Euthanasia: A Most Difficult Decision (Draft)

Rui Zhang (rz187)

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One of the most contentious topic in modern society and medicine 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 always readily 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) and our laws. 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.
4. Therefore, even though it is codified into law and officially endorsed by various medical societies, passive euthanasia is at best morally equal to active euthanasia and at worst is morally inferior.

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 for the physician to decide against ending the patient's life immediately by way of lethal injection is the same as extending the patient's 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. Therefore, it would be better to end the newborn's life immediately than to do nothing to end the suffering.

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 Syndrome 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 it 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 Smith watching the cousin die is better than actually killing them. In both situations, by not

saving his cousin, Smith would be, at the very least, be considered immoral. By the same logic, a doctor who refuses care is not morally superior to a doctor who administers the lethal injection. In both circumstances, the doctor has it in his power to prolong the patient's life but chooses to do the opposite. The decision that the patient would be better off deceased is the critical decision a not whether or not any action is taken after the decision.

Some may criticise the above point made by Rachel, saying that there is 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, even in passive euthanasia, 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 arguments against the moral superiority of passive euthanasia is very well-articulated. While superficially, we may look at passive as being better than active euthanasia, that is most likely only because we have been conditioned that to be the cause of death of another person is the greatest wrong. Murder, the intentional killing of an innocent, is the only crime in the United States and many other countries which carry the death penalty. Therefore, it would only be natural that we look at active euthanasia, the active action of taking a life, as a sin and an evil. However, when we consider the cirumstances we can also see why it is justified. Just as Rachel has articulated, we are not ending a life out of malice, evil intention, or personal gain. Instead, we are doing so out of mercy. The person is in extreme physical pain that, even if

they receive treatment, will continue to suffer until they eventually die. Their life would be a slow, painful, torturous death. In these circumstances, the person may decide that, instead of continuing to live in such agony they believe that it would be better that they die. In these unfortunate circumstances, if the person believes that their life is no longer worth living and the physician has judged that additional treatments would not improve their quality of life, then it should be justified to release said person from the Hell in which they live.

However, there are a few issues with Rachel's arguments. One of them is the comparison that he uses to compare active and passive euthanasia, which is that of the cousin. I do not believe that is an adequate example. In the example scenario, the person has a reason and motive to facilitate the death of their cousin (i.e. they get a large sum of money). However, in the case of euthanasia, the doctor, unless they have a Hannibal Lector-esque personality and derives sick pleasure from death, has nothing to gain. In fact, it might even be argued that they might have more to lose, such as having to deliver the bad news to the patient's families and dealing with the knowledge that they facilitated the death of the patient. Another issue is that Rachel never draws any line which distinctly states when is it appropriate that a doctor perform active euthanasia. What if the person is depressed or if they are in a lot of pain but they still have many years to live? There are certain situations which he did not account for which passive euthanasia can sidestep. And while the main topic of the piece is not dealing with when is it appropriate to perform active euthanasia, one can argue that, because we cannot morally determine this line, we should not be allowed to perform active euthanasia until we establish this moral boundary. Finally, there is the argument that a doctor might see active euthanasia as a viable option in preventing suffering when in reality it should only be considered an option of last resort. Therefore, while I agree with his premises and conclusion, which is that active euthanasia is no worse than passive euthanasia, there are a few issues with the arguments he presented.