

## LIFE AND DEATH ISSUES: KILLING AND LETTING DIE

In this lecture, you'll learn to:

1. Apply concepts related to optional and obligatory treatments, especially as these apply to incompetent patients.
2. Explain the modern debate over legalizing euthanasia and physician-assisted death.

In the last lecture, we discussed several proposed guidelines for distinguishing between **optional** and **obligatory** treatments. This included withholding v. withdrawing, extraordinary v. ordinary, sustenance v. medical, and “the doctrine of double effect.” However, none of these guidelines seemed to work. Given this, how *should* we decide whether to treat a given patient (especially those who are incompetent, and can’t “tell” medical staff what they want)? According to B and C, there is a **prima facie** obligation to treat incompetent patients. However, this can be overruled in at least TWO different ways:

- **Treatment would be futile**—A treatment is said to be “futile” when a treatment is extremely unlikely to succeed, extremely likely to have poor results, or has an unacceptable benefit-burden ratio (it will harm the patient more than it helps). If a patient (or a surrogate) requests that a futile treatment be given, caregivers are not required to obey.
- **The treatment, even if successful, would leave the patient with an unacceptable quality of life.** A person’s **quality of life** is a measure of how valuable the person’s life is *for that person*. In some cases (e.g., if a person is in continuous, severe pain, or has such low cognitive function that he/she cannot experience pleasure), the quality of life may be so low that a person would prefer to die.
- **WARNING:** Quality of life should not be confused with “value for other people.” For example, you should not be assumed that people with severe cognitive or physical disabilities have a “low quality of life” just because *you* “wouldn’t want to live like that.”

### IS THERE A DIFFERENCE BETWEEN “KILLING” AND “LETTING DIE”?

**What is the *conceptual* difference between killing and letting die?** In ordinary English, “killing” involves directly *causing* a death, whereas “letting die” is “an intentional avoidance of a causal intervention so that disease, system failure, or injury causes death.” Some instances of killing are obviously OK (e.g., killing in self-defense), while some instances of letting die are obviously morally wrong (intentionally allowing an infant child to drown in the bathtub)<sup>1</sup>.

**Is there any *moral* difference between killing and letting die?** While some thinkers have argued that killing is morally worse than letting die, this is not true in general. In some cases, killing is much worse than letting die (e.g., axe-murdering someone is worse than ceasing treatment for a terminally ill patient). In other cases, however, letting die can be worse than killing (e.g., it is worse to allow an otherwise happy patient with dementia to fall down the stairs and die than to assist in a “mercy killing” of a terminally ill patient who has requested aid for this purpose).

**“Under what conditions, if any, is it permissible for a patient and a health professional to arrange for assistance in intentionally ending the patient’s life?”** This includes instances cases of letting die (removing a respirator), killing (giving a lethal dose of morphine via an IV), and ambiguous cases (providing medication, equipment, or advice that you know will be used in a suicide). This is a tough issue, but here are a few key points:

- **Individual acts v. general practices**—It might be the case that our practices (e.g., laws and hospital regulations) will end up prohibiting some morally OK actions. For example, suppose that some scholars have argued that it is *sometimes* morally OK for caregivers to help patients commit suicide. However, they argue it should still be illegal, since they worry that legalizing it would lead to abuse, and to the “euthanizing” of vulnerable patients by unscrupulous caregivers or surrogates. They also worry that allowing physicians to kill would undermine patients’ trust in the medical system. [In general, states and countries that have legalized physician-assisted suicide have reported few abuses of this type. However, there is very limited data at this point.]
- **Justified v. unjustified cases of aid-in dying.** B-C argue that caregivers are morally *permitted* (though not morally required) to give **aid-in-dying** to a patient who “freely authorizes death, making an autonomous judgment that cessation of pain and suffering through death constitutes a personal benefit rather than a setback to interests.” This requires that the patient be both competent and in severe pain, and that the decision (and any potential alternatives to it) be discussed over an extended period of time with a physician who knows the patient well, and has the patients’ best interests at heart. The means of death should be quick and painless (e.g., an overdose of morphine is morally preferable than allowing a patient to die of dehydration).
- **Conclusion.** B-C argue that we ought adopt laws and policies that legalize *some* forms of aid-in-dying.

### CAN WE AVOID HARMING VULNERABLE GROUPS AND INDIVIDUALS?

<sup>11</sup> For more on killing and letting die (and babies in bathtubs!), see the highly influential (and freely available): James Rachels, “Active and Passive Euthanasia,” in *Can Ethics Provide Answers?*, 70 (Rowman & Littlefield, 1997), <http://www.jamesrachels.org/CEPA.htm>. For an up-to-date overview of the euthanasia debate, see Robert Young, “Voluntary Euthanasia,” in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Spring 2019 (Metaphysics Research Lab, Stanford University, 2019), <https://plato.stanford.edu/archives/spr2019/entries/euthanasia-voluntary/>.

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**Group harm.** Medical researchers often use the same data sets multiple times, even though the subjects only consented to have their data used in the *initial* study. This can lead to issues of “group harm” if subsequent studies either (1) make members of the affected group less likely to trust caregivers or (2) directly harm the affected group’s interests. For example, many groups are morally opposed to research concerning mental illness, genetics, and so on, and would not have consented to have their data used in this way.

**Incompetent patients.** A major issue in biomedical ethics concerns the treatment of patients who are unable to make their own decisions. In some cases, such patients will leave **advance directives** or appoint a **medical power-of-attorney**, but there is no guarantee that these will reflect the patient’s current wishes, and caregivers cannot always assume that these are to be obeyed absolutely. In many other cases, things are even more difficult. In general, B-C argue that **surrogates** for an incompetent patient should (1) be competent, (2) have adequate information, (3) be emotionally stable, and (4) be committed to the patient’s best interests. Health-care professionals should try to ensure that appropriate surrogates are appointed, and to support these surrogates in their decision-making capacity.

## PHYSICIAN ASSISTED DEATH IN THE US (EXCERPTS FROM THE HASTINGS CENTER)<sup>2</sup>

The question of whether severely ill suffering patients are entitled to a physician’s help to end their suffering by ending their lives has been debated since antiquity. The Hippocratic Oath suggested that this was outside of the physician’s professional responsibilities, but even in that time there was considerable disagreement. In the modern era, there is consistent evidence of a secret practice of PAD in western countries where it is prohibited. The medical profession and the law tend to look the other way as long as it does not become public (“Don’t ask, don’t tell.”). This secret practice was flaunted in the 1990s when Jack Kevorkian assisted in the deaths of approximately 150 patients. Although he lost his professional license in the process (he was a pathologist, not a clinician), he was not successfully prosecuted until he provided active euthanasia at a patient’s request and was subsequently jailed for over eight years.

In the United States, most jurisdictions have prohibited PAD either with specific statutory provisions or judicial application of more general statutes. There have been attempts to change the law using several methods:

- Federal legal challenges to the constitutionality of the prohibitions, including two Supreme Court cases heard together (Washington v. Glucksberg and Quill v. Vacco). Although the US Supreme Court found no constitutionally-based right to PAD, it suggested that this matter should be decided in the “laboratory of the states.”
- State referenda: while several challenges to prohibitions on PAD failed, Death with Dignity acts were passed in Oregon in 1995 and in the state of Washington in 2008. Both laws have survived a variety of legal challenges.
  - Legislative action: Vermont (2013), California (2015), Colorado (2016), the District of Columbia (2017), Hawaii (2018), and New Jersey (2019) passed laws legalizing PAD through standard legislative initiatives.
  - State constitutional challenges are working their way through several state court systems, but none has been successful in achieving legalization.

Some controversy remains about what to call the practice. Common understanding of the word suicide equates it with mental illness and irrational behavior, and the medical obligation would therefore be to prevent these acts if at all possible. Dying patients who see their lives being destroyed by illness sometimes come to view death as the only way to escape their suffering, and therefore view it as a means of self-preservation – the opposite of suicide. The states where it has become legalized now call it physician-assisted death or physician aid-in-dying.

The public remains deeply divided on the question of whether to legally permit PAD. In most surveys, approximately two-thirds of the U.S. population approve of it as an option for terminally ill patients with intractable suffering. But when the question of legalization comes to a vote, the results are usually closer to 50/50. This split reflects the inherent tensions in the debate. On the one hand, many people know of cases of severe suffering, even with excellent palliative care, where the need for some predictable escape is most compelling. On the other hand, there are fears that PAD could be used as a detour that avoids effective palliative care or as a way to eliminate the suffering of vulnerable patients by eliminating the sufferer. Similarly, a majority of physicians favor legal access to PAD, but only about 30% would be willing to directly provide such assistance even if legally permitted.

## REVIEW QUESTIONS

1. What are the best arguments FOR legally allowing physician-assisted death or voluntary euthanasia? Against legally allowing it?
2. Most (but not all) advocates of legalizing voluntary euthanasia hold that it should be reserved for competent patients who are (a) terminally ill with little hope of a cure, (b) in extreme suffering, and (c) face physical, legal, or other difficulties in ending their lives without medical assistance. These patients must also (d) consistently express this wish over a period of time. What do you think? Are there requirements you would add or remove?
3. Should euthanasia be allowed for severe (but non-terminal) mental health disorders, such as severe depression, if patients request it?
4. Should euthanasia be allowed for infants with untreatable, terminal, highly painful diseases (such as Tay-Sachs)?

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<sup>2</sup> Timothy E. Quill and Bernard Sussman, “Physician-Assisted Death,” The Hastings Center, September 23, 2015, <https://www.thehastingscenter.org/briefingbook/physician-assisted-death/>.

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5. What sorts of vulnerable groups/individuals might be at risk under legalized euthanasia? Why?