

3. Euthanasia

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1. Definitions & Distinctions

The term “euthanasia” comes from Greek. The idea arises from the concept of dying well—*eu* means “well” and *thanatos* “death.” The term “euthanasia,” however, has come to mean not so much the good death itself as the causing of a “good” death. “Euthanasia” can be defined as intentional killing another human being for the supposed benefit of, more specifically as an act of mercy towards, the person killed.¹ It will help our discussion, however, if we begin by making some distinctions.

First, euthanasia might be performed with the permission of the person killed (“voluntary euthanasia”) or without or even contrary to that person’s will (“non-” and “involuntary euthanasia”).

Second, we can distinguish a variety of senses in or near the phrase “killing another human being.” We can construct a four-point spectrum of cases, as follows:

- (1) Direct (intentional) killing—e.g.,
 - (a) executing a criminal
 - (b) administering of a lethal drug to end the patient’s suffering
- (2) (Intentionally) assisting a suicide—e.g.,
 - (a) providing someone who intends to commit suicide a prescription for lethal drugs
- (3) Doing something that may have lethal side-effects—e.g.,
 - (a) bombing an important enemy supply base despite the fact that civilians live nearby
 - (b) administering a heavy dose of morphine because that is the least amount of the drug sufficient to deaden the patient’s pain, even though the dose is sufficient to suppress respiration and thereby hasten the patient’s death; or
- (4) Letting die—e.g., refusal or neglect to
 - (a) pull a drowning swimmer from the water
 - (b) resuscitate a heart attack victim who is dying of cancer
 - (c) treat the pneumonia of a patient who is dying of cancer

Acts of any of those four types might (though, as the examples show, need not) be performed for the benefit of the person who is about to die.

¹ Definitions of the term vary. Dutch law, for example, defines it as follows: “the purposeful acting to terminate life by someone other than the person concerned on the request of the latter.” (P. J. van der Maas *et al.*, *Euthanasia and other Medical Decisions Concerning the End of Life* (1991), p. 5). This makes the request of the person to be killed, but not their benefit, part of the definition of euthanasia.

When euthanasia is defined as a type of killing, what is meant is an action or omission chosen with intent that the person die, regardless of whether the action itself is direct. All actions of type #1, by definition, are such killings. If they are done for the benefit of the person killed they will be cases of euthanasia. Actions of type #2 can be distinguished from killings causally, but not morally. If taking the drug is wrong, making it available will be so as well.

We often call actions of type #3 killings,² but as long as the death is really a side effect (and not just a second intended outcome), these are not cases of intentional killing and therefore are not cases of euthanasia as defined above. They may, of course, be morally wrong even when death is not intended.

Actions of type #4 raise difficult conceptual questions which merit independent exploration. Is removing someone from a respirator or refusing to give them food intravenously just letting them die or is it killing them? Surely refusal to do what one could do *in order that* someone die³ is morally equivalent to killing and therefore that such cases are euthanasia. The exclusion of cases of neglect and refusal to act for other reasons from the category euthanasia does not, of course, mean that such actions could not be wrong for other reasons.

On this definition, ordinary cases of physician-assisted suicide, no less than lethal injection by a physician, are cases of euthanasia. For in ordinary cases of physician-assisted suicide, the physician has the same end as the patient—the patient’s death.⁴ If physician-assisted suicide is permissible, however, it is hard to see what moral objection there could be against active voluntary euthanasia. There might, of course, be practical reasons for distinguishing them. For example, perhaps physician-assisted suicide is less susceptible to abuse.

There are at least two distinct questions which can be asked about euthanasia—the moral question (“What does performing such actions say about one’s character?” or “Is performing such actions morally wrong?”) and the legal question (“Should performing such actions be prohibited by law?”).

2. History

The Greek physician Hippocrates included in the oath he required of all his students the injunction, “I will give no deadly medicine to anyone if asked, nor suggest any such counsel.” Some version of this oath is taken by most new physicians even today.

Although there has been some agitation for the legalization of euthanasia throughout the twentieth century, the first state to legalize euthanasia was Nazi Germany, where a campaign of non-voluntary euthanasia was initiated in 1939.

² An officer might report, “We know this bombing raid will kill some civilians, but destroying that dump now is the only way to stop the enemy offensive.”

³ This has sometimes been called “passive euthanasia.” That term seems to me to be appropriate, but its extension to cases of refusal to continue futile treatment makes it a source of confusion.

⁴ This could not, of course, be said in the extraordinary case in which a physician was coerced into assisting with a suicide. Could a physician assist in a suicide (say, by giving a prescription for a poison and directions about how to use it) not because he wanted the patient to commit suicide, but merely as a provider of technical advice and legal permissions? That seems to me to be cooperating, not formally, but without sufficient reason. But since the point is not central to my thesis, I will not argue it here.

After the war, four German physicians were indicted at Nuremberg for their participation in the euthanasia program. Three were found guilty and were hanged on 2 June, 1948, in Landsberg prison,

In recent years some physicians have been increasingly willing to resort to the practice, mostly, though not only, when death is requested by their patients. The last thirty years has seen legalization of voluntary euthanasia or physician-assisted suicide in three countries. More ominously, it has also seen the extensive use of non-voluntary euthanasia, under the euphemism “life-terminating actions without an explicit request from the patient.”

The first of these jurisdictions was the Netherlands, ironically the only country in which physicians had refused to participate in the Nazi euthanasia program. Dutch legal acceptance of euthanasia began in 1973 with a decision on the part of the government not to prosecute physicians for the violation of anti-euthanasia laws as long as certain guidelines were being followed. This year, the Netherlands has decided to decriminalize euthanasia altogether.

In 1994, voters in Oregon approved that state’s “Death With Dignity Act” allowing physicians to prescribe, but not to administer lethal drugs to those who wanted to commit suicide. This act went into effect in 1997. Since then, according to official state reports, about seventy people have killed themselves in this way.

In addition, in 1995, the Northern Territory of Australia legalized euthanasia, though this law was repealed by the National Senate in 1997.

Attempts to legalize physician-assisted suicide continue to be made in the United States. The issue was on a referendum ballot in Michigan in 1998 and in Maine in 2000, although it was defeated in both states.

3. Two Views of Euthanasia

Despite their variation in points of detail, the efforts to legalize euthanasia have in common three salient conditions limiting the permissibility of euthanasia. What might be called “the Standard Permission for euthanasia” requires:

- (1) the euthanasia be voluntary;
- (2) the assistance be rendered, or the euthanasia be performed, only by a physician; and
- (3) the patient’s situation be medically bad.⁵

The teaching of the Catholic Church about these euthanasia, by contrast, can be summarized in four points:⁶

- (1) Direct euthanasia—action aimed at the death of a handicapped, sick or dying person—is morally bad.
- (2) The use of painkillers, even at the risk of shortening the patient’s life, can be good.

⁵ The criterion of medical badness varies from jurisdiction to jurisdiction. In Oregon, the criterion is terminal illness. In Holland, it is unbearable suffering with no prospect of improvement (or for which no other remedy acceptable to the patient is available) In the Northern Territory, it was unacceptable pain, suffering, or distress in the course of a terminal illness.

⁶ Cf. *Catechism of the Catholic Church*, 2276-9.

- (3) Even if death is thought imminent, withholding ordinary care from a sick person is bad.
- (4) Discontinuing medical procedures that are burdensome, dangerous, extraordinary or disproportionate to the expected outcome can be good.

In this talk, I want to answer the following questions:

- (1) What is wrong with the Standard Permission with respect to euthanasia?
- (2) Is it consistent of the Church to oppose active euthanasia while still permitting painkilling drugs that are known to hasten the patient’s death and discontinuation of treatment in some cases, even though the foreseeable result will be death?

I want to show that the distinctions made in the teaching of the Church, its prohibitions and its permissions are not just arbitrary dictates of God, but are reasonable and indeed can be defended in a way that does not depend upon Divine revelation.

4. The Standard Permission

First, in permitting the death of an innocent person, the Standard Permission permits an act that is wrong by its very nature—the deliberate killing of an innocent person. As such, it is an instance of treating someone in a way that is not due to them; it is an injustice.

There are, to be sure, two cases in which killing a person might not be treating them in a way that is not due to them. One case is those who are currently a harm to others—e.g., soldiers engaged in aggression and criminals or madmen currently endangering the lives of others. The other is those who must be punished for past crimes. Hence, the two cases of homicide accepted even by many of euthanasia’s staunchest opponents⁷—defense and punishment.⁸ In neither of these is an injustice done; so, neither of them is, in principle, wrong. Can the Standard Permission be understood as a third case where killing would not be an injustice?

The Standard Permission does, to be sure, allow only voluntary euthanasia, so the question might arise whether it even possible to treat a person unjustly as long as one is treating a person in accordance with their desires. There is, after all, an old maxim to the effect—*volenti non fit injuria*. If a customer to whom it does not matter is not given exact change, perhaps the customer is not being cheated. But this is less plausible in cases where what is at issue is not money or property, which we are all free to give away, but our own lives. And so, under contemporary law I cannot have myself killed, or even sell myself into slavery. Of this, more below. It seems as though consent does not preclude injustice or, if it does, then treating someone unjustly is not the only way of treating them wrongly.

Could death not be seen as a response that is appropriate given the medically bad condition of those to whom the Standard Permission applies? Could it not be seen

⁷ The teaching of the Catholic Church, for example, is that neither war nor capital punishment is wrong in itself, though one still must raise such prudential questions as whether capital punishment is really needed in a particular society, whether it does more harm than good, etc.

⁸ The cases are not identical. Nor does one need to accept intentional killing in each of these cases for there to be a basis for the objection under consideration.

as just because it is the only way that they can be saved from a painful or undignified end of their life?

With respect to pain, the Standard Permission is not necessary in the cases it covers. No advance in medicine will ever completely eliminate the possibility of a painful death. The accident victim burning to death and pinned under his car, the wounded soldier out of reach of a medic, and other such cases are not, however, the kind of cases to which the Standard Position even applies. The pain of patients under medical care can always be managed by measures short of killing. If nothing else works, though usually something else will, it is always possible to induce a coma. This may not be the most choiceworthy of deaths, but the issue was supposed to be whether the end of the patient's life would be painful.

Some defenders of euthanasia focus less on the avoidance of physical pain than they do with other ends, in particular the avoidance of an allegedly undignified dependence on others, even for provision of their basic needs. Sometimes this is limited to the alleged indignity of being fed and clothed by others; other times it is extended even to unconscious existence in a permanent vegetative state. This kind of concern is seen in Oregon's decision to call its physician-assisted suicide law the Death with Dignity Act.

The former state can of course be avoided by drug-induced coma, i.e. by retreat to the latter. But the real problem is perhaps a false conception of dignity. Of course, it is better, and appropriate, for adults to be able to do things for themselves. But real dignity is shown or lost in ones responses to the adversities of life. Since a dignified endurance of adversity is possible, killing is not necessary to avoid indignity. Therefore, one must ask whether the repugnance many people express at the prospect of dependence in their final years is really grounded in a sense of dignity rather than in false pride. Of course, it is better, and appropriate for adults, to be able to do things for themselves. But what principle underlies the maxim, “Death before dependence”?

An additional problem with the Standard Permission is its instability. It is a peculiar attempt to accommodate two very different moral principles, autonomy (the idea that people have the right to make their own decisions about actions that fundamentally affect themselves alone) and utility (the idea that we ought to do whatever we can to promote pleasure and prevent pain).

The principle of autonomy is (theoretically) well-prepared to protect societies that would practice euthanasia from the dangers of non- or involuntary euthanasia. Unfortunately, arguments based on autonomy are ill-suited to explaining the other two restrictions contained in the Standard Permission. The autonomy argument justifies much more than the Standard Permission for euthanasia. If the principle of autonomy permits euthanasia in the cases mentioned, why not in other cases as well?

What does their principle of autonomy say about other kinds of pain and indignity? What about emotional pain? What about the indignity, not of dependence and limited cognitive activities, but of guilt or shame?

How will a principle of autonomy that permits killing to avoid physical pain prohibit killing to avoid the pain of depression? Of course, depression can sometimes be treated by taking appropriate drugs. But so can physical pain. Does the fact that

some physical-pain killers cause general sedation make them an unacceptable choice? What about the patient who believes that the use of mood-altering drugs to conquer depression is eerily reminiscent of Huxley's *Brave New World*?

This step has already been taken in the Netherlands. In September 1991, Dr. Boudewijn Chabot assisted in the suicide of Hilly Bosscher, a 50-year-old woman in good physical health but suffering from severe depression after the death of her two sons and the end of her marriage. Dr Chabot was prosecuted only in order to obtain a legal judgment in a test case. He was convicted, but was not penalized for his actions. The Supreme Court saw no reason why the “necessity defense” on the basis of which euthanasia is tolerated in the Netherlands could not be applied to psychological as well as physical pain.⁹ A recent study of Dutch psychiatrists revealed that a majority believe that euthanasia or physician-assisted suicide would be morally acceptable in some cases of mental disorder.¹⁰

How will a principle of autonomy that permits killing to avoid the indignity of dependence and the like prohibit killing to avoid the pain of shame? Admiral Jeremy Boorda, US Chief of Naval Operations, shot himself in the chest on May 15, 1996, when it became clear that past misdeeds (his having worn unearned combat decorations for many years) was about to become public. There are a variety of conditions that make continuing to live difficult or unpleasant. It is not clear on what basis those who rely on the principle of autonomy may make the decision (for others!) that some of these problems make choosing death permissible while others do not.

How does the principle of autonomy permit the Standard Permission's restriction of the right to kill to physicians? In 1995, a Dutch nurse gave lethal injection to a friend suffering from AIDS. She was convicted, but was given only a two-month suspended sentence.¹¹ But why even a restriction to medical personnel? Suppose Admiral Jeremy Boorda had believed himself incapable of firing a suicidal shot himself. How could the committed autonomist deny him the assistance of a willing policeman?

Neither is it clear how those who appeal to the principle of autonomy can stop even here. Why does the principle give one the right only to choose death over a bad life?

Suppose some altruistic young man, realizing the number of people whose lives depend on finding an organ donor, decides to donate *all* his organs immediately. Conscientious altruist that he is, he foregoes his own happiness, realizing that his donations will cause a net gain in the total amount of happiness in the world. On what basis will he be denied the right to make this gift?

Or suppose a director decides to make a film more realistic by hiring people who will agree to be killed on camera. How can the adherents of the principle of

⁹ Alan D. Ogilvie & S. G. Potts. “Assisted suicide for depression: the slippery slope in action?” *British Medical Journal* 309 (1994):492-3; Markje Spanjer. “Mental suffering as justification for euthanasia in Netherlands,” *Lancet* 343 (1994): 1630.

¹⁰ Johanna H. Groenewould *et al.*, “Physician-Assisted Death in Psychiatric Practice in the Netherlands,” *New England Journal of Medicine* 336: 25 (June 19, 1997): 1795-1801.

¹¹ Markje Spanjer, “Nurses cannot assist suicide in Netherlands,” *Lancet* 345 (1995): 849.

autonomy deny to the film-maker’s willing victims the right to choose death (whether for the sake of art or for the benefit of their heirs) which they have just accorded to others?

Obviously, what is wanted in all these cases is a claim about how the approved cases (pain, degenerative disease, &c.) differ from the disapproved ones.¹² Such an argument will be based, not on the principle of autonomy, but on the utility principle. Let us, then, turn to what might be called the situation-based case for euthanasia.

In order to avoid assisted suicide for the ashamed, organ-harvesting from the generous, and similar absurdities, the defense of the Standard Permission must be based on an objective assessment of the badness of the patient’s situation, indeed that the situation of some people is so bad that, for them, death really would be better than continuing to live.

What is one led to if one begins with the observation that the situation of some patients is really so bad that, for them, death is better than continued life, and so bad that we should honor their request to kill them? In two ways, one may be led to non-voluntary, and perhaps even involuntary, euthanasia. Here it is the first point of the Standard Permission that comes under pressure.

The first way comes from questions like these: Why should such a prompt and merciful death be limited to those who are still able to make such a request? Why should it be granted to some (those who had the foresight to request it in advance or who have the ability to request it now) but denied to others (who lacked the foresight then and lack the ability now)? Would it not be viciously punitive to refuse such an important mercy to some merely because they lacked the foresight to make provision?

That leads from voluntary to non-voluntary euthanasia. This move is apparently well underway in the Netherlands, where, according to an official government inquiry, over half of the physicians interviewed indicated that they had or could conceive of circumstances under which they would perform “life-terminating acts without the patient’s explicit request,”¹³ i.e., non-voluntary euthanasia. These figures exclude killings of new-born children, which is also becoming an increasingly accepted part of Dutch medical practice. In 1993, Dr Henk Prins used a muscle-paralyzing drug to kill Rianne Quirine Kunst, a new-born baby with hydrocephalus, spina bifida, and leg deformities. Although Prins was convicted of murder, no punishment was meted out on the grounds that his choice was justifiable.¹⁴

¹² One attempt to do so is offered by Margaret Pabst Battin in “Suicide: A *Fundamental* Human Right,” in M. Pabst Battin & D. Mayo, eds., *Suicide: The Philosophical Issues* (St Martin’s, 1980) and reprinted in *The Least Worst Death: Essays in Bioethics on the End of Life* (Oxford, 1994). Battin attempts to distinguish permissible from impermissible suicides, but without confronting the problem raised here.

¹³ P. J. van der Maas *et al.*, *Euthanasia and other Medical Decisions Concerning the End of Life* (original version: *Medische Beslissingen rond het levenseinde* (the Hague, 1991)), p. 58. The report warns that “some of the respondents interpreted the [phrase “life-terminating acts] much more broadly than the investigators had intended” (p. 57). A follow-up study was published as G. V. van der Wal & P. J. van der Maas, *Euthanasie en andere medische beslissingen rond het levenseinde* (1996).

¹⁴ “Infants’ euthanasia sets off new Dutch debate,” *American Medical News* January 1, 1996,

The decision of the US Ninth Circuit Court, since overturned by US Supreme Court, exhibits the same trend by giving prominence to the doctrine of substituted judgment: “Finally, we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.”¹⁵

The second way to non- or involuntary euthanasia works as follows. Margaret Battin, a leading philosophical defender of euthanasia, defends suicide in one case she considers by saying that “it may leave one less example of human degradation in the world.”¹⁶ If the suicide of a recently widowed sufferer from glaucoma and cancer “leaves one less example of human degradation in the world,” what would that woman’s refusal to commit suicide be? Is the answer not that it would be keeping one more example of human degradation in the world? If the only difference is the unwillingness to die, what else could the answer be? That may, of course, not be anything Battin says or even thinks. But the question is not what today’s defenders now actually think, but what people who adopt their views will go on to think. The question is not what conclusions the position’s original expositors are willing to draw, but what conclusions validly follow from the position taken. Euthanasia, like the guillotine, may fall into the hands of people less humane than its inventors.

In general one may ask, if going on living really is worse than dying right now and it is permissible to kill even some people for whom that is true, why is the hesitation of those unwilling to be killed decisive? Their condition, after all, usually does not affect them alone. What of the inconvenience and emotional suffering inflicted on their family as they watch the slow deterioration? In the physician interviews conducted by the Rummelink Commission, 32% of physicians interviewed cited the fact that “relatives could not cope” as one of “the most important considerations ... to perform a life terminating act without explicit request of the patient.”¹⁷ What of the cost of therapy and care which someone has to pay? The defender of euthanasia on the basis of the situation-based argument must explain why their argument does not permit some non- or even involuntary cases as well as the voluntary cases of the Standard Permission.

5. Dangerous Painkillers and Suspension of Treatment

If the Church holds, as it does, that the intentional killing of patients (active euthanasia) is morally wrong, how can it permit the suspension of treatment and even the use to kill pain of drugs that may hasten the patients death.

The answer to this question comes in the recognition that there are three ways an act can be bad—by its very nature, in the end aimed at, or in the circumstances under which it is performed.

¹⁵ *Compassion in Dying v. Washington* 850 F Supp. 1454 at note 120. This case was overturned by the US Supreme Court in *Washington v. Glucksberg* (1997) 117 S. Ct. 2258.

¹⁶ “Suicide,” *The Least Worst Death*, p. 282.

¹⁷ Rummelink, p. 66. In assessing this statistic, one must keep in mind the Commission’s concerns about the way physicians interpreted the question.

Killing patients (e.g., giving them a poison) is wrong by its very nature. Even giving painkillers that have as a side-effect the hastening of death or suspension of treatment with the intention that the patient die would be bad. So would doing either of these things in situations where there was not a sufficient reason to do so.

It does not follow from these principles, however, that every action that has as a consequence someone's death is morally wrong. Most vaccinations have bad side effects, including even death, in some of the people who use them. The fact that a few deaths are foreseen in these cases does not mean, of course, that the deaths are intended. Foreseen, but unintended, consequences are evaluated on a different standard from the standard for intended consequences. If the physicians at the vaccination clinics really were trying to kill a few people, we would judge their actions bad. Even if they were not trying to kill people, we would judge their actions bad if the harm done by the vaccine in question outweighed the good it did.

This standard is summarized in a principle called the Principle of Double Effect. The standard formulation of this principle is that of the 19th century Jesuit priest, Joannes Gury:¹⁸ An act which had a bad side effect may nevertheless be performed as long as the following four conditions are met:

- (1) The ultimate end of the agent must be good;
- (2) The cause of the effects i.e., the action itself must be good (or at least indifferent);
- (3) The good effect must not come from the bad; and
- (4) There must be a proportionally grave reason for positing the cause, so that the agent would be under no obligation (e.g., of justice or charity) to omit it.

Not every use of patient-endangering levels of painkillers would meet this criterion. American physician and (illegal) euthanasia practitioner Dr. Jack Kevorkian on several occasions used carbon monoxide on patients. He claimed to be doing this to relieve their suffering. He fails the first criterion, as his end was certainly the death of the patient, not merely the ending of their pain. In addition the good at which he aimed followed from the bad. Carbon monoxide only relieves pain by killing the patient. The death of the patient is a means to the end of stopping the pain, not a side-effect.

The use of morphine, even at levels which endanger the life of the patient could be different. The end need not be the death of the patient. The cause, giving a pain-killer, surely good. The death of the patient is not the means to the relief of pain. Morphine kills pain directly. It is also possible that there is a good reason to use that level of morphine. If, for example, it were the only way to relieve severe pain, one would have a good reason to use even dangerously high doses.

Similarly with the suspension of treatment. This would not be permissible if one intended to kill the patient that way or without a sufficiently grave reason. But one might suspend a certain treatment because of its excessive cost or because the burdensomeness on the patient was out of proportion to the benefit expected from it. In these cases, suspension of medical treatment could be justified

¹⁸ *Compendium theologiae moralis.*

The distinctions made by the Church here can, therefore, be justified.