CMDFA Medical ethics
Medicine and end-of-life care

1) **The issue's prominence and its importance**
   a) Recent media treatment in Australia and assisted dying legislation in Victoria and the UK
   b) Euthanasia and physician assisted suicide in Europe and North America
   c) Relevant distinctions: physician assisted suicide; euthanasia—voluntary, non-voluntary, involuntary; palliative care; refusal, withholding and withdrawal of life-prolonging therapy
      i) **Euthanasia:** the intentional bringing about or hastening of death (by act or omission) in order to relieve a person's suffering. It may be voluntary, involuntary or non-voluntary
      ii) **Physician assisted suicide:** provision by a doctor of drugs (or other means) for self-administration, at that person's voluntary and competent request.
      iii) **Withdrawal of life prolonging therapy:** the withdrawal (or withholding) of life prolonging or burdensome therapy from a dying patient in order to avoid needless suffering.
      iv) **Palliative care:** specialised care for the dying that: affirms life; regards dying as a normal process; neither hastens nor postpones death; provides symptom relief; offers support for active living; offers support to help families cope. (note the morphine myth: morphine and sedatives in *therapeutic* doses do not shorten life).
   d) The personal dimension.

2) **Arguments for euthanasia**
   a) The primary argument: **autonomy**.
      i) The principle of autonomy states that each individual has the right to conduct their own affairs and make whichever choices they see fit, so long as this does not impinge on another person's exercise of their own rights. This entails a right to die: for any limitation of my decision to end my life is an imposition of another person's will on my right to determine the manner and timing of my death.
      ii) Singer presents a *preference utilitarian* variant of this argument using the satisfaction (and not thwarting) of a person's rational preference to die rather than to live. The structure of the argument is the same, although he does not believe in rights or principles, *per se*.

   b) Secondary arguments: killing is (morally) the same as letting die; compassion; quality vs quantity of life; utility or benefit.
      i) There is no relevant ethical distinction between killing (euthanasia) and letting die (withdrawal of therapy and provision of palliative care): death is the end in each case, there is no relevant difference in the nature of the acts themselves, and death is envisaged, or even willed, as the end in both cases; thus they are equivalent ethically.
      ii) Euthanasia is compassionate: suffering is only tolerable if it is in the service of a greater good; for terminally ill people there is no such good; thus suffering should be terminated, by death, if necessary.
      iii) Voluntary euthanasia upholds the importance of *quality* of life versus its mere continuance.
      iv) The benefits of euthanasia outweigh its drawbacks: it will alleviate suffering, promote autonomy, save the community wasted resources, and allay the fears of many elderly and dying people that their deaths will be undignified and attended by pointless suffering.

   c) Countering the arguments

3) **Arguments against euthanasia**
   a) The primary argument: **the sanctity (or value) of human life.**
      i) A theistic version: Life is God's gift, and it is God's prerogative alone to give or withhold it. To deliberately take my own life, or that of another innocent human being, is to despise God's gift, and violate the sanctity of human life.
      ii) A secular version: Humans are invested with irreducible dignity which suffering does not erase. To deliberately take my own life, or that of another innocent human being, is to violate the irreducible dignity of human life.

b) Secondary arguments: euthanasia is (morally) distinct from allowing someone to die; problems with (articulations of) the principle of autonomy; compassion; utility or benefit
   i) There is a relevant distinction between euthanasia and the withdrawal or withholding of life-prolonging therapy, which means that the latter is justified in some circumstances, even though the person's life may be shortened as a result, whereas the former is not. This may be based on the distinction between killing and letting die; the doctrine of double effect; or the difference between the ethical status of 'ordinary' ('proportionate') versus 'extraordinary' ('disproportionate') therapy.
   ii) Individualistic, 'atomistic' notions of autonomy are philosophically flawed and theologically unacceptable.
   iii) Compassion is a motive for action, it cannot determine its content—it motivates us to act in another's best interests; it does not tell us what those interests are.
   iv) Implementing euthanasia is likely to have harmful consequences, especially for the weak and vulnerable.

4) Biblical and theological resources

a) Texts
   i) Genesis 1:26-31 (& 9:5-6)
   ii) Exod 20:13
   iii) Matt 22:34-40 and Luke 10:29-37
   iv) 1 Cor 15:26, 55-57 (and Rev 21:4)

b) Theological principles
   i) Shalom, life, death and health care
   ii) Human life is to be valued as God's gift
   iii) Human *bodily* existence is a relative, not an absolute good
   iv) Suffering and death are relative, not absolute evils

5) Another line of argument (with a familiar conclusion)

a) The importance of 'worldview' in arguments for and against euthanasia: (theological) anthropology, community and the role of medicine.

b) The nature of medicine: caring for this frail flesh.
   i) Vulnerability and frailty are inescapable.
   ii) Medicine exists to care for vulnerable human beings, whether they will be 'cured' or not.
   iii) Euthanasia would illegitimately distort the (inherently moral) character of medicine in ways that other responses to suffering and dying would not.

Further reading

Theology of medicine:

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Paul Ramsey, *Ethics at the Edges of Life*, New Haven: Yale University Press, 1978, 145-188;

Robert Wennberg, *Terminal Choices*, Grand Rapids, Eerdmans, 1989

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