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**

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<thead>
<tr>
<th></th>
<th>Voluntary</th>
<th>Involuntary</th>
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<tbody>
<tr>
<td>Passive</td>
<td>Easiest to justify</td>
<td>Hardest to justify</td>
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<tr>
<td>Active</td>
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<td>Passive</td>
<td>Our focus now</td>
<td>Discussed later</td>
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Moral Difference Between Active Passive

- 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
Rachels’ Argument for Active Euthanasia (in different 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.

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?)

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Therefore, in some cases active euthanasia is morally acceptable.

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 right to lead our own lives must be conditioned by, and be compatible with, the good of the community, which is more than the aggregate of self-determining individuals.”
Callahan, p. 712-1 (column 1)
Communitarian? Check this out
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.

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.
- 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

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 and Holland
- 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
- Later issue we’ll discuss: treatment versus “enhancement” (e.g., negative and positive eugenics)
Euthanasia

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?
A Request to Die (case in assignment 3)

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?

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