ical Association, has recommended that the California AIDS confidentiality laws be reformed to allow physicians to disclose, with immunity, to an endangered third party that his or her sexual partner has tested positive for HIV antibody and is therefore infected and contagious.[2]

Physicians practicing in California frequently discuss among themselves the dilemmas imposed upon their performance of medical care by the California confidentiality laws. At least one peer-reviewed report has discussed and documented the conflict existing between the law's imposition of confidentiality and the existing community standards of medical practice and medical ethics, which demand disclosure.[3]

No other contagious public health menace has similar legally imposed confidentiality restrictions that are in conflict with medical care standards and medical ethics that demand disclosure. This is especially problematic in California,[4] which currently has about 8,000 persons with AIDS, and ARC, and at least 400,000 who are infected with HIV but seem well. These nearly half-million persons infected with HIV at the present time, and more later, may not be aware of their status and so may, wittingly, or not, infect innocent others including fetuses.

Does the confidentiality of 400,000 or more Californians infected with HIV take precedence over medical standards and ethics? These demand disclosure of the infective status of these individuals to innocent sexual partners, health care workers, and others exposed to their genital secretions and/or blood.

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[Editor's Note: Since this letter was written, California passed legislation allowing physicians to disclose the results of positive HIV-antibody tests to "spouses."]

A Reply to Dr. Fribourg

To the Editor:

The recent proposals to amend California's Health and Safety Code to permit physicians to disclose HIV-antibody status ignore the social reality antibody-positive individuals face and dangerously offer a false sense of security to all Californians.

People with AIDS have experienced the overwhelming burdens of discrimination in employment, housing, and insurance, and are regularly denied access to businesses and health care services. Individuals merely suspected of HIV-antibody positivity, and their friends and families, are frequently the victims of harassment, abuse, and physical violence. Support organizations such as the Lambda Legal Defense and Education Fund, Inc., are deluged with accounts of unfair (and frequently, unlawful) treatment —the doctor who is locked out of his home, his possessions thrown out onto the street; the patient denied treatment for a major injury; the child prevented from attending school; the young man murdered for confessing mere seropositivity. To suggest that health care workers may, with impunity, disclose a patient's HIV status against the wishes and without the consent of the patient in this hostile social climate is to open the door for even further discrimination and abuse towards HIV-positive individuals. Like all patients—perhaps even more so—seropositive persons have the right to their privacy.

Perhaps more importantly, policymakers must avoid creating the dangerous impression that the medical profession will protect the public from exposure to HIV. The consensus of health experts and all those who have studied AIDS is that the only effective way to slow the spread of HIV is to educate the public that each individual must take the responsibility to engage in safer sexual practices and avoid the sharing of intravenous needles. Yet if doctors are encouraged to disclose HIV status to the sex partners of seropositive persons, many will be lulled into the false sense of security that health care workers will protect them in advance from those who are seropositive. In this time of crisis, no one should be led to believe that his or her sexual partners are free from exposure to HIV unless they are informed otherwise; it is essential that efforts to persuade each person to take responsibility for his or her own high-risk conduct not be undermined.

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The Case Against Active Voluntary Euthanasia

To the Editor:

In her article "The Case for Active Voluntary Euthanasia" [*Law, Medicine & Health Care* 1986, 14(3–4): 145–48], Helga Kuhse claimed to have made persuasive arguments for legalizing physician-administered lethal injections to patients on request. I would like to suggest that her arguments are not persuasive, and that legalizing voluntary active euthanasia is a bad idea.

Kuhse suggests that there is no morally relevant difference between passive or allowing-to-die and active mercy killing, but this view is not supported by our common perceptions. She has obscured the moral difference between allowing to die when death results from the underlying patholog-

ical condition and killing by omission when one kills by omitting an action required by justice. Physicians who withdraw burdensome, useless, or radically expensive medical treatments are not considered to be killers. But the Nazi physicians, for example, who administered lethal injections to badly injured soldiers or senile, elderly, "useless eaters" were unanimously condemned. Kuhse fails to see that causality is critical in many instances for determining moral responsibility. In instances of legitimate allowing to die and not euthanasia by omission, the physician's action is not the fundamental and underlying cause of death. In true euthanasia by omission, the omission of the action required to save the life of the person is the fundamental cause of death. When one causes death, moral culpability accrues to the agent, which is not the case when true allowing to die occurs.

Kuhse fails to see that allowing voluntary active euthanasia would also be bad law. Legalizing this form of euthanasia would require the law to recognize some motives as legitimating some homicidal actions against the innocent. Legalizing euthanasia would force the law to ascertain the motives of killers, and this is often not possible to do with certainty because the best witnesses of mercy killings would be dead. Undoubtedly there would be some people who would kill the suffering out of compassion for their plight, but there would probably be many who would kill to get rid of troublesome and annoying elderly, handicapped, and terminally ill patients, and there would be no way of providing secure protection from them.

Kuhse fails to see that legalized active voluntary mercy killing would overturn the common-law tradition against homicide. This tradition never allowed private citizens to directly and deliberately kill other innocent private citizens, but Kuhse would allow this. The common-law tradition has held that the innocent cannot be deliberately killed by either the state or by private citizens. Legalized mercy killing would bring about a revolution in this tradition. If American common law were to admit in principle that innocent private citizens could be deliberately killed by other private citizens to alleviate suffering, it would be logically committed to permit killing of the innocent for othersimilar reasons. It might be possible in other legal systems to permit mercy killing, but it is not at all clear that the American common-law legal system could tolerate this without the killing rapidly getting out of control.

Legalizing euthanasia would be bad law because the history of euthanasia in the twentieth century suggests that legalized mercy killing cannot be controlled. It certainly was out of control in Nazi Germany, and there are signs that it is quickly getting out of control in Holland. On the one hand, voluntary mercy killing quickly generates involuntary mercy killing, because the law holds that the rights of the competent are not to be denied the incompetent. Once the right to end one's life is given to competent persons, others will demand that right be given to them in the event of their incompetency, which would result in the legalization of active nonvoluntary mercy killing.

Euthanasia is also uncontrollable because there is nothing in the principle that those who are suffering or who have lost their "dignity" can be killed to limit killing to any one class of patients. Who is to say that the suffering of a terminally ill patient is worse than the suffering of a lovelorn teenager, and who is to say that one but not the other should be allowed to receive euthanasia?

Legalized voluntary mercy killing is also bad public policy because of the educational value its legalization would have. If voluntary mercy killing were allowed for the mature, elderly, emotionally stable, wise, competent, and insightful, that would stand as a sign to the immature and emotionally unstable that self-killing in the face of grave suffering was a sign of maturity and intelligence. It would educate them that coping with and tolerating sufferings in life was not worthwhile and that the truly courageous and brave individuals choose death over life in times of despair and suffering. In the past year, nearly 500,000 American teenagers attempted to kill themselves. If we legalize mercy killing and make it permissible for the mature and emotionally stable, how will we be able to persuade the young and unstable that it is not the way in which they should cope with their sufferings? We should recall that the immature and unstable do not perceive reality in the way that the stable and mature do, and that they will not make the same subtle distinctions that the elderly and mature do.

There are certain practical paradoxes entailed by legalized mercy killing. Advocates want mercy killing legalized ostensibly so that people can be relieved of suffering quickly. But the more quickly one gives euthanasia to another, the greater the risk that it will be given to those who do not want it. To protect those who do not want it, it would be necessary to construct such formidable legal barriers that it would be impossible to give it quickly to those who want it to alleviate their suffering.

Even further, euthanasia cannot be done in secret, for then it would be impossible to control it and to assure that only those who truly want it will be given it. But it cannot be done in public either, for then it would educate the young and emotionally unstable that it was a true human good. Also, there is absolutely no consensus among ethicists, philosophers, suicidologists, psychiatrists, and physicians that those who ask for mercy killing are free and rational. If patients truly are in intolerable and untreatable pain, it would seem that their freedom would be so radically restricted that their choices could be called into question. And if the patient is not in such a condition, one could justifiably question what interest the patient would have in bringing an end to life.

From one perspective, euthanasia makes no sense. And if euthanasia were to be given because a patient had lost his or her "dignity," control would be totally lost because there is no objective way to determine the dignity of such persons.

Kuhse characterizes euthanasia of the dying, terminal, sick, and disabled as a merciful act, but it is really nothing but sentimental murder. It is, in fact, simple killing of the elderly, dying, disabled, terminal, and sick simply because they are sick, disabled, and terminal. Laws against mercy killing have sought to protect the despairing and suffering from being made the victims of others who have an interest in their deaths, and repealing these laws could seriously jeopardize the despairing, unstable, and medically dependent.

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A Reply to Fr. Barry

To the Editor:

It may well be true that according to "common perceptions" there is a moral difference between active and passive euthanasia. But that is, of course, precisely the view I am challenging. It will not do to point at the "common view" to discredit my argument—for history is replete with examples when the common view was wrong. So what is required is not reference to "common perceptions" of what is right or wrong, but rather argument as to why we should accept one perception rather than another. Simply to assert, as Professor Barry does, that there is a moral difference between "allowing to die when death results from the underlying pathological condition and killing by omission when one kills by omitting an action required by justice" is not an argument, nor a contribution to enlightenment, but rather an exercise in obfuscation. For the whole question is: what *does* justice require?

Reference to the killings by Nazi physicians is misplaced and can do nothing to show that voluntary euthanasia is wrong. What the Nazi physicians did when they killed the senile or "useless eaters" was emphatically not the practice of voluntary euthanasia. In voluntary euthanasia a person *requests* to be killed. The victims of the Nazi elimination program did not request to die; many were incapable of expressing a view, others were killed against their wishes. To kill a person who wants to go on living is murder; to kill a terminally ill or incurable person who wants to die is voluntary euthanasia. There is a world of difference between the two.

Professor Barry is correct when he says that causal responsibility is often critical for determining moral responsibility. He is wrong, though, when he assumes that some deliberate omissions are causes whilst other deliberate omissions are not. When I deliberately allow someone to die, I am responsible for that person's death—both causally and morally. Whether my omission was justified or unjustified is a different question altogether.[1]

Next the point that the legalization of active voluntary euthanasia would be bad law because it would require us to ascertain the motives of the doctor in question. We do not currently focus on the motives of doctors who practice passive euthanasia by allowing their patients to die; rather, emphasis is on a patient's informed and free refusal of life-sustaining treatment. The same could be made to apply in the case of active voluntary euthanasia. What is important in both active and passive voluntary euthanasia is patient consent, and why it should be any harder to safeguard this in the case of active euthanasia than it would be in the case of passive euthanasia is a question Professor Barry does not raise. In both cases, the physician participates in the patient's death—in the one case by, say, administering a lethal injection; in the other case by, say, turning off an artificial respirator.

I am untroubled by the prospect of changing the common-law tradition to allow voluntary euthanasia. Laws are made on earth, not in heaven; and if we find that a law is a bad one, we can change it. There is no reason to think that the permissibility of voluntary euthanasia would lead to "killing rapidly growing out of control," any more than the permissibility of passive voluntary euthanasia does. As long as we draw firm boundaries around the voluntary nature of the patient's request for euthanasia, no patient who does not, or cannot consent, will be endangered.

Professor Barry fears that voluntary euthanasia for the terminally ill will lead to lovelorn teenagers also seeking euthanasia and, he asks, "who is to say that one but not the other should be allowed to receive euthanasia?" Whilst the occasional lovelorn teenager might request "euthanasia," it is of course up to us as a society to decide what categories of people would be eligible to receive it. Voluntary euthanasia should be limited, as it is in Holland, to patients suffering from a terminal or irreversible medical condition for which there is no remedy—and we could and probably should decide that euthanasia may be practiced by physicians only.

Voluntary euthanasia should be practiced openly. Patients can and do rationally choose passive euthanasia. We recognize this fact when we allow patients to refuse life-sustaining treatment. If Professor Barry really believed that people can never rationally choose euthanasia, he should also argue against the patient's right to refuse life-sustaining treatment, as well as against active voluntary euthanasia. He is faced with the difficult task of explaining how it is that people can rationally choose to die in one particular way (by passive euthanasia) but not in another way (by active euthanasia).

It is simply nonsense to assert that a patient in intolerable and untreatable pain cannot freely choose euthanasia.