

## **An Alternative to the Ethic of Euthanasia**

***Arthur J. Dyck***

In this selection, Arthur J. Dyck raises an array of objections to euthanasia, arguing that it is inherently wrong for people to kill themselves and that euthanasia is a dangerous social policy. Responding to those who defend euthanasia on grounds of compassion and autonomy, Dyck proposes another approach, which he terms "benemortasia," or good death. Professor Dyck is a Professor of Ethics at Harvard Divinity School.

The arguments for euthanasia focus upon two humane and significant concerns: compassion for those who are painfully and terminally ill, and concern for the human dignity associated with freedom of choice. Compassion and freedom are values that sustain and enhance the common good. The question here, however, is how these values affect our behavior toward the dying.

The argument for compassion usually occurs in the form of attacking the inhumanity of keeping

dying people alive when they are in great pain or when they have lost almost all of their usual functions, particularly when they have lost the ability or will to communicate with others. . . . The argument for compassion is supplemented by an argument for greater freedom for a patient to choose how and when he or she will die. For one thing, the patient should not be subjected to medical treatment to which that patient does not consent. Those who argue for voluntary euthanasia extend this notion

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by arguing that the choice to withhold techniques that would prolong life is a choice to shorten life. Hence, if one can choose to shorten one's life, why cannot one ask a physician by a simple and direct act of intervention to put an end to one's life? Here it is often argued that physicians already curtail life by means of pain-killing drugs, which in the doses administered will hasten death. Why should not the law recognize and sanction a simple and direct hastening of death, should the patient wish it?

How do the proponents of euthanasia view the general prohibition against killing? First of all, they maintain that we are dealing here with people who will surely die regardless of the intervention of medicine. They advocate the termination of suffering and the lawful foreshortening of the dying process. Secondly, although the patient is committing suicide, and the physician is an accomplice in such a suicide, both acts are morally justifiable to cut short the suffering of one who is dying.

It is important to be very clear about the precise moral reasoning by which advocates of voluntary euthanasia justify suicide and assisting a suicide. They make no moral distinction between those instances when a patient or a physician chooses to have life shortened by failing to accept or use life-prolonging techniques and those instances when a patient or a physician shortens life by employing a death-dealing chemical or instrument. They make no moral distinction between a drug given to kill pain, which also shortens life, and a substance given precisely to shorten life and for no other reason. Presumably these distinctions are not honored, because regardless of the stratagem employed—regardless of whether one is permitting to die or killing directly—the result is the same; the patient's life is shortened. Hence, it is maintained that if you can justify one kind of act that shortens the life of the dying, you can justify any act that shortens the life of the dying when this act is seen to be willed by the one who is dying. Moral reasoning of this sort is strictly utilitarian; it focuses solely on the consequences of acts, not on their intent. . . .

Because of this loss of a merely descriptive term for a happy death, it is necessary to invent a term for a happy or good death—namely, *benemortasia*. The familiar derivatives for this new term are *bene* (good) and *mors* (death). . . . An ethic of *benemortasia* does

not stand in opposition to the values of compassion and human freedom. It differs, however, from the ethic of euthanasia in its understanding of how these values are best realized. In particular, certain constraints upon human freedom are recognized and emphasized as enabling human beings to increase compassion and freedom rather than diminish them. . . .

Our ethic of *benemortasia* acknowledges the freedom of patients who are incurably ill to refuse interventions that prolong dying and the freedom of physicians to honor such wishes. However, these actions are not acts of suicide and assisting in suicide. In our ethic of *benemortasia*, suicide and assisting in suicide are unjustifiable acts of killing. Unlike the ethic of those who would legalize voluntary euthanasia, our ethic makes a moral distinction between acts that permit death and acts that cause death. . . . From the point of view of the dying person, when could his or her decisions be called a deliberate act to end life, the act we usually designate as suicide? Only, it seems to me, when the dying person commits an act that has the immediate intent of ending life and has no other purpose. That act may be to use, or ask the physician to use, a chemical or an instrument that has no other immediate effect than to end the dying person's life. If, for the sake of relieving pain, a dying person chooses drugs administered in potent doses, the intent of this act is not to shorten life, even though it has that effect. It is a choice as to how to live while dying. Similarly, if a patient chooses to forgo medical interventions that would have the effect of prolonging his or her life without in any way promising release from death, this also is a choice as to what is the most meaningful way to spend the remainder of life, however short that may be. The choice to use drugs to relieve pain and the choice not to use medical measures that cannot promise a cure for one's dying are no different in principle from the choices we make throughout our lives as to how much we will rest, how hard we will work, how little and how much medical intervention we will seek or tolerate, and the like. For society or physicians to map out lifestyles for individuals with respect to such decisions is surely beyond anything that we find in Stoic, Jewish, or Christian ethics. Such intervention in the liberty of individuals is far beyond what is required in any society whose rules are intended to constrain people against harming others.

But human freedom should not be extended to include the taking of one's own life. Causing one's own death cannot generally be justified, even when one is dying. To see why this is so, we have to consider how causing one's death does violence to one's self and harms others.

The person who causes his or her own death repudiates the meaningfulness and worth of his or her own life. To decide to initiate an act that has as its primary purpose to end one's life is to decide that that life has no worth to anyone, especially to oneself. It is an act that ends all choices regarding what one's life and whatever is left of it is to symbolize.

Suicide is the ultimately effective way of shutting out all other people from one's life. Psychologists have observed how hostility for others can be expressed through taking one's own life. People who might want access to the dying one to make restitution, offer reparation, bestow last kindnesses, or clarify misunderstandings are cut off by such an act. Every kind of potentially and actually meaningful contact and relation among persons is irrevocably severed except by means of memories and whatever life beyond death may offer. Certainly for those who are left behind by death, there can remain many years of suffering occasioned by that death. The sequence of dying an inevitable death can be much better accepted than the decision on the part of a dying one that he or she has no worth to anyone. An act that presupposes that final declaration leaves tragic overtones for anyone who participated in even the smallest way in that person's dying.

But the problem is even greater. If in principle a person can take his or her own life whenever he or she no longer finds it meaningful, there is nothing in principle that prevents anyone from taking his or her life, no matter what the circumstances. For it the decision hinges on whether one regards his or her own life as meaningful, anyone can regard his or her own life as meaningless even under circumstances that would appear to be most fortunate and opportune for an abundant life.

What about those who would commit suicide or request euthanasia in order to cease being a "burden" on those who are providing care for them? If it is a choice to accept death by refusing noncurative care that prolongs dying, the freedom to embrace death or give one's life in this way is honored by our ethic of benemortasia. What is rejected

is the freedom to cause death whether by suicide or by assisting in one.

How a person dies has a definite meaning for those to whom that person is related. In the first year of bereavement, the rate of death among bereaved relatives of those who die in hospitals is twice that of bereaved relatives of those who die at home; sudden deaths away from hospital and home increase the death rate of the bereaved even more.

The courage to be, as expressed in Christian and Jewish thought, is more than the overcoming of the fear of death, although it includes that Stoic dimension. It is the courage to accept one's own life as having worth no matter what life may bring, including the threat of death, because that life remains meaningful and is regarded as worthy by God, regardless of what that life may be like. . . . The courage to be as a part recognizes that one is not merely one's own, that one's life is a gift bestowed and protected by the human community and by the ultimate forces that make up the cycle of birth and death. In the cycle of birth and death, there may be suffering, as there is joy, but suffering does not render a life meaningless or worthless. Suffering people need the support of others; suffering people should not be encouraged to commit suicide by their community, or that community ceases to be a community.

This consideration brings us to a further difficulty with voluntary euthanasia and its legalization. Not only does euthanasia involve suicide but also, if legalized, it sanctions assistance in suicide by physicians. Legislation like the Voluntary Euthanasia Act of 1969 makes it a duty of the medical profession to take someone else's life for him. Here the principle not to kill is even further eroded and violated by giving the physician the power and the encouragement to decide that someone else's life is no longer worth living. The whole notion that a physician can engage in euthanasia implies acceptance of the principle that another person's life is no longer meaningful enough to sustain, a principle that does not afford protection for the lives of any of the most defenseless, voiceless, or otherwise dependent members of a community. Everyone in a community is potentially a victim of such a principle, particularly among members of racial minorities, the very young, and the very old.

Those who would argue that these consequences of a policy of voluntary euthanasia cannot be predicted fail to see two things: that we have already had

an opportunity to observe what happens when the principle that sanctions euthanasia is accepted by a society; and that regardless of what the consequences may be of such acts, the acts themselves are wrong in principle.

With respect to the first point, Leo Alexander's (1949) very careful analysis of medical practices and attitudes of German physicians before and during the reign of Nazism in Germany should serve as a definite warning against the consequences of making euthanasia a public policy. He notes that the outlook of German physicians that led to their cooperation in what became a policy of mass murders

started with the acceptance of that attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to include the socially unproductive, the racially unwanted, and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick.

Those who reject out of hand any comparison of what happened in Nazi Germany with what we can expect here in the United States should consider current examples of medical practice in this nation. The treatment of mongoloids is a case in point. Now that the notion is gaining acceptance that a fetus diagnosed in the womb as mongoloid can, at the discretion of a couple or the pregnant woman, be justifiably aborted, instances of infanticide in hospitals are being reported. At Johns Hopkins Hospital, for example, an allegedly mongoloid infant whose parents would not permit an operation that is generally successful in securing normal physical health and development, was ordered to have "nothing by mouth," condemning that infant to a death that took fifteen days. . . .

Someone may argue that the mongoloid was permitted to die, not killed. But this is faulty reasoning. In the case of an infant whose future life and happiness could be reasonably assured through surgery, we are not dealing with someone who is dying and with intervention that has no curative effect. The fact that some physicians refer to this as

a case of permitting to die is an ominous portent of the dangers inherent in accepting the principle that a physician or another party can decide for a patient that his or her life is not worth living. Equally ominous is the assumption that this principle, once accepted, can easily be limited to cases of patients for whom no curative intervention is known to exist. . . .

The hesitation to commit suicide and the ambivalence of the dying about their worth should give one pause before one signs a declaration that empowers a physician to decide that at some point one can no longer be trusted as competent to judge whether or not one wants to die. Physicians are also frail humans, and mistaken diagnoses, research interests, and sometimes errors of judgment that stem from a desire for organs are part of the practice of medicine.

Comatose patients pose special problems for an ethic of benemortasia, as they do for the advocates of voluntary euthanasia. Where patients are judged to be irreversibly comatose and where sustained efforts have been made to restore such persons to consciousness, no clear case can be made for permitting to die, even though it seems merciful to do so. It seems that the best we can do is to develop some rough social and medical consensus about a reasonable length of time for keeping "alive" a person's organ systems after "brain death" has been decided. Because of the pressures to do research and to transplant organs, it may also be necessary to employ special patient advocates who are not physicians and nurses. These patient advocates, trained in medical ethics, would function as ombudsmen.

In summary, even if the practice of euthanasia were to be confined to those who voluntarily request an end to their lives, no physician could in good conscience participate in such an act. To decide directly to cause the death of a patient is to abandon a cardinal principle of medical practice—namely, to do no harm to one's patient. The relief of suffering, which is surely a time-honored role for the physician, does not extend to an act that presupposes that the life of a patient who is suffering is not worthy to be lived. As we have argued, not even the patient who is dying can justifiably and unilaterally universalize the principle by which a dying life would be declared to be worthless.

### REVIEW AND DISCUSSION QUESTIONS

1. Describe the practical difficulties and dangers that Dyck envisions with policies allowing euthanasia. Are there other problems associated with euthanasia policies that would have to be dealt with? Do you think that Dyck is right to believe these problems are severe enough to reject euthanasia?
2. Explain Dyck's argument that euthanasia is wrong because it involves suicide. What does he think is wrong with suicide?
3. Most people feel better about euthanasia if there is informed consent from the person to be killed or allowed to die. What problems are there in being sure that the consent is truly voluntary? Truly informed?
4. Does suicide "repudiate the meaningfulness and worth of life"? Why or why not?
5. Do you agree that the distinction between causing and permitting death is important? Explain.
6. Is self-sacrifice (falling on a grenade to save a comrade, for example) suicide in Dyck's view? If not, then why is taking a pain-killing drug that leads to death also not suicide, assuming it is equally clear in both cases that the person will die?