



Euthanasia:

A Guide to All Sides

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Introduction

In *Nicomachean Ethics*, Aristotle wrote, "But the problem remains whether we have drawn our distinctions in the matter of acting and suffering unjustly with sufficient stringency. In the first place we may ask whether there is any truth in what Euripedes has expressed in the strange words:

A: I killed my mother, brief is my report.

B: Were you both willing, or neither she nor you?¹

Thus began a philosophical discussion about death, ethics, and right and wrong. Death is inevitable. It is part of the human condition and cannot be escaped. Yet even though it is a certain event, the timing is random for most people. Biological processes are ticking towards that time when our physical body will cease to function. Random acts of accident or violence may cause death earlier than should happen – but it would be almost impossible to live a normal life if we had to live knowing when and how we will die. It is this "secret" that adds a dimension to life that is indefinable and untouchable. We are mortal and everything mortal will come to an end.

But what if that end is manipulated in a manner that either extends or terminates the actual time? The issues become very complex, because they are related to the very definition of our essence – life itself.

- What is life?
- How is it measured?
- Who has the right to take it away?
- Do we "own" ourselves?

These questions lie at the very heart of many critical issues battled out every day in the court systems. These questions involve taking or extending of life – capital punishment, abortion, and euthanasia. For every issue that is a "for and against" and the arguments on either side are heart rending and can never be proved one way or another. Religious values, medical definitions, and legal rulings will

¹ Aristotle, *Nicomachean Ethics*, (Liberal Arts Press, 1962), p. 136.

never be able to say with certainty what comprises life itself. There will always be that grain of uncertainty.

Medical science has advanced to the point where life can be extended past the point where mortals would normally die. Biotechnology can measure brain waves, announce life has ended, pull the proverbial plug ... and the patient continues to breathe. Is this life when you cannot speak, or hear, or see, or think, or feel? Is it life when a biological organism simply exists without thought or the ability to function on its own? You may believe one way or the other, and defend your beliefs with a passion or intellectual dispassion, and still never be able to prove you that life exists or is nonexistent beyond doubt. Because of this, ethical issues surrounding the definition of life have continued unabated for thousands of years.

The following discussion will focus on the debate concerning euthanasia.

Biological Death

To begin a discussion concerning euthanasia requires a review of current beliefs about the biological event called "death". The average human being thinks of death as the sudden cessation of biological activity. But in reality, death occurs one layer at a time. In other words, every part of a body does not die at the same time. A liver may "die", but the body continues to function even though not as efficiently. One lung may become diseased and be removed as "dead", but the body will continue to live.

The question at hand is raised when critical organs fail and cause permanent damage that forever affects life itself. When the brain is deprived of oxygen, because the heart has ceased to beat before being revived through artificial means, permanent damage is caused. Clinical death at one point in time was defined as the complete absence of a heartbeat and the ability to breathe. But what if the heart is kept beating or the lungs kept breathing through medical intervention, but the brain is not functioning? This is the crux of the issue surrounding euthanasia.

Human death is more than just the cessation of life. We learn at an early age that our life will someday end. So though we do not know how or when, we live with the understanding that time is finite. Death has been celebrated and mourned in various ways by cultures from the primitive to the most sophisticated. It has also been ritualized and encased in religious, moral, and ethical values. These values are usually interjected into any discussion concerning euthanasia. For most people, it is not enough to discuss biological death. They go on to expound about "life after death".

This is not important to the medical profession in a clinical sense. But the cultural and religious beliefs have a direct bearing on how people define death, and the right to cause or prevent clinical death. A physician can argue clinical details and provide medical proof of death for hours on end. But the inability to actually prove life has ended when biological functioning continues on some level, combined with cultural ethics, makes clinical definitions of death debatable in the eyes of many. It is fascinating to note that the religious views of life cannot be proved either, so two factions discuss an indefinable

moment in time while never being to prove they are right. No wonder the courts must address the issue over and over again!

Everyone wants to believe they will die in a dignified manner and neither before or after the designated time. "As noted earlier, the absence of heartbeat and absence of breathing were long taken as the defining criteria that determined death."² But that definition has been expanded, molded, and revised as medical technology has advanced. In 1968, Harvard Medical School first addressed the issue of a person in a coma. The medical committee set new standards for defining death by writing that a non-functioning brain combined with the inability to breath independent of medical intervention is death. There are no brain waves, no response to stimuli, and no reflexes. Also, an arbitrary time limit of 24 hours was set. If a person was in this state for over 24 hours, they could be considered dead.

It is important to understand the issue that led to the Harvard Medical School definition of death. The first heart transplant performed by Dr. Christian Bernard in 1967 raised questions about prolonging life after death has clinically occurred. It also began a debate about how society will be able to control medical science and prevent its use for "legal murder". To replace a heart, you have to take a heart out. If you remove a heart, the person dies, unless artificially kept alive. The Harvard Medical School hinged their definition of death on the permanent and irreversible brain damage, not heart death alone, defined the death of a human being.

It would be nice to be able to say the matter was closed and the issue settled by the Harvard Medical School. It was not. As discussed earlier, unless a physical body is stone cold with no signs of life anywhere in the body, the discussion about death always remains on the ethical plane. When a person lies in a coma with almost no chance of ever functioning independent of medical machinery, or of being able to use the brain, there is still no proof that the people who believe the person is dead and the people who think the person is alive are right.

The debate continued to rage over what constitutes death. As medical technology continued to advance, new issues continued to arise. In 1982, Baby Doe was born with Down's Syndrome. He was also unable to eat because of a digestive blockage. An operation

² Tulloch, *Euthanasia – Choice and Death*, (Edinburgh University Press, 2005), p. 7.

would be required to save the baby's life, but serious questions remained about the quality of life and the future ability of the child to live a normal life. There could be a long debate over the definition of "normal life" versus "handicapped life", but that is not the purpose of this discussion. The case went to court and the Final Rule was issued on 1984 that said only medically beneficial treatment is necessary. That case was struck down in the Supreme Court and the Final Rule deemed invalid.

The definition of death has a major impact on a number of ethical issues including organ transplant. Do you let one person die because of refusal to remove an organ from another person being kept alive only through artificial means? The truth is that many of the answers to these questions are formed out of fear, not fact. There is an inherent, deep seated fear that medical science and the courts should not be entrusted with the decision about what constitutes life and death, because of potential abuses.

Over time the definition death has been addressed on a case by case basis. This reflects the impossibility of ever being able to anticipate all the potential medical problems and states of being that can occur. At about the point where the medical profession feels as if it has witnessed every possible coma anomaly, someone lives well beyond the last gasp of the respirator that was removed. With no conscious awareness of the world around them, the question remains: What constitutes life? It goes full circle. Defining death means defining life, which is necessary to define death.

Treatment and Medical Miracles

The right-to-die issues were given a lot of media attention when Karen Quinlan was taken off a respirator in 1983, because she was considered unable to sustain her own life through normal biological functions. It was shocking when Ms. Quinlan breathed on her own after removal of the respirator and lived another 7 years. The discussion turned to quality of life, the cost of medical care, and learned physical responses that occur without "thinking". The average person looked at the situation with pity and expressed a wish that such a thing never happened to them or their family. It was left to the philosophers and doctors to address the implications of the Quinlan case.

But on the other side of the coin, in 1995 Terri Schiavo's life support system was pulled and she slowly starved to death. There were videos of Schiavo's eyes following balloons and of her smiling. But the courts in the USA gave the doctors permission to cut-off life support. It was a difficult case for everyone involved, including the general public who followed each legal maneuver with keen interest. The Schiavo case is a perfect example of the difficulty in determining life and death. Was Schiavo really smiling, or was it just facial muscles contracting? Could she understand more than medical science believed, but was unable to communicate that fact? No one knows for sure despite all the medical tests.

There were many panels, bills submitted to the legislature to amend laws, and philosophical discussions about refusing to give someone medical treatment or ending ongoing treatment. The situation is aggravated by the propensity of people to sue for any medical miscalculation or perceived injury. The legal ramifications place doctors, dedicated to saving lives, in an uncomfortable position. How can a doctor say publicly that someone's life should be ended through the withholding of medical treatment? Is this murder or compassionate care? As you can see, even the Quinlan case did not resolve any issues related to the right to die. It only added another dimension.

The issues took another step up when the parents of Nancy Cruzan asked that their daughter's respirator be turned off and a feeding tube removed. Now the discussions concerning the right to die led to

an attempt to differentiate between medical treatments to prolong life versus giving someone the basic nutrition needed to survive. Bear in mind that the court systems around the world had agreed to a certain point that lack of awareness should be considered when determining death. A person can be conscious and unable to function physically on their own; unconscious and physically incompetent; or unconscious but physically well.

Medical science biotechnology advances forced a discussion about the different kinds of medical treatment. What is ordinary and what is beyond normal treatment? The problem is that medical treatments and equipment are considered to be beyond normal care until they become routinely used or performed. At some point people expect these treatments during the normal course of events. It is difficult to define heroic medical measures. What may seem heroic to you may be unacceptable under any circumstance to someone else. You may want a family member to be kept alive using every medical means possible and at any expense. Someone else may want to let the family member quietly pass away under natural conditions. There are always those unscrupulous people who are not unhappy when a particular person dies. These feelings are normally kept quiet, because the truth would make people suspicious of medical advice and decisions. But the fear the wrong person will have control of the death of another person is one of the many ethical issues included in a discussion on right to die issues.

It is easy to see that the history of ethics, the right to die, and technology were heading to a point where a distinction would have to be made between killing a person through a medical act or non-act, versus natural death occurring as a result of the normal cessation of brain and heart activity. You can let someone die or you can precipitate their death by actually assisting in their demise. Society has spent considerable time creating language that disguises intent. You can kill someone, bring about death, and let someone succumb or let him or her die. But the real issue is one of omission or commission.

This leads to the very heart of the matter of euthanasia. Should a doctor tangibly assist a patient with bringing on death? Is it ethical for a doctor to withhold treatment, especially when the person is not dead by legal definition? Does removing an organ for transplant from a clinically dead person create an act of murder? Some

philosophers believe there is no distinction between killing a patient by withholding treatment versus killing a patient through a specific act. They argue that withholding treatment actually is an act in itself. So what is euthanasia and what are its issues? Following is a discussion of these issues and more.

Euthanasia

A discussion of euthanasia must begin with a definition. Euthanasia in the dictionary is simply defined in the Merriam-Webster dictionary as “the act or practice of killing or permitting the death of hopelessly sick or injured persons or animals with as little pain as possible for reasons of mercy”. Euthanasia is causing *intentional* death. Accidental deaths due to mistakes or errors in judgment do not fall under the definition of euthanasia. There are several subdivisions of the euthanasia definition. The use of the word “killed” in no way is intended to imply support or opposition to euthanasia. It is only used as a matter of convenience.

- Involuntary euthanasia is when a person’s death is brought about against their expressed consent
- Voluntary euthanasia is where the person asked to be killed
- Non-voluntary euthanasia where the person killed gave no indication either way
- Assisted suicide where someone, which could be a doctor, gives someone the means to commit suicide
- Euthanasia by action requires a specific act to be performed by someone that brings about death
- Euthanasia by omission is when death results through the intentional withholding of basic nutrition (causes starvation and dehydration)³

It would appear that some of the definitions have very fine dividing lines. This is the result of the many fine-lined medical situations that occur. Euthanasia is always intentional and always meant to bring about death. But euthanasia involves more than just intention. It also addresses choice, which is reflected in the definitions. A person either is capable of making a choice or is not able to make a choice. When not able to decide for themselves, another person can step in and decide for them.

³ www.euthanasia.com/defintiions.html

James Rachels addressed the issues of active and passive euthanasia. He did it by not making a case for either one or the other. What he proposes is the idea that if one is morally acceptable, then the other is morally acceptable as well. In other words, there are two different acts of euthanasia and each has the same ethical and moral basis. The moral basis lies in the belief that prolonged suffering should not be allowed.

It is important to understand the differences between active and passive euthanasia. Active euthanasia is when a doctor or family member brings about the death of someone to end their suffering. It is also called doctor-assisted suicide or just assisted suicide. Passive euthanasia is allowing someone to die without intervention. The disease or medical condition kills the person, not another human being.

James Rachels presents his work by offering several scenarios. It is an interesting approach that forces one to think objectively in terms of the definition of intent. For example, in one scenario a man has throat cancer. He asks the family and doctor to not prolong his life because of the agonizing pain. If the doctor withholds medical treatment to end suffering, the pain will increase and thus suffering increases. That is not the intent. If medical treatment continues, the pain is lessened, but the life is lengthened. That is not the intent either. In this situation, Rachels proposes that active euthanasia is the only acceptable alternative because in both situations the intent is to end the suffering. The only way to end suffering is to end life.⁴

James Rachels directly addresses the American Medical Association (AMA) stance on active and passive euthanasia. The American Medical Association issued doctrine that said the moral differences between active and passive euthanasia are important and active euthanasia is always unacceptable and never defensible.⁵ The American Medical Association sees this philosophy as necessary to uphold medical ethics. Doctors are trained to save lives, not end them. It is morally reprehensible, in the eyes of the AMA, to ever perform a direct act that results in a patient's death. Yet the AMA did suggest that it can be permissible to withhold treatment in certain situations.

⁴ Rachels, *The End of Life – Euthanasia and Morality*, Oxford University Press, 1986.

⁵ *New England Journal of Medicine*, 292: 78-80, 1975

The implication here is that the AMA believes morals allow watching someone to die by not acting, but prohibit helping someone die to end suffering. The AMA doctrine is intended to preserve the moral integrity of the medical profession. Realistically speaking, the AMA was not willing to give doctors or nurses 'permission' to decide when someone should die. The legal ramifications are unlimited.

James Rachels points out in his work, The End of Life – Euthanasia and Morality, that the AMA also has an obligation to end prolonged suffering if the patient or family requests or circumstances dictate such action. From his viewpoint, a Down's Syndrome infant allowed to die through slow dehydration and starvation because of withheld medical treatment is being treated cruelly. The argument once again becomes circular. If suffering and cruelty are not morally acceptable, then action should be taken to prevent the suffering. When reading Rachels arguments for equal moral consideration of active and passive euthanasia, it is difficult to not suspect that prior to his work, society had simply refused to admit culturally that sometimes death may be considered the best course of action by responsible citizens.

But it is important to understand that James Rachels does not defend one form of euthanasia over another. He simply says that you cannot apply different moral basis to judge active versus passive euthanasia.

Rachels's philosophy was disputed by the Thomas Sullivan. Sullivan held that intents can be viewed differently and should be treated differently. Whereas Rachels believed moral intent was the same no matter which form of euthanasia was instigated, Sullivan believes the intent is more important than the outcome. In Sullivan's view, an infant allowed to die as a result of the withholding of medical treatment can be morally wrong if the intent is to avoid being forced to deal with a defective child - not because the child should not be allowed to die. The parents or medical professions intentions make the difference in determining what is morally right and wrong.

Thomas Sullivan addresses three questions for determining the moral intentions of euthanasia. First, he asks if the withholding of medical treatment, or the act of euthanasia, is intended to produce a death. Secondly he questions if the death is planned. Thirdly, he asks if the intent is deadly. If the answer to the questions is "yes", then the

commission or omission of an act that results in death is morally wrong.

On the other hand, Sullivan writes in, *Active and Passive Euthanasia – An Impertinent Distinction*, that passive euthanasia is morally acceptable when the intent is not to cause death, but rather to let life, or disease, take its natural course. This may result in death, but forcing death is not the intent of omission. This is a more traditional viewpoint than Rachels. This philosophy says that passive euthanasia can be justified as long as the doctor or family has the right intention such as stopping artificial extension of life.

Rebuttals to Sullivan's philosophy on euthanasia say that the intent is not important as long as the final act is morally acceptable. In other words, if you intend to do wrong, but the end result is good, the wrong intent does not matter. The moral good achieved is not lessened by bad intent. Rachels believes that intent is not important at all. These are the types of issues that ethical philosophers discuss every day. Sullivan's philosophy centers on the same goal as the AMA philosophy – to never justify murder or killing or artificially speeding up someone's death.

In 1997, the *Philosophers' Brief on Assisted Suicide* published a treatise on suicide and euthanasia.⁶ The discussion rises above individual cases. As pointed out earlier, the constant changes in medical technology coupled with frequent legal cases, had led to a disjointed discussion. The paper was written by John Rawls, Thomas Scanlon, Judith Jarvis Thompson, Robert Nozick, Ronald Dworkin, and Thomas Nagel. All are moral philosophers. The paper was eventually used in two court cases to address whether a person has a right to die.

The *Philosophers' Brief on Assisted Suicide* says that competent people have a right to make competent personal decisions involving moral, philosophical or religious values. But the paper goes on to talk about the fact that decisions are often made impulsively for a variety of reasons. In those situations, the state has a right to intervene when it is apparent the decision is being made under psychological duress. This differentiates between someone deciding to end their life while experiencing depression versus someone with a

⁶ J. Rawles, et.al, *Assisted Suicide: The Philosophers' Brief*, The New York Review of Books (27 March 1997)

disease that will result in death shortly. Once again, the moral philosophers expressed concern that the social, medical, and legal systems could implement a policy on euthanasia that is uniformly enforced. It was argued that if patients were permitted to choose legal suicide, medical efforts to reduce the pain experienced would probably rise. Many factors would cause this reaction, including fear of malpractice suits as discussed earlier in the paper.

It is interesting to note that the arguments, again, are circular. It is difficult for countries like the United States to acknowledge that there may be acceptable acts of suicide. To permit suicide potentially violates cultural and moral standards; yet terminally ill patients claim they have constitutional rights to control their final destiny. The American philosophers wrote that using common sense distinctions between acts of commission and omission alone is futile. From their viewpoint, the discussion centers on those acts intended to cause death. It leads back to intents and acts – the same issues addressed by Rachels and Sullivan.

Currently, the Oregon Death with Dignity Act is the leader in the political arena of euthanasia. The act, passed by vote of the state's citizens, allows assisted suicide. Physician assisted suicide (PAS) is defined in Oregon as the ingestion of a lethal dose of prescribed medications leading to death. There are limits of course. The person must be over eighteen years of age and terminally ill. But more importantly, the ill person must be able to clearly indicate their desire for physician assisted suicide. This still leaves the door wide open on the topic of euthanasia as used with people who are not cognizant of the world around them and cannot communicate their desires.

One other philosophical issue concerning euthanasia that should be discussed is what is called the slippery slope. The slippery slope arguments are concerned with the application of killing or euthanasia to situations clearly not intended for inclusion. It is an ethical issue that realizes situations can move from defensible stances to indefensible stances through justification. In other words, if you give an inch, people will take a mile.

An example of a suggestion that worries philosophers who use the slippery slope argument involves the fetus. A pregnant woman was kept physically alive even after brain wave activity ceased in order to

give the fetus time to adequately develop. This situation resulted in a discussion of the possible use of brain dead people as lives incubators. If this suggestion makes you cringe and shrug off the suggestion as ridiculous, you will have an understanding of why many people don't give the slippery slope argument any credence. It comes across as an argument bordering on hysteria.

Once again, there is a real underlying fear throughout the euthanasia philosophical debate that euthanasia will be used to further private agendas. That is probably its best advantage. It keeps people thinking in terms of medical possibilities. Technology is able to do so much more today than ever thought possible just 20 years ago. Research indicates the pace is not going to slow down either. With every new procedure that can artificially extend life comes the danger of extending life past the will of the patient or family.

Want more?

Pages 15-29 of this book is available for purchase on the TruthAwakens.com website for \$2.25. The following chapters are included in the full version of this book:

- Euthanasia Around the World
- For and Against – The Debate Rages
- The Future
- Summary of Arguments
- Conclusion

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