

Active and passive euthanasia research papers example

[Health & Medicine](#), [Euthanasia](#)



Introduction

This research paper considers and evaluates the arguments propounded by Rachels (2002) regarding both active and passive forms of euthanasia. In order to be clear on the precise meanings of those terms, it is appropriate to define them before discussing these topics. The research undertaken for this paper will validate Rachels' views on the issue, which are essentially that there should be no moral or ethical distinction between the two types of euthanasia – basically because in many instances active euthanasia is in fact more humane, because it drastically shortens the duration of the individual's pain and suffering.

Active and Passive Euthanasia Defined

Active euthanasia: This occurs when someone “ directly and deliberately” causes the death of the patient (“ Key terms and definitions” 2014).

Passive euthanasia: Is when the person dies because a necessary treatment or medication is withdrawn, allowing death to follow (“ Key terms and definitions” 2014).

Active and Passive Euthanasia: The Moral Issues

There is a body of opinion that passive euthanasia is from a moral standpoint more acceptable than active euthanasia. Among some medical professionals for example, there is a school of thought that passive euthanasia (e. g. withholding or withdrawing essential treatments or medications) is a way of allowing a patient to achieve their wish to die, without the doctor being concerned with the morality of intentionally killing the individual. However,

there is also the view that there is actually no such distinction, because failing to implement a needed treatment or withholding or withdrawing needed treatments or medicines are in themselves deliberate actions. For example, if a doctor switches off a respirator and the patient dies, although the cause of death can be said to be the underlying disease or chronic condition, the immediate cause of death is the ending of the life support. Effectively then, it can be said that there is no significant moral difference between active and passive euthanasia. In fact, it might be said that active euthanasia is morally superior, because the death is quicker and potentially less painful (“Active and passive euthanasia” 2014). That is also one of the main planks of the arguments propounded by Rachels (2002).

This important moral issue is highlighted in the American Medical Association policy which adheres to the concept that “it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient.” Rachels challenges this concept, referring to it as “unsound.” In his paper he offers convincing arguments in support of his view that in many instances, active euthanasia is actually better for the patient than the passive form. One example is that of a patient who is in the final stages of an incurable throat cancer, is experiencing severe pain, and is expected to succumb to the cancer within a few days. Because the pain is unbearable, he and his immediate family ask the doctor to end his suffering. Suppose the doctor accedes to those requests, and simply withdraws treatment (passive euthanasia). The patient may linger for a few days, meanwhile continuing to suffer the agonies of extreme levels of pain. Instead, the patient could be

given a painless, lethal injection, thereby ending the suffering forthwith (active euthanasia). In this instance, active euthanasia is clearly the best option for the patient, even though it is conflict with the accepted doctrine (Rachels 2002).

The doctrine of acts and omissions is a classic concept in ethics relevant to euthanasia issues. Rachels provides an example in describing the hypothetical actions of two individuals, Smith & Jones. In the first of two scenarios, Smith will inherit a large sum if his cousin aged six years should predecease him. He drowns the child in his bath one evening, arranging the scene to have the appearance of a tragic accident. In the second scenario, Jones watches as the youngster slips, banging his head, and falls face down into the bathwater, and drowns. Jones simply watches, and does nothing to save the child. In these two scenarios, Smith physically murdered the child, whereas Jones merely allowed him to die. So, the question to be asked is whether Smith's behavior was more reprehensible than that of Jones.

Rachels suggests that both men were equally guilty, since the actions of both were based on the motive of personal gain and both wished to see the child dead. In his view, claiming that letting the child die was morally better than actually killing him has no moral merit whatsoever. Furthermore, this same moral judgment should apply to the comparison between active and passive euthanasia. He criticizes the AMA policy statement in that it claims that ceasing or denying treatment does not constitute "the intentional termination of the life of one human being by another." In his view, the purpose of ending or withdrawing treatment is precisely for that purpose – to bring the life of the patient to an end (Rachels 2002).

A Religious Standpoint

In general, the view of the Christian Church is that euthanasia goes against God's will because it is God and only God who gives or takes away life, and no human being should usurp that authority. The Roman Catholic view as quoted by Pope John Paul II in 1995 is that "Euthanasia is a grave violation of the law of God, since it is the deliberate and unacceptable killing of a human person." Furthermore, the church states that no one can be permitted to kill an innocent person, specifically referring to "one suffering from an incurable disease, or a person who is dying." Additionally, the Roman Catholic Church cannot accept the principle that we humans possess a "right to die" ("Euthanasia and assisted dying" 2009). Hence the Church does not differentiate between active and passive euthanasia, so effectively aligns with Rachels' view that the two forms of euthanasia should be considered as morally equal.

Hospices and Euthanasia

According to Nelson (2013), the American Hospice Movement originally founded in Connecticut in 1971 by Florence Wald, operates what Nelson calls a "pro-euthanasia ideology" which may (or perhaps may not) use assisted suicide methods (active euthanasia), while publicly declaring that they will not use any means to hasten death (i. e. adhering only to passive euthanasia principles). As Nelson states, it is difficult for the public to know which methods are followed in any specific hospice (Nelson 2013). However, the public policy position stated by hospices clearly indicates that the hospices are extremely reluctant to admit to practicing active euthanasia, to a large

extent because it is illegal in most states, but also because it is (as Rachels states) considered to be morally and ethically more unacceptable.

Legal Issues

Euthanasia in one form or another is illegal in most countries around the world, including most of the states in the US. In 2002, the Netherlands became the first nation to make euthanasia and assisted suicide legal, although strict conditions were imposed. Those included that the patient must have an incurable illness and be “ suffering unbearable pain.”

Furthermore, the patient must be fully conscious when requesting their life be brought to an end. As a consequence, in 2010, over 3, 000 patients were administered a lethal injection (i. e. active euthanasia). In that country’s hospitals, it has also become common practice to implement a procedure of “ palliative sedation.” Patients having a life expectancy of 14 days or less are placed in a medically-induced coma, while all forms of nutrition are stopped. Note that while this is a form of passive euthanasia, the fact that the patient is placed in a coma means that they are not continuing to experience pain (Cessou et al. 2014).

In France, both euthanasia and assisted suicide are illegal. However, the Léonetti law passed in 2005 legalized the right – under strict conditions – for a patient to be “ left to die.” Doctors can cease treatments that would merely prolong life and to administer pain-killing medications that could – as a side effect – shorten the patient’s life (Cessou et al. 2014). Essentially, the Leonetti law implies that passive euthanasia is acceptable whereas active euthanasia is not. This is the very issue highlighted by Rachels, and the law

does seem somewhat illogical in that it suggests that allowing the patient's life to slowly (and probably painfully) ebb away is preferable to a quick and painless death.

Euthanasia is illegal across the US, but in Oregon, Washington, Vermont, Montana, and New Mexico, doctors are permitted to prescribe or administer medicine in lethal doses to patients who are terminally ill. In all of those five states, mentally competent patients with a terminal illness and a life expectation of less than six months are permitted to request medication to end their life (Cessou et al. 2014). That ruling does seem more logical and more considerate to the suffering patient who wants to bring life to an end. (There is no mention of passive euthanasia in this instance).

Active assisted suicide (a lethal drug prescribed by a doctor) is illegal in both Germany and Switzerland, though the law in both countries allows assisted suicide. In Switzerland, where the law is applied in a more relaxed manner, commercial organizations offering assisted dying facilities are allowed. However, the German authorities want to ban such organizations, even though two-thirds of the population recently indicated support for the introduction of active assisted suicide (Cessou et al. 2014).

Belgium became the second country in the world to legalize euthanasia in 2002. Their law states that doctors can assist patients who wish to die because they are suffering extreme pain, or if they have previously stated that wish before going into a coma or similar condition. Although the method of euthanasia is not stipulated, the doctor must be present at the end, which is not the case in the US "euthanasia" states (Cessou et al. 2014).

Why Euthanasia Should be Legalized

Having described the legal position regarding euthanasia in some countries, it should be noted that there are still many who regard euthanasia as wrong because it is irreversible, perhaps because the patient might conceivably recover or be cured if euthanasia had not been implemented. However, the evidence does not support that view. Because the laws in countries permitting euthanasia are rigorously observed, the reality is that all of those patients would have died anyway, and very soon, too. According to a 1991 Dutch report on euthanasia, a patient's life was typically shortened by anywhere between a few hours and up to a week, because they really were at death's door anyway; recovery was a virtual impossibility. The author describes such recovery as "less likely than winning the lottery and getting struck by lightning in the same afternoon" (Morris 2013).

According to Morris, not only do the public overwhelmingly support the concept of euthanasia, but –he asserts – much of the natural fear of death (accompanied by the probability of severe pain and suffering), would vanish if we could predict how and when we would die. He quotes the well-known author Terry Pratchett – diagnosed with a form of Alzheimer's disease – who is said to have stated:

As I have said, I would like to die peacefully with Thomas Tallis on my iPod before the disease takes me over and I hope that will not be for quite some time to come, because if I knew that I could die at any time I wanted, then suddenly every day would be as precious as a million pounds. If I knew that I could die, I would live. My life, my death, my choice (Morris 2013).

Morris also states that the laws making anyone assisting the suicide of a

loved one subject to criminal proceedings and possibly a custodial sentence are not just illogical but are cruel, too. He quotes the 2014 case in Ireland where the husband of a wife suffering the agony of severe multiple sclerosis was threatened with up to 14 years jail if he were to assist her death. This is just one of a number of similar cases where the law condemns terminally ill patients and their families to unnecessary suffering by prohibiting euthanasia. He also mentions the view of the anti-euthanasia elements in our society that legalizing it will “open the floodgates”, leading to murders by another name. To counter that view, he refers to the situation in the Netherlands, where each year only 1.7 percent of the population asks for euthanasia, and approximately two-thirds of those requests are refused (Morris 2013).

Unsound arguments against legalized euthanasia are made by Angelotti (2014) in the editorial of the Kane County Chronicle (Illinois). She fears that widespread legalization of euthanasia will lead to facilitating suicide for people who do not have a terminal illness. She also asserts that this is not only unethical but goes counter to the Hippocratic Oath sworn by all doctors. Further, she claims that “Respecting the dignity of the human life is at the core of this argument” (Angelotti 2014). In the view of this researcher her arguments are flawed on all three counts. Firstly, the experience of countries like the Netherlands has proven statistically that the floodgates are definitely not opened by the controlled legalization of euthanasia. Secondly, the Hippocratic Oath requires that doctors do not intentionally harm their patients (“Hippocratic Oath, Modern Version” 2010). Whilst euthanasia obviously does harm the patient, it avoids the greater harm of prolonging the

patient's agony followed by inevitable death. The third major flaw in Angelotti's arguments is that she claims that the dignity of human life is paramount, but a patient slowly and painfully dying is by no means dignified, whereas euthanasia gives the patient a more dignified and painless end. A classic example of a patient lacking dignity is that of Tony Nicklinson. He is almost completely paralyzed and can communicate only by blinking or making small head movements. He wants to end his life but is physically unable to do so, and under English law anyone assisting him would be committing a serious crime. The author points out that suicide in England is not illegal, but because Mr Nicklinson cannot manage that on his own, he does not have the same rights as the rest of us (Hope 2012).

Gilbert (2014) makes an impassioned case for legalizing euthanasia in an article published in the Japan Times newspaper. He paints a picture of a loved one, drugged by morphine in their hospital bed, while you, the next of kin, sit helplessly by, awaiting "the final rattle in the throat and the skipped breath." He suggests that in such a situation you might begin to see the merit in assisted suicide, as available through organizations like the Swiss company Dignitas. He notes that although euthanasia is defined by the Oxford Dictionary as "a gentle and easy death", it is still very much a taboo concept for many. As people are tending to live longer and the medical profession is increasingly successful in prolonging life, more and more of the older generation are clinging to life, albeit not necessarily of good quality. In his view, painless suicide should be made available by our governments (Gilbert 2014).

That there should be a qualitative aspect to the expression of a "right to

life” is indeed a valid argument supporting the legalization of euthanasia. Many terminal patients heading towards a painful end experience a very poor quality of life. If death is the only solution to end that situation, then it should be an available option for all (Goodliffe 2011).

Conclusions

It is clear from the research undertaken that the case for legalizing active, voluntary euthanasia is far stronger than the arguments against. It should be a basic human right for a mentally competent but terminally ill patient to opt to end his/her life (with medical assistance and support) rather than prolong a painful progressive deterioration heading inexorably and inevitably towards death. Furthermore, the research has also shown that Rachels is correct in stating that passive euthanasia (withdrawing treatments or medications and life support), is by no means more acceptable, because while that can still give the patient a continuance of life, it is likely to be a very poor quality of life until death comes soon thereafter.

Essentially then, there is no reason to consider active euthanasia as less acceptable or ethically or morally inferior to passive euthanasia. It is even possible that the reverse could be true in many cases.

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