 37.
[38]Brock, p. 38.

Freely and voluntarily. It is important that a patient has not been coerced into giving consent. However, the cases in which a patient has been coerced into giving consent are often very difficult to separate from those in which the patient has given free and voluntary consent.

I will use the following test to distinguish between circumstances that are truly coercive and those that are not truly coercive. If the undesirable consequences of the patient's decision are caused by the patient's illness, then those undesirable consequences are not coercive; if those undesirable consequences are caused by another agent, then they are coercive. The following examples should illuminate the distinction. Imagine a patient who is suffering from a disease, and he is told to accept a treatment, or his medication will be withheld. "If you don't accept this treatment," his doctor tells him, "I will withhold your medication and you will end up in pain." In this case, another agent would create the negative consequences that would result if the patient did not consent to the treatment. If another agent creates the negative consequences, then the patient is being coerced. Thus, in the case in which the patient is threatened with more pain by another agent unless he complies with the treatment, the patient is being coerced.

However, consider a case in which a patient will suffer equally painful consequences of not accepting the treatment, but that pain will be a result of his disease, not a result of the actions of any agent. The doctor may come to the patient and tell him, "If you don't accept this treatment, you will end up in pain", but this

is a warning about the results of his decision, not a threat. It is an unfortunate circumstance, but it is not coercive. "That all alternatives are "bad" and leave little or no "real choice" provides no sound reason to set aside the patient's choice as involuntary and to transfer the decision to another."[39]

Counterfactuals and Counterfactual Consent

A counterfactual is a statement about what would, could, might, or should be true, if some antecedent state of affairs were true. David Lewis, in the famous first line of his book Counterfactuals, says:

> '*If kangaroos had no tails, they would topple over*' seems to me to mean something like this: in any possible state of affairs in which kangaroos have no tails, and which resembles our actual state of affairs as much as kangaroos having no tails permits it to, kangaroos topple over.[40]

The sentence 'If kangaroos had no tails, they would topple over' is a counterfactual conditional - a conditional about what would, could, might or should be true if its antecedent were true. The truth value of a counterfactual conditional depends upon the truth values of its antecedent and consequent at various possible worlds[41].

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[39]Brock, p. 45.
[40]David Lewis, Counterfactuals, Harvard University Press, 1973, p. 1.
[41]Ibid, p. 1.

Lewis adopts two counterfactual conditional operators, '□->' and '◊->', which he believes to be interdefinable[42]. Lewis uses '□->' to abbreviate the counterfactual relation 'if it were the case that ___, then it would be the case that ___'. The symbol '◊->' abbreviates the counterfactual relation 'if it were the case that ___, then it might be the case that ___.' Two statements about the state of affairs, S, that an agent, A, would counterfactually consent to would be symbolized in this manner:

> If A were able to consent to S, then A would consent to S.
> A is able to consent to S □-> A consents to S
>
> If A were able to consent to S, then A might consent to S.
> A is able to consent to S ◊-> A consents to S

My discussion of counterfactuals about consent and their relevance to euthanasia will be limited to the use of the '□->' counterfactual, not the '◊->' counterfactual. While it may be interesting to consider what an agent *might* have consented to, had he been able to consent, I am primarily concerned with what an agent *would* have consented to, had he been able to consent. If an agent *might* have consented, there of course remains the possibility that the agent *might not* have consented. Since I am concerned with justifications of acts of euthanasia, considerations about whether an agent might or might not have consented are too weak for my philosophical purposes[43]. The fact that

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[42]Ibid, p. 2.

[43]Thus, I am eliminating the possibility that there are ties in comparative similarities among worlds (ie: it is not the case that there are two worlds

an agent either might or might not have consented to his euthanasia if he had been able to consent is not enough to justify killing him - the fact that the agent *would* have consented to his euthanasia if he been able to consent may have greater justificatory power[44]. If it is a question between obtaining actual consent and counterfactual consent - in which an agent either might or might not give consent - the obvious choice is to obtain actual consent. But if it is a choice between obtaining actual consent and counterfactual consent - where it is clear that the agent would give consent if he were asked - the choice is less obvious[45]. Thus, my focus will be on the counterfactual conditionals about what agents would have consented to, not merely what they might have consented to.

To determine if a counterfactual conditional is true, consider the closest possible world in which the antecedent is true. If in that world the consequent is also true, then the counterfactual conditional is true[46]. If in the closest world in which an agent can consent to being killed, he does consent to being killed, then the

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which are both the closest to an agent's actual world, such that the agent consents to being killed in one, and does not consent to being killed in the other). Lewis does permit ties in orderings of worlds; Lewis, pp. 48- 52. Robert C. Stalnaker's theory of counterfactuals is, in Stalnaker's words, "essentially equivalent" to Lewis's, expect for allowing both a limit assumption and a uniqueness assumption, which allow that for for every possible world i and every proposition which describes a change in the state of affairs of a possible world A , there is at least one A - world minimally different from i and at most one A -world minimally different from i , respectively. See Robert C. Stalnaker, Inquiry, The MIT Press, 1979, p. 133.

[44]See Chapter II for a discussion of the use of counterfactual consent to justify acts of euthanasia.

[45]See Chapter V.

[46]Lewis, p. 9.

counterfactual 'If he were able to consent to being killed, then he would consent' is true. Certainly there are worlds in which the agent does not offer consent, but not all worlds that have a true antecedent are relevant. Only the closest possible world to the agent's actual world in which he is able to offer consent is the world that need be considered. If the agent is able to consent in that world and does, then in his actual world it can be truly said 'If he were able to offer consent, then he would.'[47]

Counterfactual Consent and the Definition of 'Euthanasia'

With a clear definition of 'euthanasia' and an understanding of what is meant by "counterfactual consent" an important point about the relationship between the two can be observed. *The definition of 'euthanasia' doesn't include anything about counterfactual consent.*

Acts of euthanasia are not acts that by definition are consented to, either counterfactually or otherwise! Part 4 of E6 says "the causal means to the event of A's death are chosen by A or B to be as painless as possible, unless either A or B has an overriding reason for a more painful causal means". This is not a question of choosing or consenting to the euthanasia itself, but choosing a method of death. It may be argued that choosing a method of death is tantamount to choosing death itself. This is a

[47]In Chapter III, I will elaborate on Lewis, demonstrating that counterfactuals about consent require a more complex understanding than first anticipated.

mistake, however. I choose to die in as painless a way as possible. This is not the same as saying that I choose to die.

There is another reason for claiming that the concept of counterfactual consent is not a part of the definition of 'euthanasia'. Part 4 of E6 talks about actual choosings, either by A or B, not counterfactual choosings. A may not be in a position to say what she consents to for herself at a particular moment in time. Perhaps she is in a coma and can no longer can give consent, or is a small infant who never was able to give consent. This is not to say that the fact that she would have consented to being euthanized, or would not have consented to being euthanized, is irrelevant. 'Counterfactual consent' and 'euthanasia' are conceptually distinct. However, there are interesting and important philosophical connections between them.

In the next chapter, I will attempt to clarify the role of counterfactual consent in acts of euthanasia. First, I will ask when counterfactual consent is invoked. Which acts of euthanasia make use of counterfactual consent? Second, I will ask why counterfactual consent is invoked. When acts of euthanasia make use of counterfactual consent, what are they relying on counterfactual consent to do?

CHAPTER II

THE USES OF COUNTERFACTUAL CONSENT: ACTS AND JUSTIFICATIONS

In Chapter I, I answered the question, "What is counterfactual consent?" In this chapter, I will attempt to answer two more questions about counterfactual consent: "When is it appropriate to use counterfactual consent?" and "Why do we use counterfactual consent?"

Counterfactual consent is used to justify acts of euthanasia, but which ones? Several philosophers have drawn distinctions between different types of acts of euthanasia. One of the most famous distinctions is between "active" and "passive" euthanasia. However, I will demonstrate that this distinction is *not* helpful in determining which acts of euthanasia invoke counterfactual consent, as opposed to other forms of consent.

However, there is a distinction between types of acts of euthanasia that proves to be more helpful. I will use Helga Kuhse's and James Rachels' notions of "voluntary", "nonvoluntary" and "involuntary" euthanasia to distinguish cases in which it is appropriate to use statements of counterfactual consent from those in which it is not appropriate to use statements of counterfactual consent. I will summarize both Kuhse's and Rachels' understanding of "voluntary", "nonvoluntary", and "involuntary" euthanasia, and demonstrate the difference between their understanding of these terms. Finally, after demonstrating

several shortcomings in Rachels' terminology, I will adopt a modified form of Kuhse's terminology.

After I have explained the types of acts of euthanasia for which it is appropriate to invoke statements of counterfactual consent, I will then consider the following question: if counterfactual consent is used to justify an agent's actions, in what sense does it justify those actions? Is counterfactual consent a moral justification for an act of euthanasia, or might it succeed as a legal justification for an act of euthanasia? I will examine each of these questions in turn. I will conclude that counterfactual consent does morally justify some acts of euthanasia, but it does not and would not succeed as a legal justification for acts of euthanasia. There are mistaken arguments for the claim that counterfactual consent morally justifies acts of euthanasia, including the "best judge" argument and the "Principle of Self-Determination" or the "Principle of Autonomy" argument. I will consider each of these, and demonstrate their shortcomings. Then, using the definition of 'euthanasia' offered in Chapter I and T.M. Scanlon's view on the value of choice, I will demonstrate how counterfactual consent in fact does morally justify some, but not all, acts of euthanasia. Finally, I will examine two questions about counterfactual consent and legal justifications. Does counterfactual consent legally justify acts of euthanasia? Should counterfactual consent be used to legally justify acts of euthanasia? The answer to each of these questions is 'no'.

When is Counterfactual Consent Invoked? An Impertinent Distinction

It is not the case that counterfactual consent is appropriately invoked in all cases of euthanasia. Cases in which a competent individual asks to be killed in his hospital bed are cases in which actual consent is given, not counterfactual consent. In such cases, it is not wondered what the patient would consent to, were he able to consent. It is clear exactly what the patient would consent to - he tells us. The justification for the act of euthanizing such a person is not that this is what "he would have wanted, were he able to tell us"; rather, the justification for the act of euthanizing him is that this is "that to which he actually consented."

The above case tells us one case in which counterfactual consent is not used. In which cases of euthanasia is counterfactual consent appropriately invoked to justify the act of euthanasia? To answer this question, it would be helpful to try to distinguish between different types of acts of euthanasia. Perhaps one of the most famous distinctions between acts of euthanasia will be helpful in determining when counterfactual consent is appropriately used: the distinction between active and passive euthanasia.

James Rachels introduces the concepts of active and passive euthanasia, and attempts to draw a distinction between them:

> The distinction between active and passive euthanasia is thought to be crucial for medical ethics. The idea is that it is permissible, at least in some cases, to

> withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient.[1]

According to Rachels, active euthanasia takes place when direct action designed to kill a patient is taken. Passive euthanasia takes place when treatment is withheld, and patients are allowed to die. Thomas D. Sullivan elaborates: "By "active euthanasia" Rachels seems to mean *doing something* to bring about a patient's death, and by "passive euthanasia," not doing anything, i.e., just letting the patient die."[2] Of course, it is very difficult to draw the distinction between direct action that is designed to kill someone, and a non-action, the intended result of which is the termination of life[3]. Rachels does not attempt to rigorously analyze these two concepts. Instead, he offers several examples that supposedly illustrate the difference between the two concepts. One of these examples is of a patient who is dying of throat cancer, who asks to die and whose doctor agrees to withhold life-prolonging treatment. Withholding the treatment would hasten the patient's death, and the withholding of such treatment would be a case of passive euthanasia.[4] However, were the doctor to inject the

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[1]James Rachels, "Active and Passive Euthanasia", Biomedical Ethics, ed. Thomas A. Mappes and Jane S. Zembaty, McGraw-Hill Inc., 1991, p. 367.

[2]Thomas D. Sullivan, "Active and Passive Euthanasia An Impertinent Distinction?", Biomedical Ethics, ed. Thomas A. Mappes and Jane S. Zembaty, McGraw-Hill, p. 371.

[3]For examples of attempts to draw a distinction between actions and non-actions, see Jonathan Bennett's "Positive and Negative Relevance", American Philosophical Quarterly, vol. 20, 1983, pp. 185-194; Daniel Dinello, "On Killing and Letting Die", Analysis, vol. 31, 1971, pp. 83-86; and Bruce Russell, "On the Relative Strictness of Negative and Positive Duties", American Philosophical Quarterly, vol. 14, 1977, pp. 87-97.

[4]Rachels, "Active and Passive Euthanasia", p. 368.

patient with some drug that would kill him, then such an act would be an act of active euthanasia. In another example, a child with Down's Syndrome and an intestinal obstruction is allowed to die of starvation, rather than have the obstruction surgically removed. This is a case of passive euthanasia, for the doctors are merely withholding an operation that would save the infant, rather than taking direct action designed to kill the infant.[5]

Does the distinction between passive and active euthanasia help to draw the distinction between cases of euthanasia that might appropriately be justified using counterfactual consent and the cases that might appropriately be justified using actual consent? It does not. In the case of the patient with throat cancer, the patient certainly gave actual, and not counterfactual, consent to his own death. He asks the doctor to help him die. The doctor agrees to withhold treatment, and thus the patient dies from passive euthanasia. In this case, the doctor may justify his choice to perform an act of passive euthanasia by citing the patient's actual consent to the withholding of treatment. It would have been inappropriate for the doctor to justify his actions using counterfactual consent; actual consent was available.

However, the doctor could have given the patient an injection which would have killed him, after the patient asked to die. This would have made the patient's death an act of active euthanasia. The patient still gave his explicit actual consent. In this case, the doctor may justify his choice to perform an act of

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[5]Rachels, "Active and Passive Euthanasia", p. 368.

active euthanasia by citing the patient's actual consent to the lethal injection. Again, it would have been inappropriate in this case for the doctor to cite a statement of counterfactual consent when actual consent was given.

It seems that actual consent may be used appropriately in both cases of passive and active euthanasia. Thus, it is not the case that either active or passive euthanasias are acts of euthanasia that may appropriately be justified exclusively via counterfactual consent. Is it the case that counterfactual consent is appropriate in only passive, or in only active, acts of euthanasia? No - neither of these is the case. Rachels' Downs Syndrome infant case illustrates this fact. It is not the case that infants can offer consent to anything. Yet, the parents of the infant, along with the doctor, may reach the following conclusion: "Our child is not healthy. The quality of her life will be forever compromised. Furthermore, the time and resources that would be used in taking care of this child would disproportionately subtract from the time and resources that could be spent on our other children. Were she able to understand this, and able to tell us what she wanted, she would tell us that it is okay for us to allow her to die. Thus, it is permissible for us to withhold treatment of this infant." If this is the parents' and the doctor's line of reasoning, and they withhold giving the infant the life-saving operation, then they will have attempted to justify this act of passive euthanasia using counterfactual consent. Such a line of reasoning is an appropriate use of counterfactual consent in an attempt to justify an act of euthanasia.

A similar line of reasoning could be used for them to justify the infant's active euthanasia using counterfactual consent. The parents may consider that allowing the infant slowly to starve to death would be needlessly painful. While the infant would have wanted to die, they think, it is not the case that she would have wanted to die like this. A painless injection that would kill her, and save her days of slow starvation, is what any rational agent in their daughter's circumstances would have preferred. Thus, the parents justify their daughter's active euthanasia using counterfactual consent. This too is an appropriate use of counterfactual consent to justify an act of euthanasia.

I have illustrated that neither active nor passive euthanasia is appropriately justified exclusively using counterfactual consent or actual consent. Actual consent is appropriate in both cases of passive and active euthanasia. Counterfactual consent is appropriate in both cases of passive and active euthanasia. Another distinction between types of acts of euthanasia must be drawn to distinguish those cases in which counterfactual consent is appropriately invoked, and cases in which it is not.

Kuhse and Rachels on a Three-Way Distinction Among Acts of Euthanasia

While the passive/active distinction between acts of euthanasia has not proven helpful in determining which acts of euthanasia appropriately use counterfactual consent as part of

their justification, this is not the only distinction among types of acts of euthanasia. Several philosophers draw another distinction among types of euthanasia. This distinction is among voluntary euthanasia, non-voluntary euthanasia, and involuntary euthanasia[6]. Helga Kuhse explains the differences among these three kinds of euthanasia:

> The case of Mary F. is a clear case of voluntary euthanasia; that is, euthanasia carried out by A *at the request of* B, for the sake of B.... Euthanasia can be voluntary even if the person is no longer competent to assert her wish to die when her life is ended. You might wish to have your life ended should you ever find yourself in a situation where, whilst suffering from a distressing and incurable condition, illness or accident have robbed you of all your rational faculties, and you are no longer able to decide between life and death. If, whilst still competent, you expressed the considered wish to die when in a situation such as this, then the person who ends your life in the appropriate circumstances acts upon your request and performs an act of voluntary euthanasia.
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> Euthanasia is *non-voluntary* when the person whose life is ended cannot choose between life and death for herself - for example, because she is a hopelessly ill or handicapped newborn infant, or because illness or accident have rendered a formerly competent person permanently incompetent, without that person having previously indicated whether she would or would not like euthanasia under certain circumstances.
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> Euthanasia is *involuntary* when it is performed on a person who would have been able to give or withhold consent to her own death, but has not given consent - either because she was not asked, or because

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[6]James Rachels, "Euthanasia", Matters of Life and Death, New Introductory Essays in Moral Philosophy, ed. Tom Regan, Random House, 1986, pp. 38-39. See also Helga Kuhse, "Euthanasia", A Companion to Ethics, ed. Peter Singer, Basil Blackwell, 1993, pp. 295.

she was asked but withheld consent, wanting to go on living[7].

In summary, Kuhse claims that there are two kinds of voluntary euthanasia: 1) when the person who is killed requests to be euthanized at the time of death, and 2) when the person who is killed had previously requested that were she to be in a circumstance (c) such that she could not consent to being euthanized, she would desire to be euthanized, and c obtains. Hereafter, I will refer to these two kinds of voluntary euthanasia as 'voluntary1' and 'voluntary2', respectively. The relevant distinction between voluntary1 and voluntary2 euthanasia is that in cases of voluntary1 euthanasia the patient requests euthanasia at the time of death, whereas in cases of voluntary2 euthanasia the patient requested euthanasia at some time prior to the time of death. There are two kinds of nonvoluntary euthanasia: 1) when the person who is killed had never previously been able to consent to being euthanized, and is euthanized, and 2) when the person who is killed had previously been able to consent to being euthanized under condition (c), the person did not previously consent nor deny consent to being euthanized under c, c obtains, and the person is euthanized. I will refer to these two kinds of euthanasia as 'nonvoluntary1' and 'nonvoluntary2', respectively. Finally, involuntary euthanasia occurs when the person is able to consent or withhold consent to being killed. This person either 1) does withhold consent to being killed, or 2) is never asked for her

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[7]Kuhse, p. 295.

consent to being killed, and is killed anyway. I will refer to these two kinds of euthanasia as 'involuntary1' and 'involuntary2' euthanasia, respectively.

It is the case that the notion of counterfactual consent is used, in part, to distinguish among the different types of voluntary, nonvoluntary, and involuntary euthanasia. In several of these types of euthanasia, agents are asked to consider what the patient would have consented to, had he been able to give consent. Which of the types of voluntary, nonvoluntary and involuntary acts of euthanasia appropriately make use of counterfactual consent? I will consider each of them in turn.

It is not appropriate to cite counterfactual consent in an attempt to justify voluntary1 euthanasia. The first type of euthanasia that Kuhse considers is voluntary1 euthanasia. In these cases, the patient is actually asked for consent, and actually gives consent. It is not appropriate to cite counterfactual consent, for it is not needed. Actual consent is obtained.

It can be appropriate to cite counterfactual consent in an attempt to justify voluntary2 euthanasia. Counterfactual consent plays an important role in some voluntary2 euthanasias, but not all. Voluntary2 euthanasias are cases in which the patient says explicitly, "I consent to my doctors and family killing me when (or if) I am ever in condition c", and condition c later obtains. The statement "I consent to my doctors and family killing me when (or if) I am in condition c" is not a statement of counterfactual consent, for the patient is actually giving consent; it is the case however that the patient is giving consent to being killed when

(or if) condition c obtains, long before condition c does obtain. Perhaps the patients make these statements of consent known to their families via Living Wills, or some explicit conversation in which they state that when (or if) they were ever in the condition they are in now, that their family and doctors have their consent to euthanize them. Such a statement is a statement of assertoric antecedent consent, or problematic antecedent consent, but not counterfactual consent[8]. However, the euthanasias that appropriately use assertoric antecedent consent or problematic antecedent consent and those that appropriately use counterfactual consent are not exclusive. The family and doctors of patients who die of voluntary2 euthanasia may justify their act of euthanasia by making reference to counterfactual consent. "Were she able to give consent to her death right now, then she would give consent," they will claim. They will take as evidence for their claim the Living Will, or their earlier conversation with the patient.

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[8]It is important to note that the Living Will, and the conversation in which the patient stated that when she is in condition c in the future, then she would like for her relatives to kill her, are not statements of counterfactual consent. They are evidence for the truth of a statement of counterfactual consent, but they are not statements of counterfactual consent themselves. Rather, they are statements of assertoric antecedent consent. Similarly, the conversation in which the patient stated that if she is in condition c in the future, then she would like her relatives to kill her, is not a statement of counterfactual consent. Rather, such a statement is a statement of problematic antecedent consent. The agent, in composing a Living Will, is saying to her doctors and family, "When (or if) condition c obtains, you have my consent to kill me." This is not a statement of counterfactual consent. Consent has been given long before condition c has obtained (and it is entirely possible that condition c will never obtain!). For a complete discussion of the difference between assertoric antecedent consent, problematic antecedent consent, and counterfactual consent, see Chapter IV, "Evidence for the Truth of Statements of Counterfactual Consent."

Of course, in cases of voluntary2 euthanasia, it is entirely possible that there was no use of counterfactual consent in justifying the act of euthanasia. The doctor or family of the patient may have consulted the Living Will and said, "This is a clear statement of what the patient previously gave consent to, thus it is permissible to euthanize this patient" without considering what the patient would consent to *now* , if he were able to consent. In such voluntary2 cases, counterfactual consent is not employed to justify the act of euthanasia. Thus, counterfactual consent is appropriate in some, but not all, cases of voluntary2 euthanasia.

It can be appropriate to cite counterfactual consent in an attempt to justify nonvoluntary1 euthanasia. Deformed infants are unable to consent to being killed. We may justify their deaths by saying, "Were they to live, their lives would be unfulfilling. If they could realize this, then they would choose to be killed." Effectively, we are saying that if these infants were able to make rational choices, they would choose to be euthanized. Such is the case of the infant with Down's Syndrome and an intestinal blockage, described by Rachels. Or, we may attempt to justify their deaths by saying, "They can't make a decision, so we will choose what is best for them. Certainly, they would want what is best for themselves. Were they able to choose what is best for themselves, they would choose death." In this case, we use a best-interest criterion to determine what the infants would have wanted, had they expressible preferences. Both the "rational choice" model and the "best interest" model used to ascribe

statements of counterfactual consent to the infant.[9] Nonvoluntary1 euthanasias are performed on individuals who lack decision-making capacities, such as infants and severely retarded individuals. These are cases in which the patients are unable to make a judgment about those actions to which they would consent. Not all nonvoluntary1 cases of euthanasia are justified using statements of counterfactual consent, but it is appropriate to do so.

It can be appropriate to cite counterfactual consent in an attempt to justify nonvoluntary2 euthanasia. Nonvoluntary2 euthanasias are acts of euthanasia to which the patient neither gave assertoric antecedent consent or problematic antecedent consent, nor denied assertoric antecedent consent or problematic antecedent consent. Counterfactual consent may be appropriately used to justify the euthanasia: were this individual to be asked now, then he would consent to being killed. Alas, he did not explicitly express his preference while he still could. Now that he can't express his preferences, the best we can do is imagine what he *would* say, *were* he able to tell us. Nonvoluntary2 euthanasias are performed on individuals who at one time were able to express rational preferences. However, circumstances prevent them from voicing rational preferences when the issue of consent is actually discussed. Nonvoluntary2 euthanasia might be

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[9]For further discussion of these two models, see Chapter IV, "The Truth Conditions for Statements of Counterfactual Consent".

performed on comatose persons who were formally rational, but currently are unable to express a preference[10].

It can be appropriate to cite counterfactual consent in an attempt to justify involuntary1 euthanasia. Imagine a case of a person who might be unduly depressed by the thought of being euthanized, even though he realizes that this is the best option available to him. His family realizes this, and concludes, "Were we to ask him, he would certainly consent to being euthanized. But we ought not add more misery to his final hours. Instead, we should just euthanize him without asking his consent."[11] In this way, involuntary1 euthanasias may appropriately make use of counterfactual consent.

It is not appropriate to cite counterfactual consent in an attempt to justify involuntary1 euthanasia. . In cases of involuntary2 euthanasia, the patient explicitly denies actual consent! Since the patient was able to make an actual decision about consent , there is no need to determine counterfactually if the patient would have consented, had she been asked. The patient had been asked, and said no. However, consider the patient who at one time was rational, but no longer is. For whatever reason his judgment is impaired, and while when he

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[10]One case of nonvoluntary2 euthanasia which is currently being debated that makes use of counterfactual consent is discussed in Michael deCourcy Hinds's "Uncharted Law for a Man Between Life and Death", The New York Times, June 6, 1994. The mother of 39 year old Joey Fiori claims her son "Was an outdoors person. He was interested in sports, surfing and bowling. If he could speak, there is no way he would want to live this way [in a persistent vegitative state for the past 23 years]."

[11]For a complete discussion of such a case, see Chapter V, "Counterfactual Consent and Actual Consent".

was rational, he would have consented to euthanasia, now that he is irrational he has denied consent. Might our euthanasia of such an individual be a case of involuntary2 euthanasia, justified using counterfactual consent? I do not believe so, for I do not believe that the irrational patient truly denied consent to being euthanized. As I stated in Chapter I, an agent gives consent to x if and only if 1)he assents to x, 2) he is given enough information about x, 3) he is able to comprehend the information about x, and 4) the assent to x is given freely and voluntarily. An agent who is not rational cannot meet the third criterion, and probably cannot meet the fourth either. Thus, such an agent cannot consent, nor deny consent, to anything. Such a case would more appropriately be a case of nonvoluntary2 euthanasia, and not involuntary2 euthanasia.

But what if the patient is lying? Consider the the patient who believes that asking for euthanasia is wrong, but if he is killed, he would be better off. When asked, he denied consent. But his family is able to say "If we were to do what is best for him, we would euthanize him. It is what he wants for himself." But the family hasn't justified his euthanasia using counterfactual *consent*. The family has merely said what would be in the patient's best interest. They never said, "And he would consent to what he knows to be best for himself." This patient does not consent, and would not consent. The family may justify his

euthanasia using other methods, but not using counterfactual consent[12].

The following chart summarizes the role that consent, counterfactual consent, and lack of consent play in Kuhse's distinctions between voluntary, non-voluntary, and involuntary euthanasia:

Table 2.1: Kuhse's Distinctions Among Types of Acts of Euthanasia

	consent	counterfactual consent	denial of consent
voluntary1	yes, explicitly	inappropriate	no
voluntary2	no	may be appropriate	no
nonvoluntary1	no	may be appropriate	no
nonvoluntary2	no	may be appropriate	no
involuntary1	no	may be appropriate	no
involuntary2	no	no	yes, explicitly

[12]The patient who is lying, and the patient who is irrational, were mentioned to me by Fred Feldman as possible cases that tested the boundaries of what counts as involuntary2 euthanasia.

Kuhse is not the only philosopher to draw the voluntary/non-voluntary/involuntary distinction. James Rachels discusses these distinctions:

> *Voluntary* euthanasia occurs whenever the patient requests death. The cases of Barbara B. and Charles C. are both examples of voluntary euthanasia, since both patients asked to be killed. *Nonvoluntary* euthanasia occurs when the patient is unable to form a judgment or voice a wish in the matter and, therefore, expresses no desire whatever. The cases of Edward E. and Frances F. are both instances of nonvoluntary euthanasia; Edward was senile and only semiconscious, while Frances was permanently comatose, so neither could form a preference.
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> Finally, *involuntary* euthanasia occurs when the patient says that he or she does not want to die but is nevertheless killed or allowed to die. In this essay I will not be concerned with involuntary euthanasia. My view is that it is simply murder and that it is not justified. If a person *wants* to live on, even in great pain and even with the certainty of a horrible end, that is the individual's right[13].

Rachels and Kuhse do not have the same notions of voluntary, non-voluntary and involuntary euthanasia. According to Rachels, voluntary euthanasias are performed in cases where the patients explicitly ask to be killed. Thus, there is no need to appeal to counterfactual consent in these cases - the patients gave actual consent. However, Rachels does not say *when* the patient explicitly asks to be killed. In the cases he mentions, both patients ask to be killed at the time of their deaths. What about cases like Kuhse's voluntary2 euthanasia, in which the patients

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[13]Rachels, "Euthanasia", pp. 38-39.

ask to be killed in possible circumstance (c), before (c) actually obtains? Rachels will have to put cases of euthanasia which cite statements of antecedent consent, like Living Wills, somewhere on his list. While such cases of euthanasia aren't necessarily justified using counterfactual consent, and may be justified using only antecedent consent, some cases of voluntary euthanasia are appropriately justified using counterfactual consent. These cases belong with cases of voluntary euthanasia, although Rachels doesn't mention them.

Rachels' discussion of nonvoluntary euthanasia more closely parallels Kuhse's discussion. He discusses two kinds of non-voluntary euthanasia, cases in which 1) a patient is unable to *make* a judgment about his condition and cases in which 2) a patient is unable to *express* his judgment about his condition. The cases in which patients are unable to make a judgment are co-extensive with Kuhse's nonvoluntary1 cases, while the cases in which the patients are unable to express a judgment are co-extensive with Kuhse's nonvoluntary2 cases. In both of these cases of nonvoluntary euthanasia, it would be appropriate to cite a statement of counterfactual consent in an attempt to justify these acts of euthanasia. He says that without consent, what is supposed to have been an act of euthanasia would in fact be murder. While the patients who are euthanized in nonvoluntary cases are unable to give consent, were they to deny consent they would have been murdered. Thus, Rachels must assume that patients who are nonvoluntarily euthanized would give consent, were they able to do so. Thus, there is an implicit appeal to

counterfactual consent in justifying both types of nonvoluntary euthanasia.

Finally, Rachels discusses involuntary euthanasia. Here, Rachels departs dramatically from Kuhse. Rachels' claim is that involuntary euthanasia takes place only when the patient is asked, and denies consent to be euthanized. In these cases, the patient actually denies consent. This notion of involuntary euthanasia corresponds to Kuhse's notion of involuntary2 euthanasia. What of Kuhse's involuntary1 euthanasia, in which the patient could have consented or denied consent, but was not asked? Involuntary1 euthanasia does not correspond to Rachels' notion of involuntary euthanasia, for there may be cases in which the patient would have consented had he been asked, only he wasn't asked. Rachels claims that every case of involuntary euthanasia has a patient who is asked, but explicitly says no. Certainly involuntary1 euthanasia is not a case of nonvoluntary euthanasia, for the patient both can make a judgment and is able to voice a judgment about his death in cases of involuntary1 euthanasia. Finally, involuntary1 euthanasia is certainly not the same as Rachels' voluntary euthanasia, for again, the patient is explicitly asked and consents in Rachels' notion of voluntary euthanasia. In cases of Kuhse's involuntary1 euthanasia, the patient does neither. Rachels has no way to account for cases of involuntary1 euthanasia.

The following chart summarizes the role that consent, counterfactual consent, and denial of consent play in Rachels' notions of voluntary, nonvoluntary, and involuntary euthanasia:

Table 2.2: Rachels's Distinctions Among Types of Acts of Euthanasia

	consent	counterfactual consent	denial of consent
voluntary	yes, explicitly	unnecessary	no
nonvoluntary without judgement	no	may be appropriate	no
nonvoluntary without a voice	no	may be appropriate	no
involuntary	no	no	yes, explicitly

Kuhse's 6-part distinction among the different types of voluntary, nonvoluntary and involuntary euthanasia illuminates distinctions that Rachels fails to observe. One of these distinctions is the difference between actual consent given at the time of euthanasia, and assertoric antecedent consent or problematic antecedent consent, in the form of a Living Will. Statements of antecedent consent may be invoked as evidence for the truth of a statement of counterfactual consent. Kuhse's distinction between voluntary1 and voluntary2 euthanasia illustrates the difference between actual consent and antecedent consent which may be used as evidence for a claim of counterfactual consent. A second distinction Rachels fails to observe is the difference between acts of involuntary1 and involuntary2 euthanasia. Since Kuhse's analysis does observe these distinctions, her analysis will be more effective.

The Use of Counterfactual Consent: Justifications

Now that it is clear which acts of euthanasia appropriately make use of counterfactual consent, the next question is obvious: *how* is counterfactual consent used? What does a statement of counterfactual consent do for those who are considering performing an act of euthanasia?

Statements of counterfactual consent are used in the attempt to justify acts of euthanasia. In making reference to a claim about counterfactual consent, an agent attempts to demonstrate that this act was permissible. But how does counterfactual consent justify an act of euthanasia? In Chapter I, I demonstrated that counterfactual consent is not part of the definition of 'euthanasia'. But counterfactual consent may add something to the performance of acts of euthanasia. Does it give a moral justification for the act? Or, is it possible that it could be used to offer a legal justification for an act of euthanasia? I believe that when agents use statements of counterfactual consent to justify their acts of euthanasia, they are using those statements in an attempt to morally justify acts of euthanasia. However, there are some interesting considerations in evaluating the legal question.

A Few Words on Justification

Before I can consider if counterfactual consent either morally justifies an act of euthanasia or could be used to legally justify an act of euthanasia, it is important to understand what I mean by the claim that an agent justifies an action. What I will mean by saying 'S justifies P by mentioning Q' is that an agent, S, shows P is permissible by pointing out that a proposition, or set of propositions, Q, is true. For example, if an agent considered the following true propositions, "I am experiencing ordinary sensory data", "I am not taking hallucinogens", and "I seem to see a cat on yonder mat", he would then be "epistemically justified" in believing that there is a cat on the mat. Such propositions would convey that it is epistemically permissible to believe that there is a cat on the mat. This conception of justification is similar to William P. Alston's conception:

> To be justified in believing that *p* is for that belief to be based on adequate ground. The ground must be of a sort that is typically directly cognitively accessible to normal human subjects; and the adequacy is a matter of the grounds being sufficiently indicative of the truth of the belief.... (Justification) makes an important contribution towards making a true belief into knowledge[14].

In other words, an epistemic justification gives an agent sufficient reason to believe that the proposition he believes is true. Alston

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[14]William P. Alston, Epistemic Justification: Essays in the Theory of Knowledge, Cornell University Press, 1989, p. 10.

observes that epistemic justifications contribute to knowledge by helping us to "attain the true and avoid the false".[15]

If an epistemic justification is a proposition or a set of propositions about a proposition *p* that gives you a sufficient reason to believe that *p* is true, then a moral justification is a proposition or a set of propositions about an action *a* that gives you sufficient reason to believe that *a* is morally permissible. Similarly, a legal justification is a proposition or a set of proposition about an action *a* that gives you sufficient reason to believe that *a* is legally permissible.

It is important to note that while counterfactual consent may serve as one type of justification for an act of euthanasia, it may not serve as another. Counterfactual consent may morally justify an act of euthanasia, but would fail to succeed as an appropriate legal justification of the same act of euthanasia. Phillipa Foot claims that while some acts of euthanasia may be morally justified, it may be impossible for the practice of euthanasia to be legally justified.[16] It is not the case that every act which is morally justified is legally justified. Thus, the same proposition may serve as one type of justification, but not another.

When considering if counterfactual consent could serve as a moral or legal justification for an act of euthanasia, the question being asked is this: Is counterfactual consent a *sufficient* justification? Alston's notion of an 'epistemic justification' is of a sufficient justification. The true propositions expressed by the

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[15]Alston, p. 10.
[16]Foot, "Euthanasia", p. 59.

sentences "I am experiencing ordinary sensory data", "I am not taking hallucinogens", and "I seem to see a cat on yonder mat" are jointly a sufficient epistemic justification for believing that a cat is on the mat. This question ought not be confused with asking if counterfactual consent is a necessary, but not sufficient, part of a complete justification. Typically, when we ask if some proposition serves as a justification, we are asking if it serves as a sufficient justification. When I ask the question, "Can counterfactual consent morally/legally justify this act of euthanasia?", I am asking if counterfactual consent is a sufficient justification for the act in question.

Counterfactual Consent: Justifying the Moral Permissibility of Euthanasia?

The following argument may be presented to demonstrate that counterfactual consent does not morally justify acts of euthanasia. We often consent to acts that are not morally right. Consent, either actual or counterfactual, does not entail moral rightness. There is no moral normative theory that says that an act is right if and only if the agent/s affected by the performance of that act would have given consent to the performance of that act. Thus, it is not the case that counterfactual consent is sufficient to justify acts of euthanasia.

However, the conclusion that counterfactual consent is not sufficient to determine the moral rightness of an act of euthanasia may be too hasty. It is true that in general it is possible to

consent to an act that is not morally right, but perhaps the act of euthanasia is peculiar in that consent, either actual or counterfactual, is sufficient for that act to be morally permissible. A definition of 'euthanasia', E5, has already been advanced in Chapter I. Parts 3 of E5 reads:

> 3) (a) B's primary reason for intending A's death is cessation of A's (actual or predicted) suffering or irreversible comatoseness, where A does not intend A's death for a different primary reason, though there may be other relevant reasons, and either (b) there is sufficient current evidence for either A or B that causal means to A's death will not produce any more suffering than would be produced for A if B were not to intervene, or (c) there is sufficient current evidence for B that the causal means to A's death, when A is irreversibly comatose, will not result in any more suffering than would be appropriate to cease A's irreversible comatoseness;

and part 4 of E5 reads:

> 4) the causal means to the event of A's death are chosen by A or B to be as painless as possible, unless either A or B has an overriding reason for a more painful causal means, where the reason for choosing the later causal means does not conflict with the evidence in (3b) or (3c).

Significantly, 'euthanasia' is defined as an act that is performed with the intention to prevent actual or future suffering, and is performed in such a way so as to promote the smallest amount of suffering as possible. 'Euthanasia' is defined as the act that is among the best actualizable alternatives. Perhaps it is the case that the patient's consent, either actual or counterfactual, is

sufficient to make an act of euthanasia not merely one that is among the best actualizable alternatives, but makes euthanasia *the* best alternative. Why do we believe that consent contributes to determining which is the best alternative?

One reason is that we often believe that a person is the best judge of his or her own happiness. Ronald Dworkin cites this view as one of the reasons given for respecting the autonomy of persons: "We should respect the decisions people make for themselves, even when we regard these decisions as imprudent, because each person generally knows what is in his own best interests better than anyone else."[17] If a person would have consented to ending her own life, we often believe that ending that life is the right thing to do[18]. If a person is the best judge of the amount of happiness that her life or death will bring her, and she consents to terminating her life, then we take her at her word. Similarly, if she didn't actually consent to terminating her life, but we have evidence to believe that she would have consented to terminating her life, we use this as evidence that her death truly would be what is best for her.

However, it is important to recognize that each person is not always the best judge of her own happiness. There are three possible reasons for an agent's failure to be the best judge of her own happiness. First, people often change their minds as to what

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[17]Dworkin, p. 223.

[18]For a consideration and subsequent denial of a similar view, see Phillipa Foot, "Euthanasia", Virtues and Vices, University of California Press, 1978, pp. 40-41. Foot considers if a necessary condition on the life of an agent being a good be that the agent believe it to be a good.

will maximize their happiness. Dworkin points out that this is a problem with Living Wills and surrogates, "There is no guarantee that he [the patient] did not change his mind sometime after the last formal or informal declaration, or that he wouldn't have changed his mind if he had thought about the matter again."[19] Given that people can and do change their minds, they can not always be relied upon to settle on a course of action that will maximize their happiness. Second, people are often mistaken about what will bring them the most happiness. Third, despite the fact that we think that a person is often the best judge of what makes her happy, she may not be in a position to know what those things are. Dworkin finds the claim that others may be better judges of a patient's happiness than she is to be paternalistic[20]. Whether this claim is paternalistic or not, a mistake is made when a patient chooses for herself that which would not be best for her.

It is possible to object to the claim that each person really isn't the best judge of her own happiness. The objection is this: what is meant by "the happiness of S" is "what S wants". What a person wants precisely *is* that which makes her happy, and what makes her happy *is* what she wants. I think that this is wrongheaded. The implication is that no one can ever make a mistake about what makes her happy. But this is foolish - we make mistakes all the time! I need not come up with dozens of

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[19]Dworkin, p. 191. See also Chapter IV, "The Truth Conditions for Statements of Counterfactual Consent".
[20]Dworkin, p. 193.

examples in which people have thought that what they wanted was what would make them happiest, and they were wrong. The reader can certainly consider several examples from his or her own life[21].

A variation on the notion that "what S wants" is "what makes S happiest" is the Principle of Self Determination, or the Principle of Autonomy. These principles state that a patient has the right to make all of her own treatment decisions[22]. Why should a patient have the right to make all of her own treatment decisions? Presumably, the patient should not have the right to make all of these important decisions if it were thought that the patient would be making wrong choices. Instead, it is believed that the choices that the patient makes are *by definition* the best choices for the patient: "The patient is the best judge of his or her own interests."[23] The Principle of Autonomy is motivated by an attempt to avoid medical paternalism - doctors making decisions without the patient's input based solely on what would be "best for the patient". If what the patient decides determines what is best for the patient, then it is impossible for the doctor, without patient input, to determine what is best for the patient.

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[21]The legal term for the right of an agent to choose an alternative that is not in the agent's best interest is the "right of folly". An example of the right of folly is that an agent has the right to give all his money away to a corrupt charity, without his family preventing the transaction. Implicit in the right of folly is the notion that what an agent wants, and what would make the agent happiest, are not always identical, for it is possible to choose one without choosing the other.

[22]See Dworkin, p. 188, 190, on the Principle of Autonomy; the Hastings Center Report, p. 7, on the Principle of Autonomy; Dan Brock, Life and Death, Cambridge University Press, 1993, pp. 28-35, on the Principle of Self Determination.

[23]Brock, p. 31.

The Principle of Autonomy and Principle of Self Determination, while admirable, are too strong. Even defenders of these principles will admit that it is possible for patients to be mistaken about what is in their best interests. Dan Brock discusses the circumstances in which it is permissible to waive the right to Self Determination. One of these circumstances is when the patient admits that she is not in a position to know what is best for herself[24]. T. M. Scanlon observes that "the demand to make outcomes depend on people's choices and the demand to promote their welfare are quite independent, and they can often pull in opposite directions."[25] Phillipa Foot argues that in making the mistake that what is good is what an agent has chosen, that we are often confusing a prudential and a moral sense of goodness[26]. It may be the case that embezzling millions without getting caught is good for an agent in a prudential sense, but embezzling millions without getting caught is not good in a moral sense; hence, the pull in opposite directions.

T. M. Scanlon on the Value of Choice and Consent

Those who still think that counterfactual consent does morally justify acts of euthanasia may respond in this fashion: in fact, consent has intrinsic value. If there are two agents, and in the first case one is given consent to the performance of an act,

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[24]Brock, p. 33.
[25]T.M. Scanlon, "The Significance of Choice", The Tanner Lectures on Human Values, ed. Sterling M. McMurrin, Cambridge University Press, 1988, p. 189.
[26]Phillipa Foot, "Goodness and Choice", Virtues and Vices, University of California Press, 1978, pp. 132-147.

and in a second case the other agent is not given consent to the performance of a similar act, the case in which the agent consented is better than the case in which no consent was obtained. The case in which the agent had consented to the performance of the act is better because the consent has some intrinsic value, tipping the scales in favor of the act that was consented to. If this is true, then counterfactual consent has some value, for consent has some value in itself. Thus, if acts of euthanasia are already defined as those that will be among the alternatives that will result in the least suffering, and they are consented to (where consent has some intrinsic value), then an act of euthanasia that is consented to is the best available alternative (when it is an alternative).

The view that consent has some value in itself is expressed by T.M. Scanlon[27]. Scanlon offers two senses in which consent and choice are valuable[28]. First, those acts that agents consent to are more likely to coincide with what those agents actually want. Scanlon's example is this: if he (Scanlon) is presented with a menu in a restaurant and the food brought to him coincides with the

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[27]Scanlon, pp. 151-216.

[28]While Scanlon primarily discusses acts of choosing, and I am interested in acts of consenting, many of Scanlon's points are relevant to my discussion. Both choosing and consenting involve free and informed assent to alternatives. The difference between choosing and consenting is this: if an agent chooses an alternative, it is commonly understood that the agent who does the choosing is the one who effects a change (in that his choosing is sufficient to actualize an alternative). If an agent consents to an alternative, it is commonly understood that the agent exercises permission-granting power in offering his consent (but his consent is not sufficient to actualize an alternative). If I choose the next speaker, my free assent is sufficient for the next speaker to come to the podium. If I consent to the next speaker, my free assent contributes to the legitimacy of the next speaker to take the podium. See Chapter I.

food he chose from the menu, the food brought to him is more likely to be the food he really wants[29]. This demonstrates that consent has instrumental value - if an agent chooses or consents to something, that which he consents to is likely to be the option that best serves the agent. This example roughly parallels the intuitions behind the Principle of Self Determination and the Principle of Autonomy. Scanlon, however, rejects the intuition behind the Principles of Self Determination and Autonomy - it isn't always the case that the option the agent chooses is that which would coincide with his preferences. Scanlon offers an example that describes his experience in an exotic restaurant, when he is faced with a menu in a language that he can't read. Here, choice fails to have instrumental value[30].

However, there is a second way in which consent has value. Consider agent S, who values personality traits such as awareness, memory, imagination, skill, loyalty, and resourcefulness. S is confronted with task of buying an anniversary gift for her husband. S could just ask her husband to pick something out that her husband would like, or S could pick something out herself. Scanlon claims that if S picks out the gift herself, then the gift has "demonstrative value", for it demonstrates those personality traits that S holds valuable[31]. If S were to go out and choose a terrible gift, the gift would have low instrumental value, but it would still have the same degree of demonstrative value. Since all

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[29]Scanlon, p. 178.
[30]Scanlon, p. 178.
[31]Scanlon, pp. 179-181.

alternatives that follow from an agent's choices do have some demonstrative value, Scanlon concludes "People reasonably attach intrinsic significance to having outcomes depend on their choices."[32]

One problem with Scanlon's account is that isn't clear that there is a distinction between "instrumental" and "demonstrative" value. Might the demonstrative value that attaches to S's choosing a gift herself be cashed out in terms of instrumental value? If S chooses the gift herself, then she is happier because she did so on her own, her husband has the experience of being surprised, and her husband doesn't know precisely how much the gift cost, which he would have had he picked it out himself. S may have demonstrated some of her positive personality traits, but isn't there instrumental value in that? It may be true that the distinction between instrumental and demonstrative value is unclear, but this isn't a great problem for Scanlon. All that he needs to establish is that an action that follows from an agent's free choice, or an action to which the agent offered his free consent, is somehow better than a similar action that the agent did not choose or consent to. Scanlon has demonstrated this.

What happens if S is not available to pick out a gift, and she asks her sister to do her shopping for her? S's sister comes across a gift, and thinks to herself, "This isn't the gift *I* would have chosen for my boorish brother-in-law, but it looks to be exactly the kind of thing that S would have chosen herself. It is true that

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[32]Scanlon, p. 189.

S isn't picking out the gift herself, but as her surrogate shopper, it is my responsibility to pick out a gift that will both please my brother-in-law and would be something that S would have chosen." S's sister justifies her choice by citing a counterfactual about what S would have chosen. Without such a counterfactual to support her choice, S's sister may not have been justified in making her purchase. The instrumental value of the gift is almost entirely intact - the gift is one that S is proud to give, and one that S's husband is pleased to receive. Some of the demonstrative value of the gift may have been lost, for S did not find the gift herself. However, if the counterfactual "If S could see this gift, she would purchase it" were false, then both the instrumental value and the demonstrative value of the gift would be yet smaller.

Scanlon's account does demonstrate why alternatives that agents choose/consent to are often better than those alternatives that agents neither choose nor sanctioned with consent. Applying Scanlon's arguments to cases of euthanasia, it is easy to see that if an agent actually consents, or would have given consent had she been asked, that this is enough to elevate the status of an act which is already among the best alternatives to *the best alternative*. In this way, counterfactual consent can morally justify acts of euthanasia - the fact that this act is one that the agent would have consented to, had he been able to consent, marks this act out as the best alternative for the agent. However, it is important to recognize that counterfactual consent *only justifies those acts of euthanasia that are already among the*

best alternatives for the patient. If it is not the case that a patient's euthanasia would in fact be among the alternatives that would be best for the patient, then the instrumental and demonstrative values of the agent's euthanasia following from what she would would have chosen will not morally justify the euthanasia. If euthanasia is not among the best alternatives for the patient, then counterfactual consent does not justify the act.

A final objection may be raised, however. Has the lesson of Scanlon's experience in the exotic restaurant been forgotten? Scanlon observed that the best outcomes don't always follow from an agent's own choice - Scanlon himself admits that his choice from a menu that he could not read might end in disaster. Might the instrumental value of choosing a bad alternative be so low that no amount of demonstrative value would make up for the poor choice? This is absolutely the case - if Scanlon would find some of the choices off the menu repulsive, then the demonstrative value of choosing his own meal may not outweigh the negative result of having a terrible meal. But I have already established that counterfactual consent only justifies acts of euthanasia that are among the best alternatives for the agent. Imagine Scanlon with an illegible menu of only the most pleasing choices. Scanlon chooses one - the meal is extraordinary! Not only was it pleasing to the palate (instrumental value), but Scanlon's dish was one he chose himself, as a competent and responsible adult (demonstrative value). Agents for whom euthanasia is already among their best alternatives, who actually consent to euthanasia, or for whom it can be truly said that they

would have consented had they been able to consent, will have the act of euthanasia transformed from a good choice to the best choice. Having consented makes a good choice all the better. Thus, counterfactual consent can and does morally justify some acts of euthanasia.

Counterfactual Consent: Justifying the Legal Permissibility of Euthanasia?

Counterfactual consent morally justifies some acts of euthanasia. Might it also be used to legally justify acts of euthanasia?

The question I am asking is not, "Does counterfactual consent in fact serve as a sufficient legal justification for acts of euthanasia in the United States?" or "Is counterfactual consent in fact necessary to legally justify acts of euthanasia in the United States?" These are straightforward empirical questions, that can be answered by looking into a law book. In fact, counterfactual consent is neither sufficient, nor necessary, to legally justify euthanasia in the United States[33].

It is not in fact a sufficient legal justification. There have been many highly publicized court cases of men and women who wanted to die, asked for assistance in dying, and yet the agents who helped them die performed acts which were legally wrong. If actual consent is not sufficient to legally justify an act of

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[33]Marcia Angell, "Euthanasia", Biomedical Ethics, ed. Thomas Mappes and Jane S. Zembaty, McGraw-Hill, 1991, p. 382.

euthanasia, it seems improbable that the same act could be legally justified using counterfactual consent.

Without a Living Will, or a surrogate established by a Durable Power of Attorney, to speak on behalf of a patient, it is legally impermissible to terminate that patient's life[34]. Living Wills contain statements of assertoric antecedent consent or problematic antecedent consent that can presumably demonstrate the truth of a statement of counterfactual consent. Durable Powers of Attorney sanction the use of surrogates to speak on a patient's behalf. Since the surrogate is supposed to give voice the patient's beliefs and preferences, the surrogate presumably is in a position to utter a true statement of counterfactual consent on behalf of the patient. A patient whose life is terminated as per the directions in a Living Will or the order of a surrogate does have support for a claim about counterfactual consent to legally justify his death. As mentioned earlier, the surrogate bears a special relationship to the patient. This relationship intimates that the surrogate's claim that the patient's life may be terminated is based in part on a belief about the patient's counterfactual consent. But it is not the case that a Living Will or Durable Powers of Attorney *themselves* are statements of counterfactual consent. A surrogate may say many things to legally justify an act of euthanasia. A statement of counterfactual consent need not be one of them. Thus, counterfactual consent is in fact not necessary to legally justify acts of euthanasia in the United States.

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[34]Hastings Center Report, pp. 6-8.

I am asking a more interesting philosophical question than the straightforward empirical question, "Is counterfactual consent in fact sufficient or necessary to legal justifications for euthanasia?" I am asking if counterfactual consent *ought* to be considered as either a sufficient legal justification, or a necessary part of a legal justification, for acts of euthanasia?

One of the most important distinctions between moral and legal justification is provability. For something to serve as a sufficient legal justification, it would have to serve as sufficient legal evidence. Ronald Dworkin says that legal evidence must be "clear and convincing".[35] Unlike a moral justification, which merely asks if it is true that the act in question is morally right, a legal justification must be one that can establish proof of the legality of the act. The problem with using counterfactual consent in this manner is that while there is a fact of the matter about what a person would have consented to, had he been able to offer consent, it may be difficult to provide sufficient legal evidence for this claim.[36]

Living Wills and Durable Powers of Attorney that establish surrogacy are legal documents, but they are contestable, thus the claim that they in fact provide "clear and convincing" evidence is disputable. It is possible to argue that the agent who signed the Living Will was not in a position to determine what she would

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[35]Dworkin, p. 187.

[36]Drew Christie has argued that there is no fact of the matter about what a person would have consented to, had he been able to offer consent. For a reply to the objection that these counterfactuals don't have a truth value, see Chapter IV.

have wanted were she to be come gravely ill. After all, at the time that she wrote the Living Will, presumably she was not gravely ill. She was consenting before the fact to a state of affairs about which she could not possibly be able to offer informed consent. Thus, she could not accurately state what her wishes would have been in the very situation she describes.[37] Similarly, an agent may believe that in signing over a Durable Power of Attorney to a relative or close friend, that she has chosen someone who best represents her interests. But she may be mistaken about this fact - the individual may not represent her interests at all. Finally, Justice Scalia of the United States Supreme Court has claimed that a state is not legally required to honor a Living Will if it has decided that the precedent it sets in honoring the Living Will would be an insult to the sanctity of life.[38] The counterfactual consent that agents ascribe to patients on the basis of the Living Will may still be legally disputed.

Without a Living Will or surrogate, it would only be more difficult to legally justify an act of euthanasia using counterfactual consent. It has been argued in the Missouri Supreme Court that the "informal, casual statements" of friends and family do not offer the same "clear and convincing" evidence of a patient's wishes as a Living Will.[39] Questions about why the person acting as a surrogate is best qualified to represent the interests of the patient could be raised[40]. It appears that counterfactual consent

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[37]This and other problems with Living Wills are discussed in Chapter IV.
[38]Dworkin, p. 198.
[39]Dworkin, p. 187.
[40]See Chapter IV for a discussion of the qualifications of surrogates.

should not be used as a sufficient legal justification for acts of euthanasia.

Similarly, counterfactual consent should not be necessary to a legal justification for acts of euthanasia. Our evidence for the truth of claims about counterfactual consent is simply not up to the legal standard of "clear and convincing". Living Wills, one of the best indicators of what a person would have consented to under trying circumstances, can be contested. If they are, and it is legally impossible to determine if there is counterfactual consent or not, then it would be impossible to determine if the act of euthanasia in question would be legally permissible or not. If this were true, then there would be no legally permissible acts of euthanasia. Insofar as there are some morally permissible acts of euthanasia, it is wrong to hold a legal standard that is so high that it would be legally impossible to perform those morally right acts of euthanasia.

CHAPTER III

COUNTERFACTUAL CONSENT AND THE RATIONAL MAN PARADOX

Often we consider cases in which the patient is actually unable to consent to euthanasia. We attempt to justify euthanasia in these cases by use of the concept of counterfactual consent: if the patient were able to consent, then he would consent. However, what if the very conditions that *prevent* the patient from consenting are those conditions that determine what the patient's choice would be? There are cases in which the closest possible world where the patient is able to consent, the very property of being able to consent is sufficient for the patient to withhold consent. How then is counterfactual consent to be understood?

I will begin this chapter by considering a problem for counterfactual consent: the Rational Man paradox. I will then offer a number of solutions to this problem: odd-worlds solutions, the ideal surrogate solution, several versions of the double modality solution, and the implicit actuality solution. I will demonstrate the mistakes in each of the odd-worlds solutions, the ideal surrogate solution, and the double modality solutions. However, the double modality solutions will illustrate an important point about any true interpretation of counterfactuals about consent - the need for a cross-world comparison. I will then consider a final reading of counterfactuals about consent, the implicit actuality solution. The implicit actuality solution succeeds

as a reading of counterfactuals about consent. The Rational Man paradox is solved. I will conclude this chapter with a reformulation of precisely what is meant by counterfactual consent.

The Problem of Counterfactual Consent and the Rational Man

Statements of counterfactual consent typically take this form: If A were able to consent to S, then A would consent to S. As stated in Chapter I, one of the necessary conditions on an act being an act of consent is that the person consenting is rational. If an individual is not rational, then it makes very little sense to say that he/she is consenting to anything. As discussed in Chapter I, the truth conditions for a statement of counterfactual consent require us to travel to the closest possible world in which the subject is able to consent to some state of affairs. If, in that world, the subject does consent to that state of affairs, then the statement "If A were able to consent to S, then A would consent to S" is true. In other words, if in the closest possible world in which the antecedent is true, the conclusion is also true, then the counterfactual is true. True statements of counterfactual consent are often cited as justifications for performing euthanasia.

However, there may be a problem with our conventional understanding of the truth conditions for statements of counterfactual consent. The Rational Man illustrates this problem. Imagine a man who values his rationality to such a degree that being rational is both necessary and sufficient for him to think

that life is worth living. Pleasures of life like eating, traveling, studying, and any experience you could name may come and go, but as long as he is able to think, the Rational Man believes that life is worth living. While such a view seems odd to many, it is certainly metaphysically possible that such a man exist. For the Rational Man, losing his rationality is enough that we would say truly of him, "If he were able to consent to being euthanized now that he has lost his rationality, then he would consent to being euthanized."

According to the conventional method of determining truth conditions for counterfactuals, we have to go to the closest possible world in which the Rational Man is able to consent to being euthanized, and we ask him, "Do you consent to being euthanized?" But in that world, he is rational, for rationality is a necessary condition of his being able to consent. Being rational is both necessary and sufficient for him to refuse consent to our euthanizing him. Life is worth living for the Rational Man in the world in which he is able to consent. So, even if the rational man loses his rationality, we have nonetheless spoken falsely when we claim "If he were able to consent, then he would consent to being euthanized." And yet, it seems that we are able to say truly of the Rational Man "If he were able to consent, then he would consent to being euthanized" in those cases in which he is no longer rational[1].

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[1]Edward Wierenga introduces a version of the Rational Man paradox in "Proxy Consent and Counterfactual Wishes", The Journal of Medicine and Philosophy, vol. 8, no. 4., November 1983, pp. 405-416. Wierenga describes an 83 year old priest, Brother Fox, who made known during his lifetime his

It would seem that counterfactuals about consent are more complex than ordinary counterfactuals. The Rational Man paradox demonstrates that the conventional analysis of counterfactuals is not always sufficient to give the truth conditions for all counterfactuals about consent. A new means of determining the truth conditions for counterfactuals about consent must be found. How do we solve the problem of the Rational Man?

A First Solution: Odd Worlds

A possible solution to the problem of the Rational Man is to claim that there are some very odd worlds, in which the Rational Man is both rational and not rational at the same time. In these worlds, the Rational Man has the rationality to perform an act of consenting, and yet he is arational enough to desire that he be euthanized because his life is no longer worth living. Thus, the Rational Man, in being both rational and arational, both can consent to being euthanized, and has sufficient motivation to consent to being euthanized.

A second odd world solution may be to posit a world in which the Rational Man was rational for a brief period after the

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belief that the withdrawing of life support machines from some unconscious patients was morally permitted. When Brother Fox lapsed into a coma, the court concluded that "were Brother Fox competent, he would direct the termination of the respirator that presently supports him" (Wierenga, p. 410). Wierenga points out however that if Brother Fox were competent, that he would not allow the respirator to be turned off, for it was not part of Brother Fox's view that *conscious* patients need not be assisted by life support machines. "Accordingly, it is false that if Brother Fox were competent he would direct the termination of the use of the respirator." (Wierenga, p. 411).

accident that rendered him comatose. In this world, he regained consciousness and rationality for just enough time for his doctors to ask him, "Do you consent to being euthanized? We may lose you again in another few seconds, so answer quickly!" In this world, the Rational Man is about to face a life of arationality, but he is rational for just enough time to consent to being euthanized. This solution does have some appeal. Certain facts have to be fixed for the question, "Do you want to be euthanized?" to have any relevance. The Rational Man would have to have lost his rationality, or at least be sure of losing it very soon, for such a question to have any relevance. In this world, that fact is fixed. Furthermore, in this world the Rational Man is able to consent to being euthanized, because he is rational for just enough time to consent. In this world, the Rational Man both is able to consent to being euthanized, and has sufficient motivation to truly give consent to being euthanized. Perhaps this is how many of us understand the plight of those suffering from Alzheimer's disease. Those patients have short moments of lucidity as the disease progresses. Might the closest world in which the Rational Man consents be one of these worlds in which he moves in and out of arationality?

However, both the odd worlds solutions have only limited appeal. The first solution is nonsensical - it is meaningless to say that anyone is both rational and arational at the same time. It is a logical contradiction for anything to be both rational and arational; this state of affairs cannot obtain at any possible world.

I do not believe that the second odd worlds solution is an appropriate solution to the Rational Man paradox. The Rational Man paradox illustrates an interesting problem. What are the truth conditions for a counterfactual, C, if in traveling to another world to find a true antecedent for C, you have eliminated the very conditions that must be held fixed for the consequent of C to obtain? Counterfactuals about consent are precisely the counterfactuals that suffer from this problem. Consider this example: "If Nixon could consent, then he'd consent to our cremating him". This counterfactual is false: in the closest possible world in which Nixon is alive and able to consent he does not consent to being burned to ashes. Yet, it may true that Nixon would have wanted to be cremated. Considering a world in which Nixon is alive, and then dead, doesn't help us to better understand this counterfactual; rather, it masks the problem of the true antecedent that eliminates the possibility of a true consequent. Briefly rational worlds offer an ad hoc solution to the Rational Man paradox. There is no true paradox in the briefly rational worlds - we can just wait it out until the Rational Man is rational again, and the paradox disappears. This is no way to solve the Rational Man paradox.

Edward Wierenga offers a second objection to the second odd worlds solution. In briefly rational worlds, the Rational Man who comes out of his arationality for a brief moment may make the following claim: "I seem to be in a world in which miracles happen. I remember being rational, then they told me I became arational, and now my rationality is back! If such miracles can

happen, I am a fool to consent to my own euthanasia - another miracle may occur, and I could get my rationality back, permanently. I will not consent." In the briefly rational world, the Rational Man does not offer consent, and the counterfactual "If he were able to offer consent, then he would" is false, not true[2]. The briefly rational world is too miraculous to give a solution to the Rational Man paradox.

I believe that neither of the odd world solutions to the Rational Man paradox resolves the problem. A better solution must be offered.

A Second Solution: Ideal Surrogates

Consider this counterfactual: "If I traded stocks, I'd buy low and sell high." How do we determine whether this counterfactual is true? We go to the closest possible in world in which my counterpart trades stocks. Certainly *I* am not trading stocks in that world - I am here, in the actual world. But there is someone very much like me in that world - an individual more like me than anyone else in that world. She is my counterpart. Whenever we say of someone that he/she does something in another possible world, what we mean is that his/her counterparts do those things in other possible worlds. We are not trans-world individuals - we exist in one world, and one world only[3].

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[2]Wierenga, pp. 411-412.

[3]David Lewis, On the Plurality of Worlds, Basil Blackwell, 1986, p. 213. Lewis denies the possibility that there are trans-world individuals. There are views about trans-world individuals, counterparts, and the interpretation

There is a counterpart of mine who trades stocks in another possible world. This world is the closest possible world to the actual world that has a counterpart of mine who trades stocks. This counterpart is the individual in her world who is more like me than anyone else in her world. We watch her movements very carefully. One day my counterpart places an order. "By low and sell high," my counterpart whispers into the phone. The counterfactual "If I traded stocks, I would buy low and sell high" is true after all, for in the closest possible world in which I have a counterpart who trades stocks, she does buy low and sell high.

Consider the following counterfactual, "If I were you, I'd buy low and sell high." One way to analyze this counterfactual is to go to the world in which your counterpart holds your position, but in that world your counterpart has many of my beliefs and preferences. Perhaps your counterpart has the same job as you do now, lives in the same house, has the same breakfast in the mornings as you do. But in that possible world your counterpart has many of the relevant characteristics that I have in the actual world that incline me to buy low, and sell high. In that world, your counterpart has my extensive knowledge of the stocks, my impressive connections in the bonds market. In that world, your counterpart is still *your counterpart* , but your counterpart thinks about stocks the same way that I do in the actual world. This is the way that we understand the counterfactual, "If I were you, I

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of counterfactuals other than Lewis'. However, in the interest of simplicity and brevity, I have chosen to consider the Rational Man paradox solely from Lewis' perspective.

would buy low and sell high." We imagine one of your counterparts - the counterpart who also has some of *my* beliefs and preferences.

Perhaps in the case of the Rational Man, we ought to interpret the counterfactual "If the Rational Man were able to consent to his euthanasia, then he would" in the same way that we understand counterfactuals like "If I were you, then I would buy low and sell high." We ought to go to the closest possible world in which the Rational Man's counterpart is still comatose, but *an individual with all of the relevant beliefs and preferences of the Rational Man* is standing close-by. This individual is the Rational Man's counterpart's ideal surrogate: someone who has the Rational Man's counterpart's desires, for these desires are the same desires that the ideal surrogate has himself. The Rational Man's counterpart's ideal surrogate would want to be euthanized in those cases in which he were to lose his rationality. As he stands over the Rational Man's counterpart, he gives consent for the Rational Man's counterpart's euthanasia. Thus, it is true that the Rational Man would have wanted to be euthanized if he were comatose, for in the case that the Rational Man's counterpart was comatose, the Rational Man's counterpart's ideal surrogate would consent to the Rational Man's counterpart's euthanasia. Positing an ideal surrogate might solve the Rational Man paradox - perhaps it is the case that if the Rational Man were able to consent to his euthanasia, then he would consent, for his ideal surrogate does consent to the Rational Man's counterpart's euthanasia.

There are advantages to the ideal surrogate solution over the previously considered odd-worlds solutions. First, the use of the ideal surrogate in solving the Rational Man paradox is not logically impossible, like the first odd-world solution. Nor does the ideal surrogate solution fail to address one of the problems for all counterfactuals about consent, like the second odd-worlds solution. Second, in the ideal surrogate solution, the Rational Man's counterpart is comatose in the world in which his ideal surrogate consents to the Rational Man's euthanasia. Thus it is still relevant to ask if euthanasia is an appropriate option for the Rational Man.

However, despite these advantages, the ideal surrogate solution has deep problems. First, consider what the ideal surrogate says of the Rational Man's counterpart in the world in which he consents to the Rational Man's counterpart's euthanasia. He probably says something like "If I were in his position, then I would want to be euthanized." The ideal surrogate believes that he is speaking truly when he utters this counterfactual. How do we determine the truth of this counterfactual? We can determine if it is true only by going to the closest possible world in which the ideal surrogate's counterpart is comatose, and determine if in that world the ideal surrogate's counterpart would consent to being euthanized. But the only way to determine this is to have yet another individual standing at the ideal surrogate's counterpart's bedside - the ideal surrogate's counterpart's ideal surrogate. This second ideal surrogate then looks down at the counterpart of the first ideal surrogate and says, "If I were in his position, then I

would want to be euthanized." Yet a third ideal surrogate is needed, at a fourth possible world, to determine if this counterfactual is true. This goes on infinitely. It seems we can never determine if the ideal surrogate speaks truly about whether or not he would want to be euthanized.

However, this may not be what the ideal surrogate is thinking. Perhaps he thinks this: the previously rational agent in front of me has ceased being rational. Rationality is a necessary condition for life being worth living. Since this person has lost a necessary condition for life being worth living, then he should be euthanized. This may be the ideal surrogate's line of reasoning, but it runs against another problem - the problem of the egocentric person. Imagine that the Rational Man and any counterpart of the Rational Man is incredibly conceited. The Rational Man has great faith in himself, and his own strength of will, but he hasn't much faith in anyone else. He believes, mistakenly, that his counterpart does not share the beliefs that he has, even though his counterpart certainly does have those beliefs. The conceited Rational Man says truly, "I want to be euthanized if I am ever comatose, but I wouldn't put such words into other people's mouths. Other people just don't have the strength of character that I have." Imagine the possible world in which the conceited Rational Man's counterpart is lying comatose, as his conceited ideal surrogate stands at the bedside. The conceited ideal surrogate who speaks on the Rational Man's counterpart's behalf would say truly that he believes that the Rational Man's counterpart would not want to be euthanized, although it is still

the preference of both the ideal surrogate, the Rational Man's counterpart, and the Rational Man to be euthanized under these circumstances. So even though the ideal surrogate speaks on behalf of the Rational Man's counterpart, the ideal surrogate gives the wrong answer! Having an ideal surrogate does not solve the Rational Man paradox in the case of a conceited Rational Man.

But the Rational Man and his counterparts may not be egocentric. This brings me to a final problem with the ideal surrogate solution. Who is this ideal surrogate anyway? Why do we require such a complicated apparatus to interpret a seemingly straightforward counterfactual like "If he were able to consent to being euthanized, then he would consent to being euthanized." The world in which ideal surrogates exist is very far away from ours. Do we have to travel such a great distance to understand what is meant by counterfactuals about consent? It is implausible that ideal surrogates are required to understand otherwise simple counterfactuals. There has got to be a more natural interpretation of counterfactuals about consent than one that requires traveling to very distant worlds and the postulation of an ideal surrogate. A third solution to the Rational Man paradox is required.

The First Double Modality Solution

Perhaps we ought to reinterpret counterfactuals about consent altogether. Up until now, I was content to read counterfactuals about consent in the conventional way of reading

all counterfactuals. A conventional counterfactual about an agent, x, consenting to x's euthanasia, would read:

> If x were able to consent to x's euthanasia, then x would consent to x's euthanasia

Formalized using David Lewis' '□->' symbol for counterfactual implication, the above reads:

> x is able to consent to x's euthanasia □-> x consents to x's euthanasia[4]

Those who endorse the double modality interpretation believe that we ought to read counterfactuals about consent with a double modality, which I will call 'DC1' for the 'Double Counterfactual Solution One':

> DC1: If x were able to consent to x's euthanasia, then x would consent to being euthanized if x is ever arational

Formalized, DC1 reads:

> x is able to consent □-> x consents to (x is arational □-> x is euthanized)

According to DC1, the consequent is a counterfactual about what x would consent to about situations in which x is in a coma in another possible world. In other words, rather than going to the closest possible world in which x 's counterpart is able to consent and ask him what he would want in that world, we ought to go to the closest possible world in which x's counterpart is able to

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[4]David Lewis, Counterfactuals, Basil Blackwell, 1973, p 1.

consent, and then ask him what he would consent to for his counterpart in the closest possible world to *that* world in which he is comatose. As I have just described counterfactuals about consent, the Rational Man's counterfactual consent requires us to consider three possible worlds:

world1		world2		world3
The Rational Man is comatose and we look to the closest possible world in which	--->	The Rational Man's counterpart is able to consent to the euthanasia of his counterpart in	--->	The closest possible world in which the counterpart of Rational Man's counterpart is comatose

Figure 3.1: The Rational Man Across Three Worlds

According to this solution, the Rational Man is lying comatose in his actual world. However, it is the case that we can say truly of him that if he were able to consent to his euthanasia, then he would consent. For we look to the the closest world in which he is able to consent, and in that world he utters the counterfactual, "I consent to being euthanized, if I were comatose." Thus, the Rational Man paradox is solved using the double modality solution.

This solution does not require the postulating of an ideal surrogate. It is true that it is complex, but its complexity is in the analysis of the counterfactuals and the postulating of other possible worlds, not in the postulating of some fantastic ideal

surrogate. This solution requires both a double modality and two cross-world analyses to understand counterfactuals about consent. While the conceptual apparatus in understanding these counterfactuals is slightly complex, it is philosophically mundane to use counterfactuals in this way, whereas the postulating of ideal surrogates is far more extraordinary. This is one reason why this version of the double modality solution to the Rational Man paradox has merit.

There is a second reason why the double modality solution has merit. The above description of the double modality solution suggests that the world in which the Rational Man actually exists (world1), and the world in which his counterpart's counterpart exists (world3) are not the same world. This is not necessary. It may be that the closest world to world1 in which the Rational Man has a counterpart who is conscious is world2, and the closest world to world2 in which world2's Rational Man has a counterpart who is comatose is world1. Since the counterpart relation is symmetric, it makes sense that one of the counterparts of the actual Rational Man's counterpart is the actual Rational Man[5]. There is not even any guarantee that the counterpart of the actual Rational Man's counterpart has any other counterpart besides the actual Rational Man. It is possible that the entire double modality scenario requires only two worlds, and not three. In this case, the cross-world comparison is simplified dramatically:

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[5]Lewis, p. 214.

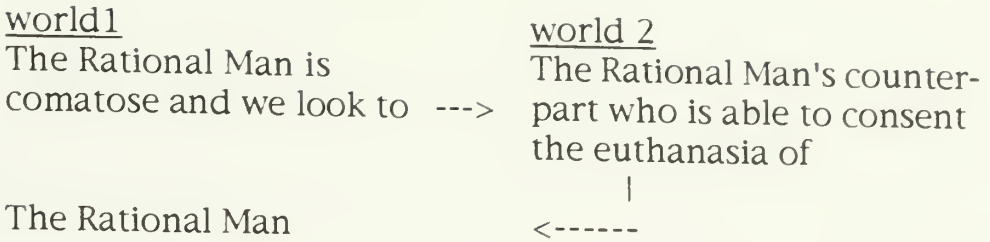

Figure 3.2: The Rational Man Across Two Worlds

With this interpretation, the double modality reading of counterfactuals about consent makes a great deal of sense. This does seem to intuitively capture what we mean when we utter statements of counterfactual consent on behalf of those who in the the actual world can not consent themselves, but whose counterfactual consent does relate to something in the actual world. When we say "If he were able to consent to his own euthanasia, then he would" we picture a scenario much like Figure 3.2. We are in the actual world, with the Rational Man, thinking about those actions to which he would give his consent. We consider the closest possible world in which he isn't comatose, and is able to consent. In that world, he consents to his euthanasia in the closest possible world in which he is comatose. That world in which he is comatose is the actual world - we can cite counterfactual consent in an attempt to justify the Rational Man's euthanasia in the actual world. This captures our common-sense intuition about what happens when we attempt to justify someone's euthanasia via counterfactual consent. The double

modality reading of counterfactuals about consent offers a solution to the Rational Man paradox[6].

However, there are several problems with this version of the double modality solution to the paradox of the Rational Man. The first problem is that it isn't clear that seemingly simple counterfactuals like "If she were able to consent, then she would consent" require the complex apparatus of a cross-world comparison and a double modality. Isn't there a more straightforward approach to these counterfactuals than moving across two worlds and including two counterfactuals in a sentence that appears on the face of it to include only one? Those who have not been trained in philosophy would never think to consider that an otherwise simple statement of counterfactual consent really means something far more complex.

A second objection to this solution considers the difference between the solution that pictures the Rational Man across three worlds and the solution that pictures the Rational Man across two worlds. It is simpler to consider the two worlds solution - in that solution the actual Rational Man's counterpart is consenting to his counterpart's euthanasia in the actual world. But that solution assumes that the closest "comatose Rational Man" world (world1) to the "conscious Rational Man world" (world2) is the same world

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[6]There is another advantage to the double modality solution. It offers a straightforward parallel to cases in which patients have written Living Wills that offer statements of assertoric antecedent consent or problematic antecedent consent. For example, when there is assertoric antecedent consent, the Living Will states "I consent now ("now" corresponding to the condition of the patient in world2) to being killed in those cases in which I am comatose ("the cases in which I am comatose" corresponding to the condition of the patient in world1). See Chapter IV.

as the Rational Man's actual world. Hence the arrow in the Figure 3.2 that points back to world1, instead of pointing out yet a third world. But it is not necessarily true that the closest comatose Rational Man world to the closest conscious Rational Man world in fact *is* the first comatose Rational Man world. What if the closest comatose Rational Man world to the closest conscious Rational Man world is not the actual world? How would this change the double modality solution?

Figure 3.1 illustrates a case in which the Rational Man's counterpart is not consenting to the euthanasia of the actual Rational Man, but instead he is consenting to the euthanasia of someone else. It is possible that the actual Rational Man's counterpart is consenting to the euthanasia of a counterpart who is many worlds away. This version of the double modality solution doesn't allow that the Rational Man's counterpart is consenting to the euthanasia of all of his counterparts - he may only be consenting to the euthanasia of his very closest counterparts. If the double modality solution guarantees counterfactual consent only in the closest possible world to the world in which the Rational Man's counterpart is able to give consent, and that world is not the Rational Man's actual world, then the double modality solution does not guarantee counterfactual consent in the Rational Man's actual world. In fact, the double modality solution does guarantee counterfactual consent only in the closest possible world to the world in which the Rational Man's counterpart is able to give consent; the actual world is not necessarily the closest world. Therefore, the double

modality solution does not guarantee counterfactual consent in the Rational Man's actual world. Any solution that does not guarantee counterfactual consent in the actual world is not an appropriate analysis of counterfactual consent, for the point of the analysis is to determine what a statement of counterfactual consent on behalf of the actual Rational Man means. Thus, the double modality analysis is not an appropriate analysis of statements of counterfactual consent.

A Revised Double Modality Solution

However, it is possible to breathe some life into the double modality solution. The greatest problem with the double modality solution is that it is not necessarily the case that the Rational Man's counterpart is consenting to the euthanasia of the actual Rational Man. Rather, the Rational Man's counterpart is consenting to the euthanasia of one of *his* counterparts, who is not necessarily the actual Rational Man. One way to remedy this problem is to qualify the counterfactual in the consequent of the larger counterfactual with a necessity operator. I will call this revision of the double modality solution DC2:

> DC2: If x were able to consent to x's euthanasia, then x would consent to necessarily being euthanized if x is arational

DC2 may be open to several interpretations, but I take it to read:

> x is able to consent $\Box\!\!\rightarrow$ x consents to $\Box$(x is arational $\Box\!\!\rightarrow$ x is euthanized)

How does the DC2 reading succeed over the DC1 reading? The DC1 reading does not say anything about the world in which the patient should be euthanized. The counterfactual consent given according to DC1 is for any world that is the closest comatose world to the consent world - and this world is not necessarily the actual world. The Rational Man's counterpart may be giving counterfactual consent, but not to the euthanasia of the actual Rational Man, but to one of his other counterparts. The DC2 reading does say something about the comatose world in which the Rational Man's counterpart consents to being euthanized: all of them! The Rational Man has counterfactually consented to being euthanized in every possible world in which he is comatose. The actual world is one of those worlds. Thus, the Rational Man's counterpart has consented not merely to his counterparts' euthanasias several worlds away, but he has consented to his counterpart's euthanasia in the Rational Man's actual world.

However, DC2 is much too strong to be a true reading of a counterfactual about consent. Imagine if a counterpart of the Rational Man were in an irreversible coma, but the existence of life on his earth would be destroyed by his euthanasia. According to DC2, that Rational Man would still consent to euthanasia if he were in those circumstances. But obviously this is false - the Rational Man's counterpart would not have consented to euthanasia if his entire earth hung in the balance. While he may have thought that life was no longer worth living once he was no longer rational, it is not the case that he would have consented to being euthanized and taking his entire planet with him. In the

world in which the Rational Man's counterpart is comatose, but his euthanasia would have resulted in the destruction of his entire planet, he would have hoped for a speedy, but natural death. Thus, DC2 is an incorrect reading of counterfactuals about consent. DC2 is too strong - a further revision will have to be made to the double modality solution for it to stick.

It is possible to revise the double modality solution by altering the second counterfactual. If the second counterfactual stated "If no one else's harm would result from his euthanasia, then the Rational Man would consent to his euthanasia", would this solve DC2's problems? I don't believe so. It may solve the problem that I stated above - the reluctance of the Rational Man's counterpart to be euthanized in those worlds in which his entire earth would be destroyed by his euthanasia. But this solution is also unsatisfactory. Consider the possible worlds in which there is life after death, acts of euthanasia are punished by endless suffering in hell for the person who dies as a result of euthanasia, and those people who are alive in that world are entirely aware of these facts. In those worlds, the Rational Man's counterpart would not look forward to his body lingering in a meaningless existence without rationality. However, he certainly would not have consented to euthanasia either, for fear of what awaited him. The Rational Man's counterpart in that world would hope for a speedy natural death if he were to end up in a coma, just as the Rational Man's counterpart whose euthanasia would result in the destruction of his entire planet would hope for a speedy natural death if he were to end up in a coma. Any attempts to fix DC2 by

merely changing the circumstances that are described in the second counterfactual will not be sufficient to cover all the cases. One can always come up with a counterexample in which the Rational Man in that world would not have consented to his euthanasia, and would have preferred a natural death if he were to end up in a coma.

The problem with DC2 is that it is too strong. In including a necessity operator in the consequent of the larger counterfactual, the result was that statements of counterfactual consent committed us to consent to acts of euthanasia in situations that clearly would not merit consent. The necessity operator made counterfactuals about consent too strong. However, the necessity operator did do some important work in the double modality solution. Including the necessity operator guaranteed that the Rational Man's counterpart, in giving counterfactual consent, was counterfactually consenting to the actual Rational Man's euthanasia in the actual world.

A true solution to the Rational Man paradox would not have the Rational Man consenting to his counterpart's euthanasias in worlds which are significantly unlike the actual world: worlds in which the entire earth would be destroyed if the Rational Man were to be euthanized, or worlds in which he knows that he would linger in hell forever if he were to be euthanized. The necessity operator picked out too many conditions under which the individual known as the Rational Man is euthanized. However, it is possible to limit the conditions under which the Rational Man is euthanized to the conditions he is in at the actual world. An

actuality operator will perform this function. I believe that implicit actuality solution offers both the most elegant, and ultimately the most intuitive, reading of counterfactuals about consent.

The Implicit Actuality Solution

Consider the following counterfactual conditional: If I were six feet tall, then I would be taller than I am. How do we understand this counterfactual conditional? It doesn't make sense to say that I travel to the closest possible world in which my counterpart is six feet tall, and see if she is taller than she is. Obviously no one is ever taller than she is - no matter which world you choose. Yet, this counterfactual does make sense.

The way we understand such a counterfactual is by recognizing an implicit modal operator in the consequent of counterfactual conditional. This modal operator is the adjective 'actual', and it operates on sentences. Instead of the counterfactual literally reading 'If I were six feet tall then I would be taller than I would have been (at six feet tall)', we read this counterfactual in this way: 'If I were six feet tall, then the height I would have would be greater than the height that I actually have.' We interpret this counterfactual by looking to the closest possible world in which my counterpart is six feet tall. In that world, my counterpart is taller by seven inches than I am in the actual world, at five-feet, five-inches. There is a cross-world comparison in understanding this counterfactual - we compare my

counterpart's height in another world with my height in the actual world[7]. The implicit actuality reading of a counterfactual about consent,'IA', will read as follows:

> IA: If x were able to consent to x's euthanasia, then x would consent to being euthanized if x should ever be in the medical condition x is actually in

Formalized, using '@' to symbolize the actuality operator, the above reads:

> x is able to consent to x's euthanasia □-> x consents to (x is in the condition, C, such that @(x is in C) □-> x is euthanized)

Using the actuality operator, it is possible to come up with another solution to the Rational Man paradox. When we say of the Rational Man "If he could consent to his euthanasia, then he would consent" we recognize an implicit actuality operator in the counterfactual. The Rational man's counterpart who is able to give consent does give consent, but he gives consent if he should ever be in the Rational Man's *actual* condition. The IA solution picks out precisely the conditions under which the Rational Man's counterpart would consent to euthanasia - the Rational Man's actual condition. The IA solution is illustrated in the following way:

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[7]Lewis' example, "If I had turned to crime, (the world) would have been worse than it is" captures the same idea. Certainly no world is worse than it is - this is logically impossible. Rather, the world in which Lewis had turned to crime is worse than the actual world is. A cross-world comparison is needed to properly understand this counterfactual conditional (Lewis, p. 124).

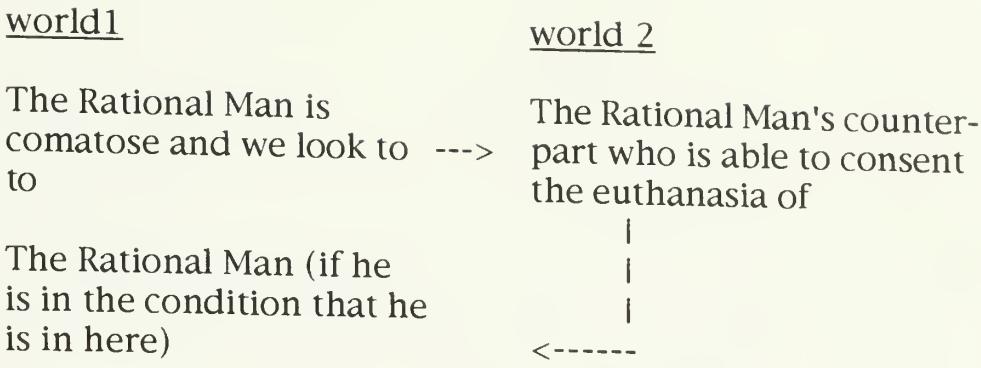

Figure 3.3: The Rational Man's Counterpart Consents to the Euthanasia of His Counterpart in the Rational Man's Actual Condition

Unlike many of the double modality solutions, the IA solution does not confuse the conditions the Rational Man's counterpart picks out when he consents to being euthanized. One of the problems with DC1 was that it was unclear under which conditions the Rational Man's counterpart was offering consent to be euthanized in, because he was only offering consent to acts in the closest world. It was not necessarily the case that the closest world was in fact the actual world. DC2 attempted to remedy the problem, by using a necessity operator to allow the Rational Man's counterpart to consent to euthanasias in every world in which he had a counterpart in a coma, including the actual world. However, in solving one problem, DC2 created another. It is true that DC2 guaranteed that the Rational Man's counterpart consented to the actual Rational Man's euthanasia while he was in the condition of being in a coma, but the counterpart also consented to the euthanasia of many counterparts for whom consent would be inappropriate, and even disastrous! Any attempt to solve this

problem would allow that the Rational Man offer consent only in those conditions that were similar to his own. But which conditions were these? The IA solution clearly picks out precisely which conditions the Rational Man's counterpart picks out - the Rational Man's actual conditions. Just as including an implicit 'actuality' operator in counterfactuals like "If I were six feet tall, then I would have been taller than I am" helps us to better understand these counterfactuals, it seems that the Rational Man paradox can be solved by including an implicit actuality qualifier in the statement of counterfactual consent that we utter on behalf of the Rational Man[8].

Figure 3.2 demonstrated the very best DC1 scenario. Optimally, the closest world to the world in which the Rational Man's counterpart is able to consent in which the Rational Man's counterpart has a counterpart who is in a coma is the Rational Man's actual world. If this is true, then the Rational Man's counterpart consents to the euthanasia of the actual Rational Man. However, it is not always the case that the DC1 solution will have this result. The IA solution will always have this result, though. With the IA solution, the world that the Rational Man's counterpart picks out as the world in which he would consent to a counterpart being euthanized is always the actual world, for the

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[8]The IA solution assumes that the 'actual world' always refers to the Rational Man's actual world, and not to the actual world of the counterpart who is offering consent. This is a rigid reading of the word 'actual', one that always refers to a single world, as opposed to an unrigid, indexical reading of 'actual'. Lewis, pp 92-94.

Rational Man's counterpart consents to the euthanasia of the Rational Man only if he is in the Rational Man's *actual* conditions.

Counterfactuals about consent often are stated in the following manner: 'If x were able to consent to being euthanized, then he would consent to being euthanized.' However, this chapter establishes an important fact about counterfactuals about consent: while you may have to travel to another world before a person is able to consent to something (the world in which the consequent is true), you must hold fixed the conditions such that he is consenting to to be euthanized if ever in them (the facts that make the antecedent true). It may be the case that in traveling to another world to find a true consequent, you have eliminated the very conditions that must be held fixed for the antecedent to be true. This problem, illustrated by the Rational Man paradox, forced me to pursue another way of reading counterfactuals about consent.

Given the IA's success in solving the Rational Man paradox, it is important to recognize the double modality and implicit actuality operator in every counterfactual about consent. Counterfactuals about consent should be read to literally mean: If he were able to consent to being euthanized, then he would consent to being euthanized if ever in the condition that he actually is in.[9]

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[9]I would like to thank Fred Feldman, Phil Bricker, Willem deVries, Ned Markosian, Morgan Hott and Jennifer Armstrong for their invaluable help in writing this chapter.

CHAPTER IV

EVIDENCE FOR THE TRUTH OF STATEMENTS OF COUNTERFACTUAL CONSENT

Actual statements of consent are performative utterances, and as such have no truth value[1]. Counterfactuals about consent appear to have a truth value - it is either true or false that an agent would have consented to an act, if he were asked. But the evidence for the truth of these counterfactuals is difficult to sort through. The Rational Man paradox, discussed in Chapter III, demonstrates that counterfactuals about consent are not analyzed in the same manner as counterfactual conditionals that are not about consent. In Chapter I, I considered the counterfactual conditional 'If kangaroos had no tails, they would fall over.' If at the closest possible world to the actual world in which kangaroos have no tails, they in fact do fall over, then the counterfactual 'If kangaroos had no tails, they would fall over' is true.

Counterfactuals about consent can be analyzed using the same possible world semantics. However, it is not the case that we consider the closest possible world in which the counterpart of the patient is able to consent to being killed and see if he consents to his death in *that* world to determine if the counterfactual 'If he were able to consent to his own death, then he would' is true. Rather, the counterpart is consenting to a death of a patient in

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[1]J. L. Austin, "Performative Utterances", The Philosophy of Language, ed. A.P. Martinich, Oxford University Press, 1985, pp. 115-124.

that patient's actual circumstances, not the counterpart's own circumstances.

However, it is the case that we must determine what the patient's counterpart would say to the question 'Would you consent to being killed if your circumstances were such that you were in a coma?' In this chapter I will consider possible sources of evidence for claims that a patient's counterpart either consents or denies consent. I will first consider two objections that have been raised to the claim that there are truth values for counterfactuals about consent. These are objections from either the lack of a fact of the matter about the consequent of any statement of counterfactual consent, or the overabundance of facts of the matter about the consequent of any statement of counterfactual consent. Neither of these objections will prove to be very strong. I will then explore assertoric antecedent consent, problematic antecedent consent, surrogacy, the "best interest" test and the "rational agent" test as possible evidence for the truth of a claim about counterfactual consent. I will conclude that none of these offers sufficient evidence to support a claim about what a patient's counterpart consents to.

Two Objections: No Truth Values, or Too Many

Some philosophers claim that possible world semantics are too weak to determine the truth values of any counterfactual. Those who believe this claim may cite one of two possible objections to the claim that there is a fact of the matter about

what a patient's counterpart counterfactually consents to. The first is an objection from the claim that counterfactuals about consent have no truth value at all. The second is an objection from the claim that counterfactuals about consent have too many truth values.

The objection from the claim that counterfactuals about consent do not have truth values is as follows. Counterfactuals about consent are propositions about states of affairs that, except in very special circumstances, have not obtained. Very rarely do we say "If he were able to consent to our killing him, then he would" in those cases in which the patient is able to consent to being killed[2]. It is not that there are no counterfactual conditionals with antecedents that obtain in the actual world. Such counterfactual conditionals do have truth values. But let us focus on the ones that do not - specially, the ones about individuals like the Rational Man of the previous chapter, who is in an irreversible coma when we say of him "If he were able to consent to being killed, then he would." There will never be a case in which a patient in an irreversible coma will consent to anything. The antecedent of a counterfactual about what such a patient would consent to, if he were able to consent, never obtains in the actual world.

Some philosophers claim that such counterfactuals have no truth value at all. Drew Christie has offered the example of determining what should be done about a terminally ill relative.

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[2]Such a case is discused in the following chapter.

No one will be able to agree that any course of action is "What Dad would have wanted", because "there is no objective truth and to say there is is to falsify the moral situation."[3]

This objection is closely tied to a type of objection from paternalism against using counterfactual consent to justify acts of euthanasia. If there is no fact of the matter about what a patient would have consented to, had he been able to consent, then those agents who try to use counterfactual consent to justify their act of euthanasia are not acting based upon what the patient would want for himself, but what they want for themselves. If what they want is to "further the patient's best interests", then it can be said that they are performing a paternalistic act - intervening on a person's behalf so as to promote his best interests without that person's permission[4].

When the objection is raised that counterfactuals about consent do not have truth values, it seems that the objection has more to do with the moral weightiness of performance of an act of euthanasia than with the lack of a fact of the matter about the truth value of counterfactual conditionals. Would these philosophers object to the truth of the claim "If I were to let go of this pen, it would fall down"? No. However, very little is at stake in the dropping of a pen. Much more is at stake when we utter a

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[3]Drew Christie offered these comments at a reading of a version of Chapter III at the University of New Hampshire on November 17, 1994. Professor Christie went on to argue that the project undertaken in Chapter III, an attempt to analyze what counterfactuals about consent mean, is a fruitless one precisely because there is no fact of the matter about the truth of any counterfactual.

[4]This objection was also raised at the reading at the University of New Hampshire, by Professor Val Dusek.

counterfactual about consent in an attempt to justify the taking of a life. Perhaps the reluctance of an agent to assign a truth value to a counterfactual about consent will lead him to erroneously believe that there is no fact of the matter about the truth value of counterfactuals about consent. Or, it may be argued that since we can never actually test the truth of a counterfactual about consent, such statements must be neither true nor false. A radical empiricist may argue that if the truth values of counterfactuals about consent cannot be tested for, then they simply do not exist. It would be prohibitive for me to argue against this radical empiricist view at this point, but suffice it to say that such a radical empiricist view is at the least controversial. Regardless of the reason for the mistake, it is nonetheless a mistake to claim that there is no fact of the matter about what an agent would consent to, if he does not consent.

The objection from the claim that counterfactuals about consent have too many truth values is as follows. If in the closest possible world in which the patient's counterpart is able to consent to being euthanized, he consents to being euthanized if he were comatose in the actual world, then the counterfactual "If he were able to consent, then he would" is true. But consider the case in which there is more than one world which is the closest world in which the patient's counterpart is able to consent. Consider two worlds, w1 and w2, and their relation to the patient's actual world. Let us say that both w1 and w2 are equally close to the patient's actual world, and that there is no other world that is closer to the actual world in which the

patient's counterpart can consent than either w1 or w2. Imagine that in w1 the patient's counterpart does consent to being euthanized if he were comatose in the actual world. In w2, however, the patient's counterpart refuses to consent to being euthanized if he were comatose in the actual world. We can no longer say that the patient either would or would not consent to being euthanized if he were able to consent - at best we can say that he *might* consent. It is not the case that there is no fact of the matter about what the patient's counterpart consents to; rather, there are too many. He might have consented, he might not have; each state of affairs is equally possible in the actual world.

If the patient merely *might* have consented to being euthanized, then we can not use a counterfactual about consent in an attempt to morally justify his euthanasia. As I have discussed in Chapter II, counterfactual consent can morally justify some acts of euthanasia. But that is true only if it can be said that a patient *would* have consented. If the patient might, and at the same time might not, have consented, then it cannot be said that the patient *would* have consented. Without the true claim that *the patient would have consented,* the counterfactual may not be invoked. Hence, my adoption of Robert C. Stalnaker's uniqueness assumption - for every non-empty proposition A and for every possible world *i*, there is at most one A-world minimally different from *i*.[5] Thus, there is no more than one world which is the

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[5]Robert C. Stalnaker, Inquiry, MIT Press, 1987, p. 133.

closest world to the actual world in which the patient's counterpart can consent to being euthanized if he needed to be euthanized.

Although I have adopted Stalnaker's methodology in determining the truth conditions for counterfactuals, this is not to say that the counterfactual "If he were able to consent to his death, he might have consented" is false, or meaningless. In such a counterfactual, the word 'might' could have one of two meanings. First, those things that "might" have happened may be those states of affairs that possibly happen in some world, perhaps the closest possible world, perhaps one a little further away. This way of reading "might" counterfactuals establishes a metaphysical point about the possibility of the truth of such counterfactuals. When I say "If I had bought I ticket this week, I might have won the lottery," I mean that there is some possible world in which my counterpart does win the lottery. That world is not necessarily very close though; rather, the state of affairs is not logically impossible. That is not the same as saying "If I had bought a ticket this week, I would have won the lottery." The latter statement implies that the world in which I won is rather close. Perhaps the winning numbers were 04-22-67, my birth date, and if only I had played those lucky numbers this week, I would have won, because in fact those were this week's winning numbers. Second, those things that "might" have happened may be those states of affairs that happen in some possible world, but in saying they "might" have happened I concede that I have no idea how far away the world in which those states of affairs

obtain is. This way of reading "might" counterfactuals establishes an epistemic point about such counterfactuals. "If Harry and Sally hadn't gotten a divorce, then they might have been happy together." I don't know enough to say if they would have been happy, but I won't rule the possibility out. The closest possible world in which their counterparts didn't get a divorce may have been one in which they were happy, and it may be one in which they were not. Both of these are readings of the "might" counterfactual that do not incorporate ties for closeness among possible worlds. Either one, or both, may be what is meant by the counterfactual "If he were able to consent to being killed, then he might have consented". However, given Stalnaker's uniqueness assumption, it is a mistake to assume that the "might" counterfactual implies that the worlds in which the patient consents to being killed and denies consent are equally near.

Antecedent Consent: The Living Will

Derek Humphry introduces the notion of a Living Will:

> If you have not already done so, sign a Living Will and have it witnessed. Get the one that is valid for your particular state. This document is an advance declaration of your wish not to be connected to life-support equipment if it is adjudged that you are hopelessly and terminally ill[6].

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[6]Humphry, p. 21. Phillipa Foot, who calls Living Wills "eminently sensible", would concur with Humphry's view that if you have not already done so, you should sign a Living Will. Phillipa Foot, "Euthanasia", Virtues and Vices, University of California Press, 1978, p. 59.

If a patient is able to make a declaration of his wishes ahead of time, while he is still able to make a rational and informed decision, his statement would be either one of assertoric antecedent consent, or problematic antecedent consent. Immanuel Kant introduces the distinction between assertoric hypothetical imperatives and problematic hypothetical imperatives:

> A hypothetical imperative thus says only that an action is good for some purpose or other, either *possible* or *actual.* In the first case it is a *problematic* practical principle; in the second case an *assertoric* practical principle.[7]

By 'assertoric antecedent consent' I mean a statement of consent that an agent gives before the state of affairs that would result in the agent's need to give consent has obtained, when it is clear that such a state of affairs will obtain. For example, the patient with Lou Gehrig's disease may say, "I consent to your killing me if I am ever in a coma and am relying solely on life machines to survive" is a statement of assertoric antecedent consent. Lou Gehrig's Disease will inevitably result in the patient lying in a coma, relying solely on life support machines to survive. The patient consented for you to perform an action before the fact, and it is sadly inevitable that the time will come that such consent will be needed. By 'problematic antecedent consent' I mean a statement of consent that an agent gives before the state of affairs that

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[7]Immanuel Kant, The Groundwork of the Metaphysic of Morals, ed. H.J. Paton, Harper and Row, 1964, p. 82.

would result in the agent's need to give consent has obtained, when it is not clear that such a state of affairs will obtain. For example, consider a man with cancer whose doctors predicted that he would end up in a coma, but such a state of affairs was not guaranteed as part of his prognosis. If such a man said to you, "I consent to your killing me if I am ever in a coma and am relying solely on life machines to survive", he would be offering you actual consent about a possible, but not guaranteed, state of affairs. He has actually consented to your performance of an action, but it is not clear that the state of affairs that would result in the action he has consented to will obtain. Either assertoric antecedent consent or problematic antecedent consent may be used as evidence to support the truth of a statement of counterfactual consent.

A Living Will may be either an expression of assertoric antecedent consent, or problematic antecedent consent. If an agent writes a Living Will with no expectation that the state of affairs will obtain such that the Living Will will be invoked, then the Living Will documents the agent's problematic antecedent consent. The agent is giving consent to a course of action if a certain state of affairs obtains, but he has no expectation that such a state of affairs will obtain. He just wants to be prepared for that contingency. If, however, the agent writes a Living Will with the expectation that the state of affairs will obtain such that the Living Will will be invoked, then the Living Will is a statement of assertoric antecedent consent. The agent recognizes that the time will come that others will have to decide whether or not to

terminate his life support, and he offers them consent to do so before the time has come for the life support to be terminated.

Of course, there are other forms of assertoric antecedent consent or problematic antecedent consent than Living Wills. A patient may have merely discussed what he would want, without writing it down, if he ever were on a life support machine. An accurate reporting of that conversation could serve as evidence for the truth of a statement of counterfactual consent. But such informal statements of assertoric antecedent consent or problematic antecedent consent are of course very difficult to verify.

Problems for Antecedent Consent

One problem for both assertoric antecedent consent and problematic antecedent consent is that both are statements of consent that are made long before the patient is faced with a mortal decision. Consider the Living Will that states 'I consent to my life support machines being turned off, if I am ever in a coma and am relying solely on machines to survive.' The agent who thus consents is not in a coma when he consents to having the life support machines turned off. In most cases the agents who are making such a prediction have never been in a coma. How can the agent make an informed decision about a state of affairs he has never experienced? Both assertoric antecedent consent and problematic antecedent consent are offered long before the patient has experienced the state of affairs that directly precedes

the action to which he is consenting. Can such consent possibly be informed?

There are two replies to the objection that assertoric antecedent consent and problematic antecedent consent to acts of euthanasia are not informed, and thus should not be used as evidence to support the truth of a claim about counterfactual consent. The first is that it may be true that most people who give assertoric antecedent consent or problematic antecedent consent have never been experienced states of affairs similar to those they describe in their Living Wills, but some of them have experienced similar states of affairs. There are some people who have been in comas or have relied on life-support machines, have recovered, and after their ordeals have written Living Wills. It is the case that their consent to be killed in case they are in a coma, or have their life support machines turned off, is informed. However, it is the case that not every individual who writes out a Living Will has experienced being in a coma or relying on life support machines. I contend that this reply is not a very strong one - it does not demonstrate that all cases of assertoric antecedent consent and problematic antecedent consent are informed.

The second, stronger reply, is that we often offer statements of antecedent consent before the fact, even if we are consenting to something we have never experienced before. We have no problem offering consent in many of these cases. For example, I will offer this statement of antecedent consent: I hereby consent to your invading my personal space and giving me CPR, if you

ever rescue me from drowning'. I've never drowned; I've never even come close. I've never been given CPR. Yet, despite my ignorance in these matters, I am confident that if such a situation arose, that my antecedent consent would still stand. The objection that statements of antecedent consent ask agents to make judgements about states of affairs they are ignorant of, and thus they are not statements of informed consent, is not very convincing.

Or perhaps it is more convincing than my drowning analogy would let on. I don't know what it is like to drown, or to be given (or not given!) CPR in such an instance. But I do know what my life is like - I'm pretty pleased with it. I am well acquainted with at least one of the alternatives, and feel I could do much worse than to have that alternative actualized. But the healthy agent making out his Living Will is choosing among alternatives *that he has never experienced*. The Hasting Center Report claims that the patient is responsible to "consider all possible alternative futures that the patient might experience."[8] How is this even possible? A patient simply can not be responsible to consider all possible alternative futures and appropriately plan for them. There is just too much to consider. At least I am somewhat acquainted with what one of my alternatives holds for me when I consent that you try to keep me alive. In cases of antecedent consent to acts of euthanasia, the agent who is offering consent is unable to make an informed choice.

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[8]Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying, Hastings Center, 1987, p. 21.

There is a second problem for both types of antecedent consent that is closely related to the problem of the agent making an uninformed choice. What if the writer of the Living Will changes his mind? Consider the agent who makes out a Living Will that says "If I am ever relying solely on life support machines to keep me alive, please remove them and allow me to die peacefully". After making out the Living Will, she meets with an accident and is forced to rely solely on life support machines to stay alive. While she is unable to respond to her doctors, she has a complete understanding of everything that is going on around her. She changes her mind, however. She realizes that this is not so horrible an existence for her. What happens when the doctors meet in her hospital room to discuss the fact that they have located her Living Will and are planning to shut off the life-support machines? They cite her antecedent consent in her Living Will as evidence for a claim about counterfactual consent - they believe that if she were able to consent to having the machines shut off, then she would. They are wrong, of course. Now that she has changed her mind, her Living Will does not reflect what she currently wants for herself. If she were able to withdraw the consent she had given in the Living Will, she would do so.

The Hastings Center Report considers the problem of changing your mind. It advises that "the individual should review the directive (eg: the Living Will) every one or two years to ensure that it continues to represent his or her wishes. The individual may make additions, changes, and deletions at any

time."[9] Similarly, the person may revoke the directive at any time. However, this recommendation doesn't say enough. Our preferences may change more rapidly than once "every one or two years" - this is not enough to ensure that it represents our preferences. More importantly, the moment when it is most important to make changes to the Living Will, or perhaps revoke it altogether, is probably the very moment when it is no longer possible to do so. Only after it is too late will the patient be qualified to know if the directive in the Living Will is what she wants at that moment.

Dan Brock does not believe that the changing of a patient's mind is as serious a problem as I have claimed, when the patient's decision-making capacities have been impaired:

> At least when our future decision-making capacities will be impaired, there is nothing morally objectionable, in itself, in our present self binding our future self in a way which will be contrary to the desire of the future self. This is a function in part of the fact that we each view ourself as one single self that continues over time, so that it is my future that my present action seeks to control. Odysseus lashed himself to the mast for just such purposes...[10]

Brock's point is that sometimes we desire things for our future selves, that we nonetheless are unable to recognize as the things we desire when the time comes to actualize our choice. Today I may resolve to go on a diet. Tomorrow I may be tempted by

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[9], The Hastings Center, p. 81.
[10]Dan Brock, Life and Death: Philosophical Essays in Biomedical Ethics, Cambridge University Press, 1993, p. 104.

chocolate, but by resisting the chocolate I am true to myself and my desires. When we are likely to be tempted away from what we truly want, it makes sense for us to make antecedent claims about what we want, even if we appear to change our minds in the future. Brock's argument works only in cases in which our future decision-making capacities are impaired, however. In the case I described above, in which the patient changes her mind after realizing that her circumstances are not so bad, what will Brock say? What if the patient's decision-*making* capacities are fine, but the patient's decision-*expressing* capacities are not? This remains a problem for all statements of assertoric antecedent consent and problematic antecedent consent.

The Hastings Center Report claims that a Living Will dictates "what form of care (the patient desires) under various circumstances."[11] Unfortunately, however, the best that the Living Will can do is dictate the form of care that the patient desires *at the time that he composes the Living Will.* There is no guarantee that a statement of assertoric antecedent consent or problematic antecedent consent reflects the patient's desires at the time that the directive in the Living Will is carried out. Problems such as the fact that a patient can not know what his views will be until after he is unable to change his Living Will, or the agent's changing his or her mind, prevent the Living Will from effectively demonstrating what a patient would counterfactually

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[11]Hastings Center, p. 13.

consent to[12]. In light of this, assertoric antecedent consent and problematic antecedent consent cannot be used as accurate predictors of the actions to which we can ascribe an agent's counterfactual consent.

Durable Powers of Attorney and Surrogacy

There are three cases in which a patient is not able to make a rational and informed choice for himself. A patient (a) may no longer be able *to express* his rational and informed choice. In this case, the patient has preferences, but is unable to articulate them. The patient (b) may have lost his both his ability *to make* and *to express* rational and informed decisions. In this case, while the patient is able to express some things, he is no longer able to express rational or informed wishes about his case, for his capacity for rational thought has left him. In these cases, it is often assumed that someone else will either articulate the decisions, or make decisions, for him. Finally, a patient (c) may have never been able to make a rational and informed choice for himself. In each of these cases, either a Durable Power of Attorney will be cited to name a surrogate, or a surrogate will be assigned.

Humphry introduces the notion of a Durable Power of Attorney:

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[12]Brock mentions two other legal and/or practical problems with the type of antecedent actual consent or antecedent predictions of consent found in Living Wills: not enough people have Living Wills, and the legal effects of advance directives are often limited by the language of Living Wills. See Brock, pp. 154-155.

> A more potent document [than the Living Will] is the Durable Power of Attorney for Health Care, which, in different forms, is available in all American states. Here you assign to someone else the power to make health care decisions if and when you cannot[13].

Durable Powers of Attorney allow for a friend or relative, someone who is/was aware of the values and preferences of the patient, to be asked to make the decision for the patient. In these cases, the patient is unable to make such decisions on his own, but the patient at one time was able to express and make his own decisions. No Living Will exists - there is no formal statement from the patient about his wishes now that the current state of affairs had obtained. Instead, such circumstances have occurred, it is up to friends and relatives to make a choice on behalf of the patient. Effectively, the Durable Power of Attorney allows agents to give consent on behalf of the patients they represent. Those individuals who are given decision-making power by Durable Powers of Attorney are called "surrogates".

All cases of Durable Power of Attorney are cases in which the patient previously consents to having someone else make his decisions on his behalf. The use of a Durable Power of Attorney to assign surrogacy demonstrates one of two types of cases in which surrogacy may be employed. In the first case the patient is unable to express and/or articulate a rational preference. Perhaps the patient has become senile - at one time he was able to express a rational preference, but no longer. In such cases, the patient

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[13]Humphry, p. 22.

may have explicitly named his surrogate (with a Durable Power of Attorney), or a surrogate may be chosen for the patient. These cases represent (a) and (b), introduced at the beginning of this section. In the second case the patient never was able to express a rational preference. Perhaps the patient is an infant, with no rational capacity, or a severely retarded individual of any age. In such cases, the surrogate was obviously chosen for the patient. These cases represent (c), introduced at the beginning of this section.

It should be noted that there is a crucial difference between a Living Will and the use of a surrogate. A Living Will states the wishes of an individual if or when certain states of affairs obtain in the future. When writing a Living Will, a person will ask himself, "What do I want (now), if c were to obtain in the future?" In this case, the person projects himself into the future, changing as little as possible about himself so as to accurately be able to assess his circumstances. The person imagines the closest possible world in which c obtains, and determines what he presently wants for himself in those future circumstances.

The surrogate states what he believes the wishes of the individual he represents to be as certain states of affairs obtain in the present. The surrogate asks himself, "What would my friend want done now that c has obtained, if he were able to tell me?"

> When the patient lacks the capacity to make the treatment decision, so that a surrogate decisionmaker has decisionmaking authority instead, the surrogate

should seek to choose *as the patient would if he or she were able*.[14] (italics mine)

It is important to stress that the surrogate chooses not what he wants for the patient, but rather "decide(s) as the patient would have decided if he or she had been competent."[15] The surrogate is the patient's advocate. Optimally, the surrogate has a close personal relationship with the patient, so that the surrogate will be a good predictor of the the patient's beliefs and preferences. Of course, it is possible that the closer the surrogate is to the patient, the more the surrogate's assessment of what should be done with the patient will be shaped by his own preferences, and not the preferences of the patient. For example, a parent may be the best judge of what a child would want for herself, but the parent's recommendation may be closer to what the parent wants for the child, not what the child would want for herself.

Another crucial difference between a Living Will and a surrogate lies in the distinction between a patient giving consent for his own treatment, and someone other that the patient giving consent for the patient's treatment. The Hastings Center summarizes the distinction: in Living Wills the attending physician "follow(s) the patient's explicit directive", whereas surrogates determine what should be done by "applying the patient's preferences and values".

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[14]Hastings Center, p. 27. See also The Boston Globe, Thursday, May 26, 1994, "Drop Presumption to Live, Journal Urges", about the role of the surrogate to consent to what the "person would have wanted".
[15]Brock, p. 155.

In one case the patient seemingly has made a claim about what he wants for himself, whereas in the other case the surrogate makes a claim about what he believes the patient would want for himself.[16]

Problems for Surrogacy

There are several problems for surrogacy. The first is a problem of agents whose preferences are in principle unable to be expressed by a surrogate. The following case serves as an example:

The Case of Scrooge. Scrooge was an unkind, curmudgeonly old man. Everyone who knew him knew that two things were certainly true of him: he hated to do what other people told him to, and he hated when people tried to predict his behavior. If someone said, "Scrooge will want the cherry pie," he would choose the apple pie, just to spite the person who tried to guess his tastes. When he fell into a coma, a surrogate was appointed to make decisions about Scrooge's health care. All the surrogate knew was that whatever he chose on Scrooge's behalf, Scrooge would have wanted something different. After a night of deliberation, the surrogate declined his role as a surrogate. No matter what he would have chosen, it would have been contrary to Scrooge's wishes. The case of Scrooge illustrates one way in which

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[16]See Chapter II for Thomas Scanlon's discussion of the value of an agent choosing for himself over having another individual make a choice on his behalf.

surrogacy can fail to represent a patient's wishes. If a patient's wishes are in principle unable to be expressed by others, then no surrogate can ever speak on his behalf.

While I believe in principle that this is a problem for the notion of surrogacy, it may not be so great an issue. The case of Scrooge may be too esoteric - perhaps there are no Scrooges, and the lesson of Scrooge has no practical application. This may be true, and the case may not demonstrate sufficiently that surrogacy is flawed. However, there remain other problems with surrogacy.

Presumably the surrogate knows the beliefs and preferences of the patient for whom he is uttering a statement of counterfactual consent. However, two points may be called into question. First, how well must the surrogate know the patient before he is qualified to speak on the patient's behalf? The surrogate is expected to know the patient's "preferences and values"[17], but sometimes this is impossible. As with assertoric antecedent consent and problematic antecedent consent, the patient is not always in a position to know what he would consent to, if he is forced to choose among alternatives with which he is not acquainted. How is the *surrogate* supposed to state what the patient would want for himself, if the patient *himself* would not have known?

A second problem involves the surrogates for individuals who never had preferences about euthanasia. Small infants,

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[17]Hasting Center, p. 28.

children, and mentally incapacitated individuals who never made decisions and never had preferences nonetheless have surrogates who make important decisions about terminating these individual's life support machines. These are the nonvoluntary2 cases that were discussed in Chapter II[18]. In many cases the surrogates may not consider what these individuals would have consented to, had they been able to consent. However, in some cases such considerations are made[19]. When they are made, there are two possible means for determining what such individuals would have consented to, even though they never had consented to anything previously. These are the Best Interests Standard and the Rational Agent standard.

The Best Interests Standard. In some cases in which the patient is unable to consent, and never had consented to anything in the past, we make the following claim about what he would have consented to: he would have consented to this course of action, because this is what would be best for him[20]. What else would an agent have consented to, but that which is best for him? This line of reasoning is faulty, however. As mentioned in Chapter II, it is a mistake to say that what an agent consents to is by definition what is best for him. Similarly, what is best for an

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[18]See David H. Smith's "On Letting Some Babies Die", Killing and Letting Die, ed. Bonnie Steinbock, Prentice-Hall, 1980, pp. 92-108, for the view that all cases of euthanasia of newborns are involuntary euthanasia, not nonvoluntary euthanasia.

[19]James Rachels claims that in cases in which infants or mentally handicapped people are euthanized, there is no sense in which the patient's wishes were taken into account. See James Rachels, The End of Life: Euthanasia and Morality, Oxford University Press, 1986. p. 60.

[20]Hastings Center, p. 28.

agent is not by definition what the agent would have consented to. Consent may be one of several factors that contributes to the goodness of any alternative, but consent alone is not sufficient to determine which alternative is the best.

Furthermore, what is "best" for an individual differs from one to the next. Some individuals believe that living without physical pain is their best alternative. Others value autonomy and strength, and believe that fighting death every step of the way is best. Ronald Dworkin recounts the story of a seventy-six year old widow who refused to give consent to a "do not recessitate" order, and whose family upheld the woman's wishes based on a family "tradition to fight to the bitter end".[21] For this woman, the Best Interest standard seems to indicate that a great deal of pain and suffering were in her best interests, counter to our intuitions about what is in a person's best interest. The doctors needed to know about the woman's history and beliefs before they could do what was best for her. How can we apply a Best Interests Standard though to infants and the mentally handicapped, about whom we know so little?

The Rational Agent standard. A variation on the Best Interests Standard is the Rational Agent standard[22]. Using the Rational Agent standard, individuals who are killed by nonvoluntary2 euthanasia have the property of being rational

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[21]Ronald Dworkin, Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom, Alfred A. Knopf, 1993, pp. 186-187.

[22]Michael J. Resnik claims that "rational actions [are], in other words, [those] that [are] in one's best interest" to perform. See Michael J. Resnik, Choices: An Introduction to Decision Theory, University of Minnesota Press, 1987, p. 6.

agents counterfactually ascribed to them. Hence, we say of them, "If they were rational agents and able to consent to their own death, given their present circumstances, then they would consent to their death." Brock says "Lacking any knowledge of this particular patient's wishes, such decisions will inevitably involve asking what most reasonable persons would want for themselves in the circumstances."[23] The Hastings Center says that in these cases the surrogate should "choose as a reasonable person in the patient's circumstances would."[24]

The Rational Agent standard may in fact just collapse into the Best Interests Standard. If a rational agent is merely one who always acts in accord with his best interests, then the two are the same. It makes little sense to say that a rational agent is merely one who is able to make informed judgments about his circumstances, without also incorporating some criteria of preference ordering into the notion of the rational agent. If this is true, then all of the problems for the Best Interests Standard will be shared by the Rational Agent standard.

A final problem with both the Best Interests Standard and the Rational Agent standard is that both may be *too* objective[25]. For example, if the Best Interests Standard is useful in determining what ought to be done for a small infant, then presumably anyone can make a claim about counterfactual consent on the infant's behalf. However, this is not what is

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[23]Brock, p. 155.
[24]Hastings Center, p. 28.
[25]This problem was raised by Fred Feldman.

commonly done. Parents are believed to have a privileged status in these cases - their judgment about what an infant would counterfactually consent to is held in higher regard than that of the infant's doctor[26]. But if both are using a Best Interests standard for determining what is best to do for the infant, why should the parent's statement of counterfactual consent be necessary? Why couldn't the parents show up at the hospital one afternoon to find their dead infant, and the doctor calmly telling them that his euthanasia of the infant was permissible because after all, the infant would have wanted what was best for himself?[27]

Ruth Macklin argues that since there is a distinction between who is authorized to give consent and who is the best advocate for the child, that perhaps in this case the doctor was authorized to kill the infant without the parent's permission[28]. Macklin may be taking too radical a "rational agent" standard, however. Our intuitions may lead us to believe that what the doctor did was wrong because we counterfactually not only ascribe rationality to the infant, but also some of the parent's beliefs and preferences. For example, if the parents are Catholic and would have raised their child to be Catholic, then we would counterfactually ascribe Catholic views, including the view that

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[26]Smith upholds the view that the parents have the right of surrogacy over the infant's doctor; p. 95.

[27]The Hastings Center, which says that one of the doctor's obligations is to respect the considered choice of the patient or the patient's surrogate, would find this to be morally wrong. Hastings Center, p. 19.

[28]Ruth Macklin, "Autonomy, Beneficence and Child Development", Social Research on Children and Adolescents Ethical Issues, ed. Barbara Stanley and Joanne Sieber, Sage Publications, 1992.

euthanasia was morally wrong, to the infant. Thus, the child is understood not merely as a rational agent, but one with many potential beliefs and preferences along with rationality.

Brock would agree with this reply to Macklin. Brock gives two reasons for preferring statements of counterfactual consent from the patient's own family members over that of the doctor, despite the fact that the doctor may be in a better position to access the patient's case. First, if the only concern is the continued life of the patient, then it would appear that the doctors alone should make the judgements. However, the medical well-being of the patient alone is not the sole concern. Quality of life, which takes into account a variety of very personal facts about the patient, is the primary concern[29]. The patient would not be merely a rational agent, were he to survive. Presumably he would be much more than that, and it is important to consider what that would be before a decision is made on his behalf. It is important to note that Brock, in making this claim, seems to be arguing against the application of both the highly impersonal Best Interests standard and the equally impersonal Rational Agent standard. Second, there are social concerns, such as the "value of the family" that is preserved when the family makes a decision for one of its own, and the fact that "the family member will care most about the patient's well-being and so be most concerned to represent it."[30] It seems that both the Best Interest sstandard

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[29]Brock, pp. 148-149.
[30]Brock, p. 156.

and the Rational Agent standard are not as solid as they first appeared.

These problems demonstrate that the practice of surrogacy, even when legally sanctioned by a Durable Power of Attorney, is flawed. If the practice of surrogacy is flawed, then statements of counterfactual consent that rely on surrogates to demonstrate their truth value must also be called into question. We can not rely on surrogates to tell us what patients would have consented to, had they been able to consent.

In conclusion, there are many problems in trying to determine the evidence for the truth of statements of counterfactual consent. The arguments that counterfactuals about consent have no truth values or too many are not convincing. However, assertoric antecedent consent, problematic antecedent consent, and surrogacy are rife with problems. Surrogacy for those individuals who never had or never expressed beliefs or preferences is especially problematic. While counterfactual consent has the power to morally justify some acts of euthanasia, its practical application may be less than successful.

CHAPTER V

A PRINCIPLE ABOUT COUNTERFACTUAL CONSENT AND ACTUAL CONSENT

> In the case of a patient without decision making capacity, this discussion [about the termination of life-sustaining treatment] should involve a surrogate for the patient. If possible, however, the health care professional and patient should talk together.... any patient who can participate to any extent in the decisionmaking process should be encouraged to do so[1].

Some people will make this claim: if you can justify an act of euthanasia by obtaining actual consent from a person, it would be wrong to rely on counterfactual consent to justify that act of euthanasia. In the passage quoted above, the consent of the surrogate is secondary to actual consent. The Hastings Center Report notes "It is the patient who is the key decisionmaker, with the power to give binding consent or refusal. When the patient lacks the capacity, the key decisionmaker is someone else, a surrogate."[2] In cases in which the patient is unable to give actual consent, the strength of the surrogate's consent is derived from the surrogate's belief that were the patient able to express consent, then his statement of consent would be in keeping the surrogate's expression of consent. As stated in the previous chapter, the surrogate's responsibility is to express what the patient would have wanted for himself, not what the surrogate

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[1]The Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying, The Hastings Center, 1987, p. 22.
[2]Hastings Center Report, p. 22.

wants for the patient. But according to the Hastings Center, the surrogate should be relied upon to give consent only if the patient is not competent to give actual consent. If the patient is able to give actual consent, then relying on the surrogate's statement of consent would be wrong. The surrogate may offer a statement of counterfactual consent as one of her reasons for the termination of life support. "I knew him all his life, he would never want to live this way; I know that if he were able to offer consent to our killing him now, he would." While not all surrogates will rely on a statement of counterfactual consent, some will. And yet, all consent by a surrogate is considered by the Hastings Center to be secondary to actual consent. Hence, there is a significant relationship between actual consent and counterfactual consent, assuming that both are in fact available to the person/persons performing the act of euthanasia. Actual consent is always better than counterfactual consent.

In this chapter, I will attempt to do four things. First, I will state a principle that has been endorsed by many philosophers about the relationship between actual consent and counterfactual consent. I call this principle the Superiority of Actual Consent Principle (SAC1). Second, I will review many of the arguments in support of SAC1. Third, I will consider an argument that demonstrates that SAC1 is false. Finally, I will present a second, far weaker principle about the relationship between actual consent and counterfactual consent, called SAC2. Despite (or perhaps because of) SAC2's being far weaker than SAC1, I will endorse SAC2.

The Superiority of Actual Consent Principle

In Chapter I an analysis of informed consent was introduced. However, the analysis of informed consent did not distinguish between actual consent (AC) and counterfactual consent(CC):

> AC: A patient, S, gives actual consent to treatment x for condition y iff 1) S assents to treatment x for y, 2) S is given sufficient information about x and y and the effect x would have on y, 3) S is able to comprehend the information given to him about both x and y, and 4) the assent given by S for an agent to perform treatment x for y is given freely and voluntarily

> CC: Counterfactual consent is offered on behalf of a patient, S, to treatment x for condition y iff it can be said truly that if S were able to offer AC to the treatment x for y, then S would offer AC to the treatment of x for y

The difference between AC and CC is that while CC relies on determining what the patient would have consented to, had he been asked, with AC consent is given by the patient who is to be euthanized.

In Chapter II, I introduced the categories of voluntary1, voluntary2, nonvoluntary1, nonvoluntary2, and involuntary1 and involuntary2 euthanasia. Involuntary1 euthanasia cases are of particular interest to the AC and CC distinction. Involuntary1 euthanasias are cases in which we *can* get actual consent for a

person's euthanasia, but fail to do so. Involuntary1 euthanasia cases are cases in which a rational, capable person is euthanized, but the person did not offer either assertoric antecedent consent or problematic antecedent consent (in the form of a Living Will, or some other informal statement of consent), nor give actual consent to being killed at the time of death[3]. Despite the fact that the agents who kill the patient in cases of involuntary1 euthanasia could have gotten actual consent from the patient, they fail to do so, and euthanize him without actual consent. However, even without actual consent, they may nonetheless be secure in attributing counterfactual consent to the patient. Even if he did not actually consent to being killed, might it still be the case that if he were asked, that he would have consented?

With actual consent, in the voluntary1 cases, we have no worries that we have made a mistake. If a person is rational and able to consent, we don't have to consider what he *would* consent to, if he *were able* to consent. We can go to the source, and ask him what he will consent to. In this respect, actual consent is superior to counterfactual consent. This is the intuition behind the Hastings Center's remark at the beginning of the chapter. The patient's actual consent is preferable to the surrogate's pronoucement of counterfactual consent. If this is true, then the

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[3]Again, voluntary2 euthanasias are euthanasias that rely upon antecedent actual consent or predicted consent on the behalf of those persons being killed - typically in the form of Living Wills. These cases are justified by making reference to the statement of consent as found in the Living Will, and not counterfactual consent per se, although the Living Will can then be used as evidence to support a claim about counterfactual consent. See Chapter IV.

performance of acts of involuntary1 euthanasia, in which we can get consent, but don't, is wrong. Our attempts to justify acts of involuntary1 euthanasia by employing a notion of counterfactual consent are misguided, if actual consent is in fact superior to counterfactual consent. Actual consent was available, but we relied on counterfactual consent instead.

People who believe that all acts of involuntary1 euthanasia are morally wrong believe a principle about the superiority of AC over CC. I will call this the first Superiority of Actual Consent Principle (SAC1):

> SAC1: If a person is able to offer AC, then it is morally wrong to rely upon CC

Richard Brandt compares actual consent with counterfactual consent, and in doing so endorses SAC1:

> The patient's own expression of preference or consent, then, seems to be weighty. But suppose he is unable to express his preference; suppose that his terminal disease not only causes him great pain but has attacked his brain in such a way that he is incapable of thought and of rational speech... Must a person suffer simply because he cannot express consent? There is evidence that can be gathered about what conclusions a person would draw if he were in a state to draw and express them.[4]

Brandt believes that counterfactual consent can and ought to be considered, but counterfactual consent is secondary to the

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[4]Richard Brandt, "A Moral Principle About Killing", Beneficent Euthanasia, ed. Marvin Kohl, Prometheus Books, 1975, p. 112.

patient's "own expression of preference or consent". Counterfactual consent may be considered, but only when the patient is unable to give actual consent[5]. Hence, while it is not always wrong to rely on counterfactual consent to justify acts of euthanasia, if actual consent is available one ought to obtain actual consent rather than rely upon counterfactual consent.

Arguments for SAC1

Several arguments have been made, or could be made, for SAC1. Some of the arguments for SAC1 include the Argument from Utility, the Argument from Rights, the Argument from Paternalism, the Argument from Misinterpretation, and the Argument from Prediction. Each of these arguments will be discussed in turn.

The Argument from Utility. Michael Slote agrees that actual consent is better than counterfactual consent. Slote believes that in employing counterfactual consent, the consequences of your action may have lower utility than the consequences had you relied on actual consent. If you presume the wishes of someone, they "may feel resentment and feel unfairly treated" by virtue of the fact that they weren't asked for actual consent[6]. Relying on

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[5]"If the patient cannot give consent, is the proxy consent of relatives ethically valid?" asks Barry F. Brown in "Proxy Consent for Research on the Incompetent Elderly", Biomedical Ethics, ed. Thomas A. Mappes and Jane S. Zembaty, McGraw-Hill, 1991, p. 225. The presumption is that actual consent is primary, and proxy/counterfactual consent is secondary, echoing Brandt's views.

[6]Michael Slote, "Dessert, Consent and Justice", Philosophy and Public Affairs, vol 2, no 4, Summer 1973, , p. 344

CC, when AC is available, might insult them, or cause them to feel slighted. Insulting a person by relying on counterfactual consent would result in lower utilities, whereas relying on actual consent and involving him/her wholeheartedly in the decision-making process would not result in any lower utilities. Of course, this assumes that there is no hidden positive or negative utility in performing the act of asking the person (no deep moats have to be braved to get actual consent, no dragons need be slain). Asking for actual consent will merely prevent the lower utilities accrued by insulting the person when counterfactual consent is employed. AC is thus determined to be superior to CC.

Slote's argument is similar in many respects to T.M. Scanlon's view, as presented in Chapter II[7]. Scanlon claimed that consequences that follow from our choices may have both instrumental value (the consequences are most likely to be the ones we desire) and demonstrative value. Scanlon believes that if a choice has instrumental value then the consequences of that choice are most likely to be the ones that we desire. Scanlon believes that if a choice has demonstrative value then the free choice reflects traits that we value in ourselves, such as autonomy, independence, and creativity. Not every free choice has instrumental value - it is possible for an agent to make a choice better left to someone else. However, Scanlon believes that every free choice has demonstrative value. An agent's exercise of his

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[7]T.M. Scanlon Jr., "The Significance of Choice", The Tanner Lectures on Human Values, ed. Sterling M. McMurrin, Cambridge University Press, 1988, pp. 151-216.

free choice never fails to assert the agent's independence, creativity, and control. If there is some utility which attaches to the asserting of these traits, then those acts that an agent actually consents to will have higher utility in virtue of their demonstrative value than those that are merely counterfactually consented to, and have no demonstrative value at all.

The Argument from Rights. While Slote argued for SAC1 on utilitarian grounds, he also argued for SAC1 from a consideration of rights. It may be the case that relying on CC, and not on AC, violates the patient's rights. Dan Brock argues in favor of SAC1 by invoking "his (the patient's) right to decide."[8] Slote's election example captures this intuition:

> Rawls seems to think that certain sorts of hypothetical free consent suffice for justice, so that if people would have consented to a certain social arrangement in an original position of equality, then such an arrangement is just even when people have not actually consented to it. But the difference between actual consent and hypothetical (free) consent is very important in matters of justice. To give an example of this (that Rawls would, presumably, be able to agree with, consistent with his principles), consider a situation where certain people somehow manage to call off an election whose eventual winner, the incumbent, everyone knew would win in advance, and then simply arrange for the incumbent to remain in office. Clearly an injustice has been done here by denying the people their right to give or withhold their *actual* consent to the incumbent's remaining in office[9].

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[8]Dan Brock, Life and Death: Philosophical Essays in Biomedical Ethics, Cambridge University Press, 1993, p. 33.

[9]Michael Slote, "Desert, Consent and Justice", Philosophy and Public Affairs, vol 2, no 4, Summer 1973, pp. 343-344.

Here, Slote is arguing against John Rawls' concept of justice as fairness. Rawls considers that the just society is the one that would have been chosen by individuals in the original position. The original position is a hypothetical place behind a veil of ignorance, in which "no one knows his place in society, his class position or social status, nor does any one know his fortune in the distribution of natural assets and abilities, his intelligence, strength, and the like."[10] According to Rawls, a society is a just society if the society is the one that *would have been consented to* by its population, if they were asked which society they wanted while in the original position. Slote argues against Rawls by calling into question the notion of counterfactual consent in choosing a perfectly just society. After all, each member of society is around to give actual consent in choosing a perfectly just society. It is wrong to rely on counterfactual consent, when actual consent is available. It is not the case that the people in Slote's election example would merely be insulted by not having the chance to cast their vote. Rather, their legal right to cast their vote would be violated. It may be the case that relying on CC, rather than AC, would be a violation of the patient's moral right to actually consent to his/her own death. Thus, AC is superior to CC, for it preserves the patient's right to actually consent to his/her own death, and SAC1 is true.

The Argument from Paternalism. Similar to the argument from rights is the argument from paternalism. Some philosophers

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[10]John Rawls, A Theory of Justice, Belknap Press of Harvard University Press, 1971, p. 12.

may prefer AC over CC because relying on counterfactual consent when actual consent is available may be paternalistic[11]. Acting in a paternalistic manner is often unjust, for acting in such a manner fails to respect the autonomy of the patient. However, justifying an act of euthanasia by making reference to actual consent is never paternalistic, for in actually asking for consent from a patient, the patient's autonomy is respected. Brock endorses SAC1 using the argument from paternalism, claiming that relying on counterfactual consent rather than actual consent infringes on a patient's "self-determination"[12]. If the choice is between performing an act that respects the patient's autonomy (getting actual consent), and performing an act that fails to respect the patient's autonomy (relying on counterfactual consent), then it is better to perform that act that respects the patient's autonomy. Thus, actual consent is superior to counterfactual consent.

The Arguments from Misinterpretation. Two more arguments that might be used to justify the claim that AC is superior to CC make reference to our complex, often fallible attempts to determine the truth of counterfactual statements about consent. I have already discussed several of the epistemic problems in attempting to determine the truth of a statement of counterfactual consent in Chapter IV: the unreliable nature of assertoric antecedent consent and problematic antecedent consent,

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[11]"We should resort to fictions such as presumed consent only with the greatest care and caution, for under the guise of "consent" they may imply a more extensive paternalism than is warranted." James F. Childress, Who Should Decide?: Paternalism in Health Care, Oxford University Press, 1982, p. 85.

[12]Brock, p. 31.

the inability of a surrogate to make a decision that accurately reflects the dying person's beliefs and preferences, our inability to determine what a "rational infant" would choose, etc. Statements of actual consent have none of these problems. We ought to rely on statements that are more straightforward than statements about counterfactual consent, because statements of counterfactual consent are open to misinterpretation. For example, often a surrogate is unable to make a decision that does reflect the dying person's beliefs and preferences. The patient may have preferences that are in principle unable to be expressed by a surrogate, or the surrogate may not know enough to make such a decisions accurately, or, if the patient is an infant or severely retarded individual, the patient may never have had any preferences from the onset. If the truth conditions for counterfactual statements of consent leave open the possibility for misinterpretation, then we ought to rely on statements of actual consent. Thus, in cases where both AC and CC are available, AC is preferable to CC. If the person can give AC to being killed, why should we rely on CC to justify his death at our hands? Our interpretation of a statement of AC is never mistaken[13], whereas CC may be mistaken. In cases of voluntary1 euthanasia, the person gives actual consent to the act of euthanasia. Cases where

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[13]It is possible for a statement of actual consent to be ill-informed, or coerced, or perhaps just difficult to interpret. However, as I have stated previously, I am understanding "actual consent" to be free, voluntary, and informed. If actual consent was not free and informed, it would not be preferable to justify acts of euthanasia using actual consent rather than statements about counterfactual consent.

actual consent is available are thought to be the most straightforward cases. Thus, SAC1 is true.

A second version of the argument from misinterpretation is an argument from the claim that both assertoric antecedent consent and problematic antecedent consent are offered before the patient is euthanized, whereas actual consent is typically offered at the time that the patient is euthanized. If a person consents at time t to being euthanized at t', it is possible for him to have changed his mind during the time between t and t'. This is one of the drawbacks of assertoric antecedent consent and problematic antecedent consent that was discussed in Chapter IV - the person could change his or her mind. Living Wills, for example, could fail to be an accurate reflection of what a patient truly wants because the Living Will only states what the patient wants for himself at the time that the Living Will is composed. The Living Will does not state what the patient wants for himself at the time that the order in the Living Will is to be carried out. But a statement of actual consent, made at t' about an act of euthanasia at t', is superior to the statement of consent in a Living Will. Now that t' has obtained, a statement of consent is better informed than a statement of antecedent consent given at time t. If a person consents at time t to being euthanized at t', but then explicitly denies consent at t', which ought you believe? Given that the denial of consent at t' is informed, free and voluntary, we are likely believe the present statement of consent over antecedent statement of consent. Actual consent (or, in this case, the lack of consent) is better than assertoric antecedent consent or

problematic antecedent consent. In the same fashion, actual consent is superior to counterfactual consent. If you could consider what a person *would* consent to, and what they actually *do* consent to, which version of consent should you act on? The actual consent, of course! In this way, AC is argued to be better than CC, and SAC1 is affirmed.

An Argument for Rejecting SAC1

I have catalogued some arguments that have been made, or could have been made, in support of SAC1. While there is some intuitive appeal to such a principle, I believe those intuitions to be misguided. I would now like to consider a case of involuntary1 euthanasia that demonstrates SAC1 to be false. Consider the following case:

The Case of Old Felix: Old Felix was dying painfully in his hospital bed. Old Felix's family was gathered in the next room, trying to decide if euthanasia was the best option for Old Felix. Old Felix was perfectly rational and able to give consent to his own euthanasia, if his family attempted to get it. Suddenly Young Felix spoke up: Old Felix was a sensitive, introspective person. While he might want to be killed, while he would know that it was the best thing for him at this time, asking him might be a mistake. He might sit and fret and worry over the decision. The very act of asking him might make his last moments even more painful than they already were. Any act that would make his last moments more painful was wrong. Certainly if asked, he would consent.

But, it is best not to ask. It would be best to just euthanize him without his consent, rather than ask for his consent.

Old Felix's case demonstrates that SAC1 is not true:

1. If SAC1 is true, then Old Felix ought to give actual consent to his euthanasia.
2. It is not the case that Old Felix ought to give actual consent to his euthanasia.
3. Therefore, SAC1 is not true.

The first premise makes use of SAC1. If SAC1 is correct, then every case in which a person can offer actual consent, but counterfactual consent is relied upon, is wrong. Old Felix could have offered actual consent - he was entirely capable. Thus, relying on Old Felix's counterfactual consent, when actual consent was available, was wrong.

But as Young Felix argued, Old Felix ought not have been asked to give actual consent. His last hours would have been more miserable than they already were, if he were called upon to give his consent. Better to rely on counterfactual consent in this case, than to make Old Felix's last hours worse than they already were. With the counterexample of the case of Old Felix, it has been demonstrated that SAC1 is not true.

Defenders of SAC1 would find the above argument unsound. They could object to line one or line two. I will consider the objection to line two first. Defenders of SAC1 may claim that actual consent is so valuable in itself, that it outweighs any bad results of asking for actual consent. Those who choose this line of reasoning embrace the argument from utility in favor of SAC1.

Certainly Old Felix will be pained and disappointed by having to give actual consent. But the alternative, relying on counterfactual consent, is wrought with problems. Relying on counterfactual consent shows a lack of respect for the patient, argue defenders of SAC1. Old Felix would appreciate being asked, even though he would also be slightly pained by having to think about his own death, but if he weren't asked, he would feel slighted and forgotten. His insult, in not being asked about his own death, would result in very low utilities. Using Scanlon's terminology, the demonstrative value in allowing Old Felix to make his own choice would be lost. Character traits that Old Felix may value, such as independence and self-reliance, would not be demonstrated by him if his family made the choice for him. Certainly, it is better to have Old Felix feel appreciated, rather than slighted and forgotten. Thus, actual consent is superior to counterfactual consent.

Slote uses this defense of actual consent in demonstrating that social arrangements determined via actual consent are more just than those determined by actual consent:

> When inequalities of reward and the like are undeserved, only actual consent to their existence seems to me to be capable of rendering those inequalities, and the society in which they exist, completely just. It does not, intuitively, seem enough that people would have consented to the undeserved inequalities had they been asked. For even when one knows that this is so, one may feel resentment and feel unfairly treated because one *wasn't* asked.[14]

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[14]Slote, p. 344.

Relying on counterfactual consent to justify an act of euthanasia when actual consent is available fails to maximize utility. The utility of getting actual consent is higher than the utility of relying on counterfactual consent. Old Felix may feel resentment and anger because he wasn't actually asked for his consent. This resentment may outweigh the gain in utility that may have resulted from relying on counterfactual consent. Asking Old Felix for actual consent may have depressed him and his family, but it prevented the negative utility of relying on counterfactual consent. It may seem that asking Old Felix for his consent is a worse state of affairs than relying on counterfactual consent. But in fact, since there is a gain in utility in asking for actual consent rather than relying on counterfactual consent, asking Old Felix for his consent is a better state of affairs after all.

There is a reply to this objection. If the example were changed slightly, line two would still be true. Assume that the pain involved in getting actual consent from Old Felix was far worse than described. The suffering that Old Felix and his family would undergo in asking for his consent could be tremendous. The pain in asking Old Felix for consent could be so great that it outweighed any gain in utility that actual consent may have. In this case, it *would* result in higher utilities to rely on counterfactual consent than to get actual consent. Again, using Scanlon's terminology, it is possible that the instrumental value of allowing the family to make Old Felix's choice for him outweighs any demonstrative value that would result. If the pain that Old

Felix and his family would undergo is great enough to outweigh the seeming negative utility of relying on counterfactual consent, then it would still be better to rely on counterfactual consent rather than actual consent. Thus, upholders of SAC1, like Slote, who believe that SAC1 is true based on a utilitarian defense, are defeated on their own ground.

Those who reply to the objection that line two is false by invoking the argument from rights or the argument from paternalism in favor of SAC1 are similarly mistaken. If Old Felix does have a right to give actual consent rather than have his family act on mere counterfactual consent, then the rights of Old Felix are not respected by his family acting on counterfactual consent. However, the view that Old Felix has a right to give actual consent is not sufficient to affirm that Old Felix ought to give actual consent to his own death. There certainly many things that each of us has a right to do, nonetheless it would be better if we did not do those things. Having the right to perform an action does not mean that it is right to perform that action. In the case of Old Felix, it is clear-cut that it would be right if Old Felix were not bothered to give actual consent. His burden is already too great. Even if he did have the right to have his actual consent heard, that is not sufficient to affirm the truth of the second premise of the argument[15].

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[15]I have avoided the very difficult question of whether or not a person does have a right to give his/her actual consent. For a discussion of this issue, see Dan Brock, Life and Death: Philosophical Essays in Biomedical Ethics, Cambridge University Press, 1993, pp. 21-54.

Similarly, those who object to line one by invoking the argument from paternalism are mistaken. Perhaps it is paternalistic to rely on CC when AC is available. But the claim that an action is paternalistic does not entail that it is wrong. There are many things that we have a right to do, yet it would be wrong to do them. In the same vein, it is also the case that there are many actions that people can perform which are paternalistic, and yet paternalism is not sufficient to determine that those actions would be wrong to do. Ruth Macklin claims "Paternalistic behavior towards infants and young children is justified ethically; indeed it is ethically obligatory."[16] Paternalistic actions are not by definition wrong. Young Felix's actions may have been paternalistic. That is not to say that his actions were wrong.

The defenders of SAC1 may also object to line one. They might argue that a *true* Superiority of Actual Consent Principle would entail no such thing about Old Felix's consent. In the case of Old Felix it appears clear that no one should ask for his consent. However, in all but these very hard cases, it is clear that actual consent is superior to counterfactual consent.

While the case of Old Felix did demonstrate the shortcomings in the argument from utility, the argument from rights, and the argument from paternalism for SAC1, I would also like to say something about the arguments from misinterpretation. Both of the arguments from misinterpretation

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[16]Ruth Macklin, "Autonomy, Beneficence and Child Development: An Ethical Analysis", Social Research on Children and Adolescents: Ethical Issues, ed. Barbara Stanley and Joan E. Sieber, Sage Publications, 1992, p. 91.

for SAC1 are based on a mistaken assumption about the nature of counterfactual consent. These arguments for SAC1 focus on the epistemic difficulties in employing counterfactual consent as a justification for euthanasia. However, as stated above, SAC1 contrasts actual consent with counterfactual consent that "determines beyond reasonable doubt that if (the patient) were rational and able to give an informed, uncoerced statement of consent to being euthanized at t, then (the patient) would do so". Both of the arguments from misinterpretation rely on the mistaken assumption that CC is less accurate than AC. The arguments from misinterpretation turn on the epistemic difficulties in employing counterfactual consent. Each of these epistemic difficulties implies that counterfactual consent is less accurate than actual consent. However, given the formulation of SAC1 this is a mistaken assumption, and the arguments from misinterpretation are mistaken. The second argument from misinterpretation compares actual consent to assertoric antecedent consent and problematic antecedent actual consent. Both types of antecedent consent can fail to accurately reflect the patient's wishes for euthanasia at the time that the euthanasia is performed, since they are not statements of consent by the patient as the euthanasia is performed. Thus actual consent is more reliable than assertoric antecedent consent or problematic antecedent consent. Those who endorse the second argument from misinterpretation will claim that similarly, counterfactual consent may be less reliable than actual consent, for counterfactual consent is not a statement of consent by the patient

as the euthanasia is performed. However, this analogy does not hold. According to the analysis of AC and CC required to formulate SAC1, actual consent and counterfactual consent are equally accurate. CC is offered for a treatment when *it can be said truly* that AC would have been offered by the patient for the treatment. The second argument from misinterpretation for SAC1 is also mistaken, for it fails to recognize that given my formulations of AC and CC, both AC and CC are equally accurate.

Of the arguments discussed in support of SAC1, none of them is sound. Furthermore, the case of Old Felix demonstrated that SAC1 is certainly false.

SAC2

The case of Old Felix does illustrate an interesting point about SAC1. SAC1 has a great deal of intuitive appeal; however, if the costs in adhering to SAC1 are too high, then it would be best to ignore SAC1. In the case of Old Felix the costs were too high. Old Felix's last hours would have been more miserable had actual consent be sought, rather than merely allowing his euthanasia to be justified using counterfactual consent. In such cases, it would be wrong to rely on AC, and instead we should rely on CC. The defenders of the spirit of SAC1 might try to salvage SAC1. SAC1 would be more appealing if it were altered it to reflect the notion that if the costs are too high then SAC1 ought to be abandoned, but if they are not so high, SAC1 ought to be adhered to:

SAC2: If a person is able to offer AC, it is wrong to rely upon CC, unless it would be better to rely upon CC, in which case it is right to rely on CC

If SAC2 were substituted for SAC1 in line one of the argument, it would be clear than line one was false. It may not be true that Old Felix should give actual consent according to SAC2. Old Felix's case may be exactly the kind of case that is an exception to SAC1. SAC2 recognizes that such exceptions do exist, and thus line one is false.

Those who endorse SAC1 might not accept SAC2, however. SAC2 claims that it is better to get actual consent, unless it would be wrong to get actual consent, in which case, it would be better not to get actual consent. This weak endorsement of actual consent over counterfactual consent is not in the spirit of those who believe actual consent is superior to counterfactual consent. While I believe that SAC2 is true, and SAC1 is false, it appears that SAC2 doesn't amount to much. To conclude, there is no true principle that says actual consent is preferable to counterfactual consent in all cases. Any principle about the superiority of actual consent over counterfactual consent is a prima facie principle at best[17].

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[17]I would like to thank Owen McLeod for helpful suggestions.

CONCLUSION

Intuitively, counterfactual consent plays an important role when we are about to perform some morally interesting actions. Is it permissible to do this? How can I know if what I am doing is right? Perhaps, if I had permission, if I had consent, to do what I am about to do, it would make things okay. In lieu of actual consent, then the fact that *if I were able to ask for consent, then consent would be given*, may be enough.

I don't know if it is morally permissible to borrow your pen, but if I could ask for your consent, surely you would say it was fine. I borrow the pen. The fact that if consent could be offered, then it would be offered, seems to count in favor of the claim that borrowing your pen was the right thing to do.

We stand at a hospital bedside, and wonder if shutting off the life support machines is the right thing to do. *If we were able to ask for consent to turn off the life support machines, then consent would be given.* The fact that if consent could be offered, then it would be offered, seems to count in favor of the claim that shutting off life support was the right thing to do.

On first glance, it seems that counterfactual consent contributes something to some acts of euthanasia. I have set out to prove that our first glance may have been too fleeting. I offered a definition of 'euthanasia' as well as explained both consent and counterfactuals in Chapter I. I argued that counterfactual consent is not a necessary part of any act of euthanasia. Whatever counterfactual consent contributes to an act

of euthanasia, it is not the case that every act of euthanasia is counterfactually consented to.

My first question in Chapter II was a simple one - when is it appropriate to cite a statement of counterfactual consent in an attempt to justify an act of euthanasia? I argued that counterfactual consent is appropriately cited in cases of voluntary1, nonvoluntary1, nonvoluntary2, and involuntary1 cases of euthanasia. My second question in Chapter II was more difficult to answer - what is counterfactual consent's role in the moral justification of acts of euthanasia? Philosophers such as Dan Brock and Ronald Dworkin have considered the "Principle of Self Determination" and the "Principle of Autonomy", both of which appear to demonstrate that the act an agent chooses, or would have chosen, is by definition the best alternative for the agent. If either the Principle of Self Determination or the Principle of Autonomy was true, that fact would demonstrate that counterfactual consent does justify acts of euthanasia. But neither of these principles held up under further scrutiny. T.M. Scanlon's views on the value of choice held more promise in demonstrating how counterfactual consent can morally justify an act of euthanasia. However, even Scanlon's approach fell short. I have argued that at best, *some* acts of euthanasia are morally justified by counterfactual consent. Only those acts of euthanasia that are already among the best alternatives for the agent may be justified by an appeal to counterfactual consent. The role of counterfactual consent in justifying acts of euthanasia is not as strong as we may have thought.

In Chapter III, I attempted to analyze statements of counterfactual consent using a possible worlds semantics. What I found is that the meaning of statements of counterfactual consent is not what we thought it was. Most counterfactuals are interpreted in the following manner: if at the closest possible world at which the antecedent is true, the consequent is also true, then the counterfactual is true. "If I were to let go of your pen, then it would fall" means that in the closest possible world in which I let go of your pen, your pen falls. Counterfactuals about consent are not interpreted in that manner. Counterfactuals about consent use a cross-world comparison and an actuality operator that is not part of the understanding of most other counterfactuals. Counterfactuals about consent should be taken to literally mean "If the patient were able to consent to being euthanized, then he would consent to being euthanized if ever in the condition that he is actually in." Hence, counterfactuals about consent do not *mean* what they appear to mean at first glance.

In Chapter IV, I examined the epistemic justifications for statements of counterfactual consent. Living Wills, the practice of surrogacy, the "Best Interests" standard and the "Rational Agent" standard are mainstays of Medical Ethics literature. Any of them might be used to epistemically justify a statement of counterfactual consent. And yet, I have demonstrated that each one of them is problematic in demonstrating the truth of a statement of counterfactual consent. Living Wills, as well as all antecedent statements of consent, can be challenged. Any antecedent statement of consent is offered long before the action

to which the agent is consenting takes place - what if the agent changes her mind? What if the agent has never experienced a situation similar to the one about which she is consenting? Surrogacy, especially for individuals who have never had beliefs or preferences about euthanasia, is also problematic. Perhaps the most significant question is "Are the Best Interests standard and the Rational Agent standard *too* objective?" If so, they may not be appropriate indicators of what patients would counterfactually consent to, if they were able to consent. While it can be said that counterfactuals about consent are true or false, the basis upon which they are declared true or false is somewhat shaky.

Finally, despite all the problems with counterfactual consent that have been explored in Chapters II, III, and IV, in Chapter V I presented an argument that demonstrated that there is no philosophical reason to prefer actual consent over counterfactual consent. The Arguments from Utility, Rights, Paternalism, and Misinterpretation all failed to demonstrate convincingly that actual consent is always preferable to counterfactual consent.

Many questions remain. If counterfactual consent can morally justify some acts of euthanasia, namely those that are already among the best alternatives for the agent, how can we determine which acts of euthanasia are already among the best alternatives? If counterfactual consent is as problematic as I have demonstrated, is actual consent also more problematic than we currently believe? If actual consent is more problematic than we currently believe, in which ways is it problematic? Can these

problems be solved? The many questions surrounding the concept of counterfactual consent call for further study.

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