Doctor-Assisted Suicide (Draft)

Rui Zhang (rz187)

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One of the most contemptuous topic in modern society is the ethics of assisted euthanasia. While many would debate the merits of whether doctors should even be allowed to euthanize suffering patients, it is almost mostly agreed upon that, in the event that euthansia is necessary, passive is always better than active. It is even codified by the American Medical Association (AMA). Many people would also agree with this view, that passive euthanasia is allowed under situations where prolonging the patient's life would cause the patient to live out the rest of their lives in extreme agony. However, philosopher James Rachel would like to argue otherwise.

In his paper, *Active and Passive Euthanasia*, he argues that this commonly held belief is not necessarily morally correct with the following points:

1. By letting a patient die by withholding care, during the time leading up to the death the patient is still in immense agony
2. The conventional doctrine leads to decisions about life and death being made on irrelevant grounds
3. Idly standing by while the patient dies is not morally better than simply taking action to end the patient's life

First, he argues against the preceived moral superiority of passive euthanasia over active euthanasia by arguing that during the time between when the physician withholds care to the point at which point the patient dies, the patient is still in pain and agony. Rachel argues that, once the decision has been made by both the patient and the physician to end the patient's life, then to endorse against ending the patient's life

immediately by way of lethal injection is to argue in support of extended suffering, which is antithetical to the oaths that the physician takes. He uses the example of a baby born with Down Syndrome. While many go on to live normal lives with a bit of medical assistance, some are born with defects that would require surgery in order to keep them alive. In these cases, instead of letting the child live a life of agony, they may choose not to operate. He quotes Anthony Shaw, who states that to do nothing while the infant slowly dies over hours or days is to not only permit the infant to needlessly suffer but also to cause extreme agony to the surgeons, nurses, and the parents who can do nothing but watch as their newborn's life fades.

Secondly, he points to the fact that, through the traditionally accepted doctrine, life or death decisions are made based on grounds that have no relevance to the patient's future or quality of life. He refers to the Down Syndrom example. The decision whether to save or kill the child is not based on whether or not the child has Down Syndrome and how it will affect his or her life but entirely based on the intestinal tract obstruction. If there was no such obstruction, then there would be no reason to kill the child but now, since an obstruction is present, there is an opportunity to allow the child to die. By allowing one to decide life or death based on grounds that are completely irrelevant is, according to Rachel, a failing of the doctrine and why the doctrine should be rejected.

Finally, he questions the idea if killing someone is really morally worse than watching them die. He presents the example of a person named Smith who will gain a very large inheritence if his cousin dies. Rachel presents two scenarios. In the first, Smith kills his cousin in the bathtub and makes it look like an accident. In the second, the cousin slips and falls in the bathtub while Smith simply stands by and watch. He is also ready to force the cousin's head back underwater should the cousin manage to resurface and therefore, the cousin's death would be an accident. Is Smith really morally better in the latter situation then in the first situation? If it was true that watching someone die is truly morally better than killing them, then one would say that watching gleefully as the cousin dies is better than actually killing them.

Some may criticise the above point made by Rachel, saying that there is, indeed a difference between passive and active euthanasia, which is that in passive euthanasia the doctor does not do anything to bring about the patient's death while in active euthanasia the doctor does something to bring about the patient's death. However, the doctor does do something: deciding to not do anything. That is, the action the doctor

takes is the action of inaction. If by not doing anything a person is not guilty of a crime then that would mean a doctor who allows a patient to die when the patient had a very routine and curable illness should not be held accountable for the patient's death. This would clearly not be the case, as criminal charges would most definitely be filed against the doctor for his inaction. Therefore,the decision to not do anything should be judged just as if the doctor had taken some action, according to Rachel.

From the above points, Rachel concludes that while doctors may refrain from performing active euthanasia because it would make them legally responsible, there is still cause for concern as the law itself may very well be enforcing a doctrine which may be morally indefensible. It is for this reason that he opposes the AMA's position on active and passive euthanasia and that while he believes that doctors should follow the law medical authorities such as the AMA should not endorse it in their official statements.

Rachel's points are sound. It is very true, that sometimes there really is no distinction between doing something or simply watching. Just like how if you see someone being murdered in broad daylight and you do nothing to assist, whether it be to notify the authorities or to intervene, would be seen as immoral, the same thing could be argued for euthanasia. In fact, as Rachel notes towards the end, it may very well be that active euthanasia is the morally superior choice in this circumstance as passive euthanasia would do nothing but extend the suffering of the patient and many doctors are not following, not what they believe is right, but what the law and their medical boards say is right.

However, there is one comparison that Rachel makes which I do not believe properly illustrates the issue, which is the cousin's example. In the scenario presented, the person has something to gain from the death of his or her cousin. Therefore, they have motive in killing their cousin. However, that is not the case in medicine. Unless the physician has the personality of Hannibal Lector and derives some sick pleasure in the deaths of their patients, the physician has no gain from allowing their patient to die. In fact, one could even argue that they have more to lose if they choose to allow that grim scenario. They would have to face a M&M board, they might be blamed and disparaged by the family of the deceased, and they will most certainly bear the burden of the person's death, even if they have the comfort that the deceased is better off dead than alive. It is not in the doctor's playbook to allow or promote death. Their job is to save the sick. However, I believe if they had used another example, such as a witness to a crime in progress, the

point would more strongly reinforced. Otherwise, I believe his argument is sound. His point that passive euthanasia is not morally superior and might very well be morally inferior as it makes the sufferer live for a few more hours, days, or even weeks or months in pain only to die at the end seems to be cruel.