Euthanasia: A Consequentialist Critique of Its Direct and Indirect Results

Euthanasia is a moral hazard. As such, it opens up the possibility of breaches of ethics. Though everyone recognizes that death is an absolute certainty, not many know how to live with a fatal illness. The harsh realities of death are difficult as illnesses may last for a long period of time, and are often accompanied with substantial adversity and financial expense. Death itself is not a choice, however, its timing sometimes is, or can be. Voluntary active euthanasia seems to offer an answer for those persons who conclude that enduring suffering and the associated costs of prolonged dying is not for them. It appears to offer such individuals with the opportunity to have control over what has long seemed uncontrollable. For others, however, the concept of voluntary active euthanasia conjures up fear that the evaluation of what is to be considered excessive suffering or costs will be determined by somebody else. The logical worry for these persons would be that somebody else could seek to eliminate the excessive suffering or costs by eliminating those persons who are perceived to be suffering or costly. Disadvantaged individuals, the elderly, the poor, the disabled, and minorities are at particular vulnerability to this sort of behaviour, which results from a certain inadequacy of health care resources and the attendant constraints on medical decision making (Cohn & Lynn, 2002). As such, these communities would become victims rather than beneficiaries. For physicians, the principal worry is that active euthanasia's legalization would undermine the integrity of the medical profession, an institution that has for thousands of years protected and valued life.

This paper will argue that the direct and indirect results of permitting active voluntary euthanasia are such that it active euthanasia is always morally unjustifiable. Regardless of whether voluntary active euthanasia may or may not be morally justified in itself (a deontological argument which is not discussed in this paper) the social consequences of sanctioning practices of killing would run the serious risk of abuse and misuse causing much more harm than good. From this, it must be concluded that voluntary active euthanasia is certainly morally hazardous and therefore unjustifiable. In short, the slippery slope that arises as a result of sanctioning active euthanasia as a serviceable medical practice is such that the practice is morally pernicious and unacceptable. The argument is not that the negative results will be immediately obvious, but that they will grow incrementally over time. It is important to define two forms of the slippery slope argument. The "logical slippery slope" occurs when the legalization of euthanasia for a very limited group of people in very limited circumstances is expanded to include more people in more situations. This has also been described as "scope creep," or possibly in ethics, the thin edge of the wedge." The "practical slippery slope" occurs when euthanasia is carried out in breach of the legal requirements, either the patient themselves or as to either who may have access or the situations in which they must find themselves for euthanasia to be permissible (Somerville, Euthanasia: it's a long, long way down, 2017) This paper will address the practical slippery slope argument, and is informed by philosophical, legal, and medical issues surrounding the euthanasia debate.

For this argument to be made, some words must be dedicated to the distinction between active euthanasia and passive euthanasia. In short, the view of passive euthanasia that is held by the House of Delegates of the American Medical Association is upheld in this paper.

The intentional termination of the life of one human being by another – mercy killing [or active euthanasia] – is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association…The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family (Rachels, 1975).

In this, it follows that justified withholding or withdrawal of life-support treatment or the provision of fully adequate necessary pain management, even if that could shorten life, are not euthanasia or assisted suicide. Rachels challenges this view, offering the now-famous thought experiment of Smith and Jones to attempt to highlight the notion that killing and letting die are morally equivalent (Rachels, 1975). However, in relation to the euthanasia debate, Rachels' thought experiment is entirely disanalogous. Firstly, euthanasia does not involve the destruction of normal healthy children, so conflating this with the death of terminally ill patients is both rich and presumptive. Additionally, the thought experiment is designed such that both Smith and Jones have serious ulterior motives, namely the inheritance both of them stand to gain from the death of their six-year-old cousin. The presence of this extrinsic motivation renders the thought experiment entirely disanalogous as euthanasia by definition suggests a "good death" (from Greek), and is the practice of intentionally ending a life to relieve pain and suffering. A "good death" would not be possible if those precipitating the killing had ulterior objectives, namely the opportunity for financial gain.

Finally, just to be clear, as there is a great deal of confusion about the definition of euthanasia and physician-assisted suicide, a few words will be employed to this end. Active euthanasia is a doctor administering a substance to a person with the intention of killing the person, and physician-assisted suicide is a doctor prescribing medication with the intention that the person should use it to commit suicide. And as established above, the justified withholding or withdrawal of life-support treatment or the provision of fully adequate necessary pain management (considered passive euthanasia) even if that could shorten life, are not active euthanasia or assisted suicide (Donnelly, 2018).

One consequence of making active euthanasia legally permissible is the fact that permitting physicians to perform euthanasia would be incompatible with the professions fundamental moral and professional commitment as healers to care for patients and to protect life (Brock, 2014). This position was clearly stated in a paper by Willard Gaylin:

The very soul of medicine is on trial. This issue touches medicine at its moral centre; if this moral centre collapses, if physicians become killers or are even licensed to kill, the profession – and, therewith, each physician – will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty (Gaylin, 1998).

Actively ending a human life is something that has long been reserved for those who commit suicide, murderers, and members of the armed forces. To conflate the primary duty of a physician with this sort of behaviour is unconscionable in the deepest sense of the word, and does indeed undermine the moral centre of medicine. Written in 5th century B.C., the Hippocratic Oath remains one of the iconic medical touchstone in establishing the basis of the duty of care for the physician. The document provided the following emblematic statement: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this

effect” (Boudreau & Somerville, 2013). This paradigm has oriented medical practice towards specific ends and means and away from certain others for the last 2400 years. Traditionally, physicians who were found to have intentionally shortened the lives of dying patients risked losing their communities trust. This trust is of paramount importance to a successful doctor–patient relationship and is indispensable to the historically valued implicit moral contract between the profession and society (Cruess & Cruess, 2008). Preserving the trust of individual patients and of society is a requisite for the maintenance of professional medical status. Participating in euthanasia carries the risk of vitiating this earned trustworthiness, and therefore ‘Do not kill’ has been considered a moral absolute for most physicians for millennia. This remains the case for physicians even in jurisdictions where the public has looked favourably on legislative change.

The notion that medicine has nothing to do with the purposeful ending of life and everything to do with healing has been an imperative throughout history (Boudreau & Somerville, 2013). It is also useful to point out that the word ‘doctor’ is linked to ‘teacher’. The Oxford English dictionary's definition is: ‘one who gives instruction in some branch of knowledge, or inculcates opinions or principles’ (English Dictionary, 2012). Medical doctors can influence public opinion, much as teachers contribute to the socialization of their pupils. The recruitment of doctors to undertake a procedure, both collectively and as individuals, can greatly modify the public's view of that procedure. Changing this ancient paradigm would be to disregard over two and a half thousand years of human existence, and would prove morally hazardous to society and to the medical profession which has been sought after to perform active euthanasia.

One strong case for legalizing active euthanasia is the killing of individual competent adults who want and request this. In debating as a society whether to legalize active euthanasia, we must consider wider issues, looking beyond what an individual might desire. Some considerations must be made including the impact of euthanasia on fragile or vulnerable people: those who are old or live with disabilities, or even just perceive themselves as a burden on their families; the impact on suicide prevention of the normalization of suicide as an acceptable response to suffering; and what it means for society and our shared values to move from caring for those unable to care for themselves to killing them. What would be the impact on important values, such as respect for human life, in general, in society? Respect for life must be upheld at both the individual and the general societal level. According to the practical or empirical slippery slope arguments, there is good evidence to believe that the legislation of morally permissible acts of euthanasia would in fact lead to the performance of morally impermissible acts of euthanasia (Lillehammer, 2002). Particularly, the practice of voluntary euthanasia would lead to non-voluntary or involuntary euthanasia, where at least involuntary active euthanasia is morally impermissible. Morally permissible acts of euthanasia should therefore not be legalized. Evidence from the two countries with the longest history of legalized active euthanasia, the Netherlands and Belgium, points to the notion that there are serious practical slippery slopes in active euthanasia’s legalization (Somerville, 2017). Margaret Somerville, professor of Education and the Director of the Centre for Educational Research in the School of Education University of Western Sydney and Professor of Bioethics in the School of Medicine at the University of Notre Dame Australia, has written extensively on the topic of euthanasia and is a trusted voice in the international debate. In an ABC article of 2017, Somerville outlined a horrific account from the Netherlands.

Last month, a Dutch Regional Euthanasia Review Committee reported on a case brought before it. The woman patient had dementia. A woman doctor put a sedative in her coffee as a

prelude to euthanizing her without telling her of the sedative or her plans for euthanasia, the doctor said 'because she did not want to cause her [patient] extra distress.' In deciding to euthanize her patient, the doctor was relying on a phrase in the patient's declaration in her will that 'when I myself find it the right time' she could consider euthanasia.

While being injected with the lethal drug, the woman woke up. She struggled and the only way the doctor could continue with the injection was by asking the woman's family to help to restrain her, while she continued with the injection. The woman's case notes recorded that she had said several times in the previous days, 'I don't want to die.'

The review committee concluded that the doctor 'had crossed the line' by secretly giving the sedative and not stopping the injection when the woman resisted and had too broadly interpreted the woman's declaration, but that the doctor had acted in 'good faith' and should not be punished. (Somerville, ABC Religion & Ethics, 2017)

Much can be learned from this story about euthanasia's potential to be wrongfully employed, and the practical slippery slope is clearly evident. The first question that comes to mind is 'how could a doctor ever carry out such an obvious breach of the medical code with such disastrous results?' Unhappily, this is the same question that has been pondered many times in relation to the Nazi doctors as Somerville points out (Somerville, ABC Religion & Ethics, 2017) Could it be a result of a process of incremental desensitization of the doctor to what is involved - namely, killing her patient? This question warrants serious thought in the euthanasia discussion.

Some philosophers have suggested that there is a distinct lack of evidence suggesting that a slippery slope actually exists. Professor of Medical Ethics in the Department of Global Health and Social Medicine, Dan W. Brock submitted that, "Opponents of voluntary euthanasia on slippery slope grounds have not provided the data or evidence necessary to turn their speculative concerns into well-grounded likelihoods" (Brock, 2014). This suggestion, however, clearly misses a key concept in the debate. Regardless of whether there are numerically significant accounts of this descent into non-voluntary and involuntary euthanasia, something well outlined in the account above, any small shred of evidence that points to the killing of human beings against their will is enough to conclude that active voluntary euthanasia should not be legalized. Even if we believe that euthanasia is not inherently wrong, its requisite risks and harms to vulnerable people especially the elderly and the fragile and the disabled – far outweigh any benefits.

This essay has discussed both the certain deterioration of the medical profession, and the practical slippery slope, both resultant from the legalization of active euthanasia. In pondering the moral permissibility of active euthanasia, it is paramount that the discussion is rooted in those aspects of the medical mandate that are eternally relevant. The medical profession believes these to be the constant nature of 'illness', changeless across time, place and culture, and the resultant obligations of the healer. It is appropriate to appreciate how illness effects people in all stages of life, and that patients become vulnerable, impatient, and open to abuse. Pellegrino summarized this beautifully the nature of the clinical encounter: "a peculiar constellation of urgency, intimacy, unavoidability, unpredictability and extraordinary vulnerability within which trust must be given" (Pellegrino ED, 1991). Crossing the line in the sand articulated by Hippocrates, that as a physician 'I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect', would result in the 'doctor as healer' becoming the 'doctor as executioner'. In short, healing and euthanizing are simply not

congruous and euthanasia can never be considered ‘medical treatment’.

The practical slippery slope evident as a result of legalizing active euthanasia is more than just conjecture and poses a serious counter to the pro-euthanasia example. It is quite evident from the account of the Dutch physician that the practical slippery slope is a dangerous result of legalizing active euthanasia as the eventual practical application of this may deteriorate into non-voluntary and finally involuntary euthanasia. Nobody is suggesting this will happen overnight, nor that there are significantly significant numbers of victims to these sorts of crime. However, what is important is that if there is even the slightest possibility of active voluntary euthanasia lapsing into involuntary euthanasia, the legalizing the practice of voluntary euthanasia would be morally unjustifiable. Euthanasia is a controversial issue, and for good reason as much is at stake in this debate. It would be warranted to take a step back and consider the social, practical, and eventual moral implications of legalizing such a practice. In exploring these implications only one result can be drawn: active euthanasia’s legalization would undermine the medical profession as a healing institution and would lead to eventual misuse and abuse where innocent patients are euthanized against their will.

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