KILLING AND LETTING DIE: RACHELS ON EUTHANASIA

Ethics: Course Notes | Brendan Shea, PhD (Brendan.Shea@rctc.edu)

Let's begin by considering the American Medical Association's (AMA) current (2015) position on euthanasia (they have an almost identical position regarding physician-assisted suicide):

> **Opinion 2.21 – Euthanasia.** Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering…It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations….Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Similar positions are endorsed by the American Nursing Association. Despite these position statements, a number of U.S. states (including Oregon, Washington, California, and Vermont) have recently legalized physician-assisted suicide, and an increasing number of medical professionals (though still probably a minority) have come out in favor of it. In 2015, the Canadian Supreme Court held that citizens had a right to euthanasia, and in 2016 it became legal throughout Canada.

JAMES RACHELS' ARGUMENT FOR LEGALIZING EUTHANASIA

In a famous article in the *New England Journal of Medicine,* James Rachels argues that the AMA should change its position on euthanasia (he is discussing an older version, but the basic content is the same). He begins by differentiating between two "types" of euthanasia:

- **Passive Euthanasia** involves intentionally allowing a patient to die by withholding or withdrawing treatment, and allowing the underlying disease or condition to take its course. Rachels argues that AMA guidelines allow this, even though they don't call it euthanasia".
- **Active Euthanasia** involves "killing" a patient by means such as lethal injection. The AMA guidelines explicitly forbid this.

The Argument: Rachels argues that *if* we allow passive euthanasia (which he argues that the AMA *does* allow), then we should ALSO allow active euthanasia. *Why?* Because passive euthanasia often causes much more suffering to patients than does active euthanasia. If medical staff are genuinely interested in the well-being of their patients, they should be open to active euthanasia, at least in some circumstances.

Example: Down syndrome infants often grow up to lead perfectly happy lives. Nevertheless, many parents/physicians have chosen to allow the *intestinal blockages* often associated with Down syndrome to kill these infants (since they don't want to raise them, and there are not enough adoptive families). At the time Rachels was writing, the AMA supported the legal right of parents to make decisions "quality of life decisions" regarding the medical care of children. In years since, the AMA has states that physicians should notify ethics boards and/or government agencies in cases where parents' judgments about the quality of life for a given infant seems suspect.

Rachel's response. The AMA's original position (that it is OK to "let" these infants die, but not to kill them) is the worst of all possible worlds. If killing these infants (who might have good lives!) is wrong, then so is allowing them to die by not treating the intestinal blockage. If it *is* OK to let these infants die (perhaps out of respect to parents' choices), then it would be morally preferable to kill them painlessly (active euthanasia), rather than allow them to starve to death over an extended time period. (The AMA's revisions appear to have partly met Rachels' criticism regarding Down syndrome, though these sorts of cases—infants dying slowly over months—still occur regularly).

SMITH AND JONES: KILLING AND LETTING DIE

Rachels thinks that the AMA's position actually reflects a deeper intuition many people have: that it is *worse* to kill than to let die. He thinks that this is NOT a trustworthy intuition, and offers the following two cases in an attempt to show what is wrong with it:

> In the first, Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident.
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> In the second, Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith. Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip and hit his head, and fall face down in the water. Jones is delighted; he stands by, ready to push the child's head back under if it is necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing.

Rachels argues that *if* the difference between killing and letting die were really of moral importance, then Smith did something morally worse than Jones. However, he argues that this isn't true—both men are equally blameworthy. After all, they both men had the exact same *motive* (personal gain) and the same *end*. He recognizes that this isn't *usually* true of killing and letting die (often, most killers really *do* want their victim dead, while those who let people die might just be ignorant or preoccupied). But this just supports his main point: we need to pay attention to the specifics of the case, and not on whether it counts as "killing" or "letting." In the case of medicine, most decisions regarding passive euthanasia *are* intentional: the physicians know perfectly well both *what* will happen if they stop treatment (the patient will die) and *why* they are doing so (it is for the patients' "own good").

So what position should medical professionals take on euthanasia? For medical staff, Rachels' argument cuts both ways: he argues that passive euthanasia can be deeply morally wrong (intentionally allowing an easily curable patient to die) and that active euthanasia can sometimes be morally OK (even though it involves "killing the patient'). And none of this bears on issues such as the medical/legal "cause of death": Rachels is perfectly willing to grant that letting a patient die from cancer (passive euthanasia) really is different from killing the patient with an injection (active euthanasia). He just doesn't think that this isn't a *morally relevant* difference.

IN DEFENSE OF THE AMA?

In article that appeared a few years after Rachels' original piece, Bonnie Steinbock ("The Intentional Ending of Life") argued that Rachels (as well as some doctors, such as those involved in treating the Down syndrome infants) were actually misinterpreting the AMA's position, and that the *correct* interpretation showed why euthanasia really was wrong. Here are the highlights of the argument:

- Steinbock thinks that the AMA does not (or maybe should not) make *any* distinction between active and passive euthanasia, but instead focus on whether or not the medical staff *intentionally* caused the death of patients. If so, this is euthanasia. She argues that the case of the Down syndrome infants is, on this interpretation, a clear instance of euthanasia, and a violation of the AMA guidelines. After all, the parents/physicians refuse to do a (routine) surgery with the sole intention that the child die.
    - In subsequent years, the AMA has clarified that euthanasia means "active euthanasia" (so, Steinbock is incorrect here). However, they have also passed policies aimed at ensuring treatment for infants who have a decent chance of a good life (which agrees with Steinbock).
- Steinbock argues that, in many of the cases where physicians withdraw or withhold life-prolonging treatment, they are NOT **intending** to kill patients. Rather, they are doing so because the patient (or the patients' surrogates) have refused treatment (which medical staff have to honor, regardless of whether they agree) or as part of a treatment plan (e.g., delaying chemotherapy in the hopes that patients' immune system with rebound). In these cases, she argues that withholding treatment is perfectly fine, but that actively killing a patient would be wrong.
    - Steinbock suggests that Rachels thinks that ALL acts of withholding life-prolonging treatment are cases of "intending a patient's death." If this were true, her argument here is decisive, and Rachels is simply wrong. However, it seems plausible that Steinbock is misreading Rachels' claim. He simply thinks that are *some* cases in which physicians' choices withhold treatment are intended to lead to patient's death (and it is these cases that count as passive euthanasia).
    - Steinbock argues (correctly) that the right to refuse treatment (which medical staff *must* respect) does not entail a patient's right to demand aid in dying. Again, however, Rachels might plausibly argue that his position is merely that we should change the law to *allow* physicians to practice active euthanasia, not that we *require* we do so.
- At the very end of the article, Steinbock finally comes to a case where she and Rachels would clearly disagree: infants with severe, untreatable cases of spina bifida. While Steinbock recognizes that it may be unpleasant for family/medical staff to watch these infants die over the course of months or years, she argues that this may nevertheless be *better for the infants* than killing them painlessly (we can't ask the infants, obviously). While Rachels doesn't deal with this, the disease in question (a highly painful and ultimately terminal one) is plausibly one in which he would endorse active euthanasia.
    - Interestingly, Steinbock does NOT directly deal with cases regarding adults that are arguably similar: e.g., adults with terminal, untreatable conditions in which both the person and their medical staff agree that the best course of action is to make their death as comfortable as possible, and to avoid any measures which would prolong life. These don't appear to be either cases of the patient refusing treatment or of a novel treatment strategy. In these cases, the sort of move Steinbock uses here ("Who knows what the infants are thinking?") don't appear to be relevant.

Risk to vulnerable populations? In recent years, most arguments *against* legalized euthanasia have focused less on trying to show that some is "intrinsically" wrong with killing, and more on showing the possible negative *consequences* of allowing physicians to kill. In particular, critics of legalized euthanasia (including the AMA) have argued that vulnerable populations (such as those with Alzheimer's) risk being taken advantage of by predatory family members or medical staff. They argue that, even if active euthanasia is *morally* acceptable in some cases, it should nevertheless remain *illegal*.

REVIEW QUESTIONS

1. What does Rachel mean by *passive* and *active euthanasia?* Which of these does he think the AMA is OK with? In what way does he think the AMA's position should *change?* Do your best to explain Rachel's position in your own words>
2. What is a possible objection to Rachel's argument (see above)? Do you think it works?
3. All things considered, do you think that euthanasia and/or physician-assisted suicide ought to be legalized? Why? If it should be legalized, what sorts of policies/limits would be appropriate?