The Applied Ethical Issue Of Euthanasia Essay, Research Paper

The applied ethical issue of euthanasia, or mercy killing, concerns whether it is morally permissible for a third party, such as a physician, to end the life of a terminally ill patient who is in intense pain.

The euthanasia controversy is part of a larger issue concerning the right to die. Staunch defenders of personal liberty argue that all of us are morally entitled to end our lives when we see fit. Thus, according to these people, suicide is in principle morally permissible. For health care workers, the issue of the right to die is most prominent when a patient in their care (1) is terminally ill, (2) is in intense pain, and (3) voluntarily chooses to end his life to escape prolonged suffering. In these cases, there are several theoretical options open to the health care worker. First, the worker can ignore the patient’s request and care can continue as usual. Second, the worker can discontinue providing life-sustaining treatment to the patient, and thus allow him to die more quickly. This option is called passive euthanasia since it brings on death through nonintervention. Third, the health care worker can provide the patient with the means of taking his own life, such as a lethal dose of a drug. This practice is called assisted suicide, since it is the patient, and not technically the health care worker, who administers the drug. Finally, the health care worker can take active measures to end the patient’s life, such as by directly administering a lethal dose of a drug. This practice is called active euthanasia since the health care worker’s action is the direct cause of the patient’s death. Active euthanasia is the most controversial of the four options and is currently illegal in the United States. However, several right to die organizations are lobbying for the laws against active euthanasia to change.

Two additional concepts are relevant to the discussion of euthanasia. First, voluntary euthanasia refers to mercy killing that takes place with the explicit and voluntary consent of the patient, either verbally or in a written document such as a living will. Second, nonvoluntary euthanasia refers to the mercy killing of a patient who is unconscious, comatose, or otherwise unable to explicitly make his intentions known. In these cases it is often family members who make the request. It is important not to confuse nonvoluntary mercy killing with involuntary mercy killing. The latter would be done against the wishes of the patient and would clearly count as murder.

Like the moral issues surrounding suicide, the problem of euthanasia has a long history of philosophical discussion. On the whole, ancient Greek thinkers seem to have favored euthanasia, even though they opposed suicide. An exception is is Hippocrates (460-370 BCE), the ancient Greek physician, who in his famous oath states that “I will not prescribe a deadly drug to please someone, nor give advice that may cause his death.” The entire oath is presented below, which places emphasis on the value of preserving life and in putting the good of patients above the private interests of physicians. These two aspects of the oath make it an important creed for many heath care workers today. In medieval times, Christian, Jewish, and Muslim philosophers opposed active euthanasia, although the Christian Church has always accepted passive euthanasia.

During the Renaissance, English humanist Thomas More (1478-1535) defended Euthanasia in book Utopia (1516). More describes in idealic terms the function of hospitals. Hospital workers watch after patients with tender care and do everything in their power to cure ills. However, when a patient has a torturous and incurable illness, the patient has the option to die, either through starvation or opium. In New Atlantis (1627), British philosopher Francis Bacon (1561-1626) writes that physicians are “not only to restore the health, but to mitigate pain and dolours; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage.”

One of the most cited contemporarly discussions on the subject of euthanasia is “Active and Passive Euthanasia” (1975) by University of Alabama philosophy professor James Rachels. Rachels argues that there is no moral difference between actively killing a patient and passively allowing the patient to die. Thus, it is less cruel for physicians to use active procedures of mercy killing. Rachels argues that, from a strictly moral standpoint, there is no difference between passive and active euthanasia. He begins by noting that the AMA prohibits active euthanasia, yet allows passive euthanasia. He offers two arguments for why physicians should place passive euthanasia in the same category as active euthanasia. First, techniques of passive euthanasia prolong the suffering of the patient, for it takes longer to passively allow the patient to die than it would if active measures were taken. In the mean time, the patient is in unbearable pain. Since in either case the decision has been made to bring on an early death, it is cruel to adopt the longer procedure. Second, Rachels argues that the passive euthanasia distinction encourages physicians to make life and death decisions on irrelevant grounds. For example, Down’s syndrome infants often have correctable congenital defects; but decisions are made to forego corrective surgery (and thus let the infant die) because the parents do not want a child with Down’s syndrome. The active-passive euthanasia distinction merely encourages these groundless decisions.

Rachels observes that people think that actively killing someone is morally worse than passively letting someone die. However, they do not differ since both have the same outcome: the death of the patient on humanitarian grounds. The difference between the two is accentuated because we frequently hear of terrible cases of active killings, but not of passive killings. Rachels anticipates two criticisms to his argument. First, it may be objected that, with passive euthanasia techniques, the physician does not have to do anything to bring on the patient’s death. Rachels replies that letting the patient die involves performing an action by not performing other actions (similar to the act of insulting someone by not shaking their hand). Second, it may be objected that Rachels’s point is only of academic interest since, in point of fact, active euthanasia is illegal. Rachels replies that physicians should nevertheless be aware that the law is forcing on them an indefensible moral doctrine.

In “Active and Passive Euthanasia: An Impertinent Distinction?” (1977), Thomas Sullivan argues that no intentional mercy killing (active or passive) is morally permissible. However, extraordinary means of prolonging life may be discontinued even though the patient’s death may be foreseen. Sullivan argues that Rachels’s example of the Down’s syndrome infant is misleading, since most doctors would perform corrective surgery since it would be clearly wrong to let the infant die. Further, most reflective people will agree with Rachels that there is no moral distinction between killing someone and allowing someone to die. According to Sullivan, Rachels’s biggest mistake is that he misunderstands the position of the AMA. The AMA maintains that all intentional mercy killing is wrong, either active or passive. Although extraordinary procedures for prolonging life may be discontinued for terminally ill patients, these procedures are ones that are both inconvenient and ineffective for the patient. If death occurs more quickly by discontinuing extraordinary procedures, it is only a byproduct. In short, to aim at death (either actively or passively) is always wrong, but it is not wrong to merely foresee death when discontinuing extraordinary procedures.

In a rejoinder essay, “More Impertinent Distinctions and a Defense of Active Euthanasia” (1978), Rachels responds to Sullivan’s charges. Rachels begins noting that Catholic thinkers, such as Sullivan, typically oppose mercy killing. However, Sullivan himself concedes that it is sometimes pointless to prolong the dying process. Rachels focuses on two specific points made by Sullivan. First, Sullivan argues that it is important for the physician to have the correct intention (insofar as it is immoral to aim at the death of a patient, but not immoral to foresee his death). Rachels counters that the physician’s intention is irrelevant to whether the act is right or wrong. For, suppose two physicians perform identical acts of withholding treatment, with one physician aiming at the death of the patient, and the other only foreseeing it. Since the acts are identical, one cannot be judged right and the other wrong. Second, Sullivan argues that physicians are justified only in withholding extraordinary procedures. However, Rachels argues, to determine whether a given procedure is ordinary or extraordinary, we must first determine whether the patient’s life should be prolonged.

Rachels continues by offering several arguments in favor of the moral permissibility of active euthanasia. The first is an argument from mercy. He begins by describing a classic case where a person named Jack is terminally ill and in unbearable pain. Jack’s condition alone is a compelling reason for the permissibility of active mercy killing. A more formal utilitarian version of this argument is that active euthanasia is morally permissible since it produces the greatest happiness. Critics have traditionally attacked utilitarianism for focusing too heavily on happiness, and not enough on other intrinsic goods, such as justice and rights. Accordingly, Rachels offers a revised utilitarian version: active euthanasia is permissible since it promotes the best interests of everyone (such as Jack, Jack’s wife, and the hospital staff). Rachels also argues that the golden rule supports active euthanasia insofar as we would want others to put us out of our misery if we were in a situation like Jack’s. A more formal version of this argument is based on Kant’s categorical imperative (”act only on that maxim by which you can at the same time will that it should become a universal law”). The categorical imperative supports active euthanasia since no one would willfully universalize a rule which condemns people to unbearable pain before death. Rachels closes noting an irony: the golden rule supports active euthanasia, yet the Catholic church has traditionally opposed it.

BIBLIOGRAPHY

o Robert M. Baird, ed., Euthanasia: The Moral Issues (Prometheus, 1989). John A. Behnke, The Dilemmas of Euthanasia (Doubleday, 1975).

o A.B. Downing, ed., Euthanasia and the Right to Death (Humanities Press, 1969).

o J. Glover, Causing Deaths and Saving Lives (Penguin, 1987)

o Dennis J. Horan, Death, Dying and Euthanasia (Greenwood Press, 1980).

o D. Humphry, The Right to Die: Understanding Euthanasia (Harper and Row, 1986).

o Marvin Kohl, ed. Beneficent Euthanasia (Prometheus, 1975).

o H. Kuhse, The Sanctity-of-Life Doctrine in Medicine: A Critique (Oxford University Press, 1987).

o Daniel C. Maguire, Death by Choice (Doubleday, 1974).

o James Rachels, The End of Life: Euthanasia and Morality (Oxford University Press, 1987).

o Bonnie Steinbock, Killing and Letting Die (Prentice-Hall, 1980).

o Richard M. Zaner, Death: Beyond Whole-Brain Criteria (Kluwer Academic Publishers, 1988).