Killing vs letting die

Health & Medicine, Healthcare

In a paper entitled “ Why Does Removing Machines Count as PassiveEuthanasia?” Dr. Patrick D. Hopkins argues that “ the removal of a machine which substitutes for a failed vital organ is equivalent to removing that life-sustaining organ.”

(Killing 2004 p. 1). In this scenario, removing a breathing machine such as BiPap that essentially breathes for the patient when they are unable to breathe for themselves, would be tantamount to removing the patient’s lung in order to stop him from breathing. The ground becomes a little shaky if we rely on this theory; the patient or surrogate making decisions for the patient, when confronted with a terminally ill medical situation, asks that all “ life-support” machines and feeding tubes be removed. Is thedoctoror nurse who performs this act of mercy “ killing” the patient, or just removing artificial means of life and “ letting die?” Unlike Dr. Hopkins, I don’t feel that “ pulling the plug,” or ceasing life support machines is equal in any way to cutting out a vital organ. I believe“ letting die” is a morally responsible act, while actively “ killing” is quite another matter.

Many people make a distinction between passive euthanasia and active euthanasia. While the AMA maintains that people have a “ right to die with dignity,” and believe it “ morally permissible,” for a physician to allow the death of a person who is suffering unmercifully and has an incurable disease, they are unwilling to “ countenance active euthanasia for a person who is in similar straits, but who has the misfortune not to be suffering from an illness that will result in a speedy death.” (Tooley 2006 p. 1). Therefore, while a patient might have a terminal illness and be in extreme pain, if the illness is not likely to kill them fairly quickly, euthanasia is not an option, rather they

are required to suffer for a lengthy period of time before receiving assistance in ending their lives.

This becomes a very touchy moral issue, with passionate arguments on both sides. The motives of a person who intentionally kills someone is surely more evil than the motives of a person who lets someone die, most especially if the motives for letting that person die are purely non-selfish and a result of empathy for the person's pain. Watching a loved one die slowly and painfully is a hardship on those who love them as well as the person themselves. When a beloved member of yourfamilyis begging you to " let them go," how can it be morally wrong to grant that wish?

In the realm of withholding treatment versus withdrawing treatment, the consensus seems to be that if withholding treatment can be justified, then withdrawing it can be justified by the same criteria. (Jennings 2001 p. 2). The reality is that while administering treatment that may, in fact, have to be later withdrawn buys time in the sense that the physician is able come to a solid prognosis of the patient's chances for survival, many ethicists feel that it is " easier to justify not starting treatment." (Jennings 2001 p. 2). So, while administering treatment may allow the doctor, patient and family members time to accept the reality of the imminent death of a loved one, doctors are hesitant to administer treatment that they are fairly certain will have to be withdrawn somewhere down the line, and find it easier to let nature take it's course in the first place.

Life sustaining treatments are considered to be: mechanical ventilation, dialysis, cardiopulmonary resuscitation, antibiotics, transfusions, nutrition and hydration. While most of us are relatively " okay" with the idea of

withdrawing (or not administering in the first place) the mechanical ventilation, dialysis, or performing CPR, we are less okay with the idea of removing a feeding tube and iv's or not administering antibiotics.

We equate these acts in some sense as " starving" our loved one to death, or making them do without water, and we see this more as torture than assisting an inevitable death. The fact is that dehydration can produce a sedative effect on the brain, making the dying process more tolerable, so essentially it is an issue in our minds rather than one based on reality. Technically it is all the same; if a person is unable to feed themselves in the traditional way, or drink a glass of water, then feeding tubes and IV's are artificial means of keeping a person alive. However, if we were to disallow these basic medical care issues, many, many, people who go on to live happy, productive lives, would surely die.

The question becomes to what degree are we good with measures to sustain life? Many times " comfort measures" are determined to be the most solid course, and, in general, family members are much more agreeable to allowing a loved one to die provided they are still administered IV's, feeding tubes and pain medication.

Extraordinary measures may in some cases be determined by the level of technological complexity, yet this can be misleading. " Certain procedures for providing artificial nutrition and hydration, for example, are technologically rather complex, whereas administering chemotherapy is not." (Policy 2006 p. 3). Therefore, we cannot say that administering chemotherapy is a rather simple procedure, therefore only an " ordinary" means of treatment while the complex artificial nutrition system must then

be “ extraordinary.” There must, therefore, be an assessment of the “ benefits and burdens for the patient that each procedure or treatment provides.” (Policy 2006 p. 3).

CPR is generally used to restore breathing capabilities to someone whose breathing has been interrupted for whatever reason. Because resuscitation has no value in the management of terminal diseases, but is rather intended to return a person in ahealthcrisis to a normal healthy state, CPR, while certainly an extraordinary, live-saving measure, is not a factor in a terminally ill patient. Mechanical ventilation may be ethically removed from a terminally ill patient at their request, just as blood transfusions may be refused by the patient who is terminally ill.

Tony Bland was a victim of the 1989 Hillsborough disaster when football fans were crushed and 95 people died. Tony survived but was in a coma that doctors believed he would never emerge from. (Tony Bland 2006 p. 1). Tony could breathe on his own and all his vital organs functioned normally on his own. He could digestfoodbut could not feed himself, so was put on feeding tubes.

Because we don’t consider food and water “ medicine,” but rather basic necessities to stay alive, the feeding tube for Tony Bland could not be considered “ treatment,” and because Mr. Bland was not actually dying at the time, his food and fluids would have had to be withdrawn in order for him to die. The courts ordered, after four years of Mr. Bland being in a “ permanent vegetative state,” that the fluids and feeding tubes be removed, and he be allowed to die, a process that took nearly two weeks as well as causing the suffering of his family. (Tony Bland 2006 p. 2).

The issue of medical euthanasia is one that will be debated passionately for many years to come, with ethical arguments on both sides.

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