

Euthanasia

- QC (Quickly Considered)
Definition of death
- An ethical question, not a medical one. (Why?)
 - What should the *criteria* be? Once we know that, medical expertise can apply it.
 - What is so essential to being a person with moral standing that we lack that, we are no longer a living person?
 - Traditional standard: heart beat, respiration
 - Presently: brain death (whole brain, flat EEG)
 - Proposed by some: higher brain death

Types of Euthanasia

	Voluntary	Involuntary
Passive	Easiest to justify	
Active		Hardest to justify

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Passive		With clear prior instructions	No instructions; e.g., baby	
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- “Current doctrine” (law, AMA)
- Withdrawing life support may be okay (many oppose term “passive euthanasia”)
 - Euthanasia (active) morally wrong

Giving sedation and pain relief

- May increase chance of death
- In terminally ill patient, UMHS (and others) urge adequate pain relief even if increasing chance of death
- The *intent* is not to cause death
- “Doctrine of double effect”

Karen Anne Quinlan

- Karen Anne Quinlan famous case (began 1975)
- Father, a devout Catholic, “extraordinary treatment” (respirator) removed.
- Court finally allowed removal of respirator about 18 months later
- Others testified that Karen “would not want to live on machines”
- Weaned from respirator and survived until 1985

Nancy Cruzan

- 1983: Cruzan pronounced death after car accident but revived, in PVS
- Parents wanted to withdraw life support
- 1990: Supreme Court affirmed Missouri requirement of “clear and convincing evidence”

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Terry Schiavo

- 1990: Respiratory/cardiac arrest
- “Persistent vegetative state”; husband wanted to remove treatment but parents objected
- 2001: feeding tube removed but reinserted by court order
- March 2005: major national furor. Congress passed law that Pres. Bush signed to keep Schiavo alive
- Late March 2005: court rules that life-support may be removed and Terry Schiavo dies March 31.

Rachels against “current doctrine”

- No morally relevant difference between “active euthanasia” and “passive euthanasia”
- Rachels: issue is whether continued life a benefit
- Current doctrine leads to decisions on irrelevant grounds (e.g., Down’s Syndrome)
- Current doctrine leads to needless suffering

Sullivan: Rachels ignores important distinction between euthanasia and permissible ending of treatment

- Intention is different: *wrong to act or not act* when intention is to bring about death
- Ordinary vs extraordinary treatment: okay to withdraw extraordinary treatment
 - This distinction has long history in Catholic bioethics
 - Problematic, according to Rachels 2nd essay

Intention

- Acts properly evaluated on intention
- We may anticipate a result but not intend it, and the act is morally different
- Literacy/suicide rate; driving / wearing out tires
- Similarly: we may remove extraordinary treatment, anticipating death but not intending it
- What is immoral is acting with an intent to bring about death

Ordinary and extraordinary means

- When we withhold/withdraw extraordinary means, the intent may be comfort or something other than causing death
- But withholding/withdrawing *ordinary* means of treatment does have intention of causing death and is immoral
- Acting to cause death OR "allowing to death" are both immoral if *intention* is to bring about death, which is the case when *ordinary* means denied.

Rachels' response: intent

- The same act cannot be moral or immoral based on intent.
 - Depends only on the "reasons" for the act. [EB-I think he means "consequences"]
 - Different intent may affect judgment of person's character but not rightness of act

Rachels' response: ordinary vs extraordinary treatment

- There is no list of treatments that are "ordinary" or "extraordinary"
- Depends on context in each case
- Definition: "excessive expense"; "would not offer a reasonable hope of benefit"
- These judgments require judging: is continued life a benefit *in this case*?

Rachels on utilitarianism

- He says most philosophers reject it.
- Maybe. But he is focusing here on utilitarianism with "happiness" as the ultimate good.
- There are other forms; e.g., satisfaction of preferences. Killing someone who does not want to be killed frustrates his/her preference.

Rachels' Argument for Active Euthanasia (in second essay)

- If an act or policy benefits everyone concerned and violates no one's rights, it is morally acceptable.
- In some cases active euthanasia benefits everyone concerned and violates no one's rights.
- Therefore, in some cases active euthanasia is morally acceptable.

Rachels' Argument for Active Euthanasia (in second essay)

- If an act or policy benefits everyone concerned and violates no one's rights, it is morally acceptable.
Might it be wrong because it benefits every *individual* but harms society? Might it violate "rights of the community"? (Do communities or societies have rights?)
- In some cases active euthanasia benefits everyone concerned and violates no one's rights.
- Therefore, in some cases active euthanasia is morally acceptable.

Kant, Golden Rule, Christianity

- Kant and many conservative Christians reject euthanasia
- Rachels: Kantian principle of universalizability and Golden Rule, properly interpreted, sanction euthanasia

A Request to Die

Minnie is an 84-year-old woman with severe peripheral vascular disease, and her condition is regarded as terminal. She is certain to die within a week or so. She had refused surgery to remove arterial blood clots a few days earlier. The surgery offered some chance of saving her life, but it also might have required subsequent amputation of parts or all of one or both of her legs. She wanted no part of that, and she says repeatedly that she is ready to die. Throughout her life she has consistently favored euthanasia. Now she is in some discomfort and wants the doctor to cause her to die rather than to "let nature take its course." The family has accepted her terminal prognosis and her wishes. They are at her bedside. They see the choice as one of either deciding the time of her death and being able to say good-bye or else having her die at an unpredictable time, perhaps after suffering pain and possibly alone in the middle of the night. They ask the physician to increase her morphine dose with the purpose of bringing about a peaceful and timely death.

Putting aside current law and religious objections (which Minnie and her family do not accept) and assuming a physician is available who has no religious or conscientious objections, is there any good reason to regard complying with Minnie's wishes to be morally inappropriate?

Callahan: opposes euthanasia

- It would wrongly sanction "consenting adult killing," against longstanding prohibition
- Expands autonomy to point where it harms common good
- Changes role of medicine to promote individualistic pursuit of happiness

Callahan's "communitarian" objection

"The acceptance of euthanasia would sanction a view of autonomy holding that individuals may, in the name of their own private idiosyncratic view of the good life, call upon others, including such institutions as medicine, to help them pursue that life, even at the risk of harm to the common good. (my emphasis)

This works against the idea that the meaning and scope of our rights and obligations are determined by some kind of objective moral order, one good of which is conditioned by and dependent upon the good of the individuals which is more than the aggregate of self-determining individuals."

Callahan, p. 52-1 (column 1)

Autonomy and euthanasia

- Euthanasia involves medical professional
- Right to life cannot be waived “is our right to life just like a piece of property...?”
- Physician must judge “this is not a life worth living”; no ability to judge that

Callahan: against euthanasia

- There is a morally relevant difference between acting to kill and not acting
- Law allowing euthanasia will inevitably be abused: a slippery slope
- Euthanasia inconsistent with the aims of medicine:
 - “it is not medicine’s place to life from us the burden of that suffering which turns on the meaning we assign to the decay of the body and its eventual death...”
 - “It is not medicine’s place to determine when lives are not worth living or when the burden of life is too great...”

Arguments in favor of Voluntary Active Euthanasia

- It relieves unnecessary suffering
- It provides all of us the comfort of knowing we can choose to die rather than suffer. (Brock, p. 725-2)
- It allows the exercise of a competent patient’s autonomy (freedom, self-determination)
- It is not morally different from what we appropriately permit now (withdrawal of life-sustaining treatment)
- It saves resources better used elsewhere

Arguments Against Voluntary Active Euthanasia

- There is a fundamental moral difference between acting with an *intent* to kill and not providing life-sustaining treatment and...
- Killing innocent people is always wrong.
- It goes against the human *natural* tendency to live. (Gay-Williams)
- It will lead doctors (slippery slope) not to work as hard to preserve life (consequentialist)
- It contradicts the purpose of the medical profession (nonconsequentialist)
- **Such a policy will put pressure on patients to choose to die even when they want to live.**

Euthanasia: Underlying Issues

- Is there a morally relevant difference between euthanasia and withdrawal of life-sustaining treatment?
- Does claim (right?) to autonomy extend to decision to die and *be killed*?
- Does it violate the “purpose of the medical profession” to engage in euthanasia?
- Could a law be written to allow euthanasia without abuse down a “slippery slope”?
- Should scarcity of resources be part of the debate about legalizing euthanasia?

Autonomy and Medical Profession

- Any secular reason for persons not to “take control” of time of death?
- Should physicians be involved in judgments that a “life is not worth living”?
- Is it wrong (Callahan) for physician to help people achieve their private vision of the good life?
- We do it today, don’t we? (Doesn’t make it right)
- What is “disease”?

Can the Law Be Written Carefully Enough to Avoid Abuse?

- Experience of Oregon, Washington, Holland, Belgium
- Does “inevitability of abuse” argument count against euthanasia? Reduction to absurdity (criminal law system).
- Slippery slope (and how to evaluate)
 - The “Nazi card”
 - More careful objections

Are these good arguments against *legalizing* euthanasia?

- Patients might be pressured into deciding for it when they don’t want it.
- Possibility of wrong diagnosis
- Patients might just take “easy way out”
- Loopholes in law
- BUT: do we already confront this? Does euthanasia introduce anything NEW?

“Purpose of the Medical Profession”

- Callahan opposes using medical profession to serve private interests
- Do we do this already?
- Is it reasonable for medicine?

Are these legitimate “medical” matters?

- Cosmetic surgery
- Prozac for shyness and to be “better than well” (Kramer, *Listening to Prozac*)
- Viagra for 70-year old
- Making pregnancy possible for 55-year-old woman
- Helping Lesbian couple have children
- Helping people live to be 120

Concept of “disease”

- Not so obvious as seems
- Relates to issues in Kass and Munson-Davis on genetic engineering: treatment versus “enhancement” (e.g., negative and positive eugenics)

Economic class issues

- Would this be an incentive to “get rid of” costly patients on Medicare?
- Current inadequate end-of-life care for the poor: which way does this argue?

Incompetent Patients

- (Already discussed) Living will and power of attorney
- PSDA (Patient Self-Determination Act)
- Empirical evidence that wishes are not followed, designated people don't know wishes, etc.

The Case of Ethan Zinker

Decision Scenario (earlier edition of Munson text)

- 92, dementia, pneumonia
- Had been professor of physics, Columbia U.
- Advance directive clear: "if failing mentally, does not want continued treatment"
- Pneumonia could easily be treated with antibiotics
- He seems to enjoy his current life
- Should he be treated with antibiotics to extend his life?

Should Autonomy Extend to Incompetent? Arguments in Favor

- The next logical step in respecting autonomy
- Not only should doctor not decide, but decision should be guided by patient's *own values*
- Ask: what would patient want if he/she were competent?

Should Autonomy Extend to Incompetent? Arguments Against

- Choices from past often conflict with *present interests*
- Past patient cannot know what future self would want. (Is it a different self?)
- Would lead to death (nontreatment) of patients who have interest in continued life
- Other issues (cost, burden on family) often not confronted directly on their own terms

Might There be a *Duty* to Die?

To be discussed later (10/28), time permitting. See schedule.