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Can it ever be morally appropriate for a physician to treat a patient professionally by inducing a lethal agent into his or her body? Or, to put that question generally, can the direct and immediate termination of a patient's life ever be a morally appropriate mode of treatment in the practice of medicine? The professional oaths, declarations, and official statements made throughout the long history of medicine indicate that the consistent public response of many physicians to the question has been negative.[1] The Hippocratic Oath, for example, states rather explicitly that the physician will not give a deadly drug to any patient.[2] A similar statement on this point was made recently by the House of Delegates of the American Medical Association.

> The intentional termination of the life of one human being by another — mercy killing — is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

One of the most significant reasons for the long-standing opposition of the medical profession to patient termination would seem to be the apparent incompatibility between its humane goals and any kind of treatment which directly causes death. Preserving health and combatting or controlling disease have always been included among those goals, but death is the ultimate term of a diseased and unhealthy state. Thus, it appears that a physician would be acting contrary to the interests of his profession were he to induce a lethal agent into a patient's body.

Yet, despite the unambiguous public stance of the medical profession on patient termination, the question raised about it at the beginning of this paper is currently a concern in medical ethics because of the interest that has developed in recent years, particularly among

some specialists in that field, in having active euthanasia listed among the morally appropriate forms of patient treatment.[3] These ethicists admit that preservation of health and control of disease are proper professional goals of medicine, but they deny that any incompatibility *necessarily* exists between these goals and a physician's act of injecting a lethal agent into a patient's body. Two principal arguments have been advanced in recent philosophical literature to support this contention. In the first of these to be considered in the paper, the argument develops by showing the lack of a moral distinction between withholding or withdrawing life support or terminal disease-controlling therapy from a patient, thereby allowing the patient to die, and actively putting a patient to death. Based upon the lack of this distinction and the admission generally made by the medical profession, as well as by the public community, that it is moral at times for a physician to withhold or withdraw life support or terminal disease-controlling therapy for humane reasons, the argument then concludes that it can also be morally appropriate for a physician to terminate the life of a patient in this sort of context, if humane reasons exist to warrant the termination.

> The bare difference between killing and letting die does not, in itself, make a moral difference. If a doctor lets a patient die, for humane reasons, he is in the same position as if he had given a patient a lethal injection for humane reasons. If his decision was wrong — if, for example the patient's illness was in fact curable — his decision would be equally regrettable no matter what method was used to carry it out. And if the doctor's decision was the right one, the method used in itself is not important.[4]

The argument of James Rachel is, I believe, generally recognized to be the strongest defense for the position made thus far. The core of Rachel's argument consists in an illustration of the apparent lack of any significant moral distinction between "allowing a person to die" and "putting a person to death" in two similar cases.[5] In the first case it is stipulated that Smith will gain a large inheritance if his six year old nephew dies. To facilitate that end, Smith drowns the child while the latter is taking a bath, and arranges to make what happened look like an accident. In the second case it is stipulated that Jones will gain a large inheritance if his six year old nephew dies. To facilitate that end, Jones intends to drown the child during the latter's bath. When about to carry out his plan, however, Jones finds that his nephew has slipped, hit his head on the bathtub, and is already in the process of drowning. The child, then drowns "accidentally" as Jones watches and does nothing. In reference to these cases Rachel's argument offers the following analysis to support his contention that no morally significant distinction exists between "allowing to die" and "putting to death."

> Now Smith killed the child, whereas Jones 'merely' let the child die. That is the only difference between them. Did either man behave better, from a moral point of view? If the difference between killing and letting die were in itself a morally important matter, one should say that Jones' behavior was less reprehensible than Smith's. But does one really want to say that? I think not.[6]

Rachel's argument, however, involves some serious problems. Although his cases show that any morally significant distinction between "allowing to die" and "putting to death" is not *apparent* in those situations where the pertinent agent is as guilty for not saving a victim whose death he intends, as he would have been for killing the victim outright, the illustration shows no more than that. The apparent lack of distinction in the two cases also might be explained, for example, by one's overall perception of the following facts in the cases rather than by any real lack of moral significance between the omission and the commission: the same intention of the agent to kill the victim in each case, the same end result in each case — death, and a clear and significant moral failure in each case — a failure in justice in the killing case and failure in beneficence in the "not saving" case. Secondly, Rachel's cases really tell nothing about what moral significance between "allowing to die" and "putting to death" might be revealed in the context where the physician is acting morally in allowing his patient to die. In this context the physician is without moral guilt in letting his patient die, but in Rachel's illustration Jones is morally guilty for not saving the child from drowning. The fact that Jones was as guilty for not saving his nephew as he would have been had he actually killed him tells us nothing about how the direct termination of life is going to contrast with "allowing to die" in a medical context wherein the latter is clearly morally permissible. And, as indicated by Tom Beauchamp,[8] a moral distinction between omission and commission may well be shown from this context, since any direct termination of life there removes all possibility of life for the patient, but withholding or withdrawing life support or terminal disease controlling therapy need not do this, as the Karen Quinlan case clearly shows.

Basis of Second Argument

The second of the arguments advanced to justify the inclusion of patient termination in patient treatment is based upon the nature and function of the therapy used to serve the other goals of medicine in addition to those of preserving health and controlling disease, namely the goals of alleviating a patient's pain and comforting his suffering. The signers of "A Plan for Beneficent Euthanasia,"[9] for example, point out that a physician taking the Hippocratic Oath is committed both to the treatment and cure of disease and to the relief of suffering, and that the physician's primary concern in the terminal stages of incurable illness should be the relief of suffering. Thus they contend

that it is cruel and barbarous to require that a person be kept alive against his will and to deny his pleas for merciful release after the dignity, beauty, promise, and memory of life have vanished, and the individual is left to linger on in stages of agony or decay.

As already noted, there is general agreement among ordinary citizens as well as medical professionals that patients can and do exist in contexts where initiating or continuing life support or terminal disease controlling therapy will be of no benefit, and may even be harmful. Unambiguous contexts of this type, for example, might be those wherein a patient's capacity to continue developing his personal history, or to begin to develop it as in the case of infants, is virtually rendered permanently impotent by the disease or illness,[10] or possibly by the medication necessary for controlling it. It seems clear that the goals of medicine to preserve health and control disease can no longer be effectively achieved in these cases. Thus, the only professional and moral obligation a physician can possibly have in attending to this kind of patient is to comfort the patient in his suffering and attempt to alleviate his pain, i.e., the physician's only moral obligation is to administer a "caring therapy." The question pertinent to the paper which arises here, then, is this: could a physician morally fulfill his professional responsibility to care for a terminally ill patient for whom health-preserving or disease-controlling therapy is no longer warranted by inducing a lethal agent into that patient's body? I can find no good logical reason for denying that it could be morally appropriate for a physician to give a lethal drug dosage to a patient of the type we have been discussing if the following conditions are present in the patient's context: 1) the dosage to be administered is necessary for alleviating intolerable and irreversible pain, 2) administering it is compatible with the ordinary medical procedures for pain-alleviating therapy (e.g., the drug administered is a pain-killing drug), 3) the patient concurs, explicitly or clearly by implication, to the procedure. Termination made under these conditions would simultaneously serve medicine's desirable goal of pain-alleviation in a way consistent with normal medical procedures for alleviating pain. Furthermore, termination under these conditions cannot possibly violate medicine's goals of controlling disease and preserving health, since these goals cannot be achieved within the context of the patient in question.

Absolute objections to any inclusion of patient termination in patient treatment, including the rather limited one just suggested, have been made most often from theological arguments and the empirical form of the wedge argument. These theological arguments generally contend that the direct killing of a patient for any reason would necessarily cause the physician to violate a fundamental relation existing between God and man, in which God alone is understood to have absolute dominion over innocent human life.[12] The empirical form of the wedge argument generally supports a utilitarian type thesis: any

inclusion of patient termination in patient treatment would cause society to weaken its general moral defense against killing and ultimately have the undesirable consequence of encouraging and permitting termination in all sorts of unwarranted cases.

> If, for example, rules permitting active killing were introduced, it is not implausible to suppose that destroying defective unborns (a form of involuntary euthanasia) would become a common and accepted practice, that as population increases occur the aged will even be more neglectable and neglected than they are now, that capital punishment for a wide variety of crimes would be increasingly tempting, that some doctors would have appreciably reduced fears of injecting fatal doses whenever it seemed propitious to do so, and that the laws or war against killing would erode in efficacy even beyond their already abysmal level. [13]

Insofar as the objection to any direct killing in a theological argument is defended by a line of reasoning which rests ultimately on a religious faith belief, as frequently occurs, little damage is done to the argument for patient termination made above. A theological claim of this sort may be required of physicians who share the pertinent faith belief, but it is not, nor should one expect it to be, a compelling claim for any reasonable physician who simply takes morality seriously. Furthermore, in regard to the type of theological objection to direct termination which rests on purely philosophical argumentation, the history of philosophy shows rather clearly the difficulty one encounters in attempting to delineate through reason alone the precise relationship which obtains between human creatures and their Creator. To my knowledge, no compelling philosophical argument of this kind has been developed that any reasonable physician could be expected to accept (i.e., who, in not accepting the argument, would necessarily be either stupid or ill-willed).

Turning now to the empirical form of the wedge argument, one difficulty with it is that its objections to any patient termination often lack sufficient empirical evidence to be convincing. The horrendous genocide resulting from the national euthanasia policy of Nazi Germany is, for example, the most significant piece of empirical evidence many recent wedge arguments use in making their objection; but does that evidence really indicate what unwarranted liberties with human life a physician functioning in a civilized society would take, if it were admitted that the termination of a patient's life in the process of pain-alleviating therapy could be morally permissible?

Difficulty with Wedge Objections

A second and related difficulty with wedge argument objections is that they are often based, at least partially, upon gratuitous assumptions about how the perverse tendencies in human beings will become unleashed if patient termination is considered moral. In defending his objection Joseph Sullivan, for example, states that "once the respect

for human life is so low that an innocent person may be killed directly even at his own request, compulsory euthanasia will necessarily be very near."[14] The text from Tom Beauchamp's study cited previously in the paper is also full of gratuitous assumptions of this kind. The critical issue here then is why anyone inclined to favor the inclusion of patient termination in patient treatment should take seriously any objections to that leaning based upon gratuitous assumptions. Moreover, are there really any substantive reasons for believing that physicians would unjustly kill their patients, were patient termination deemed morally acceptable in the process of pain-alleviating therapy, any more than they currently unjustly withhold life support or disease-controlling treatment from their patients? No doubt some injustice exists in current practices of withholding and withdrawing, especially in cases involving infants, but few people advocate correcting this abuse by eliminating the permissibility of withholding and withdrawing in patient treatment. Even if it is true, as some ethicians suggest,[15] that no form of patient termination should be sanctioned at this time, either in law or in professional medical codes of ethics, because of the possible harm that might result, it does not deny the theoretical point established previously: a physician could be acting morally in inducing a lethal agent into a terminally ill patient's body during the process of caring therapy, when that is the only form of patient treatment warranted in the context.[16] Nevertheless, this theoretical point may in itself have little practical relevance for patient treatment. Medical institutions dedicated to serving terminally ill patients, such as the famous St. Christopher's Hospice in London, England, seem to be able to administer caring therapy to their dying patients in a satisfactory manner without being required to terminate their lives. In fact, Cicely Saunders, an internationally respected physician and director of St. Christopher's, reports that "in treating patients much pain can be relieved without resorting to analgesics at all."[17]

Yet, if the argument for patient termination in the context of pain-alleviating therapy is theoretically substantive, it does raise the interesting query of whether justification for patient termination in patient treatment can be made in contexts other than the one involving pain-alleviating therapy.[18] It can be readily denied, I believe, that any other justification for patient termination can be made in any context involving conscious patients. Since the goals of medicine properly direct physicians to care for their patients as well as to preserve their health and control their disease, whenever that is possible and beneficial, physicians would seem to have a professional obligation to continue administering caring therapy to any conscious patient, even when a patient can no longer benefit from disease-controlling therapy.

An objection to this exclusion made by Daniel Maguire states that "persons who are quite accessible to human caring might, in spite of

their accessibility, find good reasons to prefer death to continued living."[19] In fact, Maguire argues, "the care they might want is assistance in hastening death."[20] If, however, it is true, as Maguire's statement implies, that a physician can no longer have a moral obligation to continue administering caring therapy to a dying patient who refuses treatment, although the person is accessible to the therapy, it must also be true that caring therapy by its nature requires the patient's acceptance in order to exist at all. Thus, the physician cannot really have any professional obligations to a patient in this context and, as a physician, cannot have any moral reason or justification for terminating the person's life. Maguire's contextual position seems to suggest that the goals of medicine are pragmatic goals, which have developed in the manner of a typical producer-consumer process. The history of medicine, however, does not support the suggestion. Medicine's professional goals of preserving health, controlling disease, and administering care to patients have remained constant throughout medicine's long history primarily because they relate to important human goods, and not because they fulfill the wishes or desires of individual patients, regardless of the value or disvalue that will result from the fulfillment.[21]

The remaining context where additional justification for patient termination in patient treatment might possibly be made, then, is one involving a self-respirating but irreversibly comatose patient for whom disease-controlling therapy is no longer warranted. It seems clear that some sort of therapy would still be professionally required for any other comatose patient context, whether the coma is or is not reversible. Can it be morally permissible then, for a physician to inject a lethal agent into the body of an irreversibly comatose patient who continues to self-respirate? Prescinding from the absolute injunctions against any form of patient termination reviewed and evaluated earlier, perhaps the best reason for answering this question negatively might be that the person in the comatose context under consideration continues to be a genuine medical patient; he can be fed, his waste can be removed and, in addition to other similar things, his bed position can be changed periodically. Thus no termination can possibly be warranted for this type of patient because he continues to be a viable recipient of caring therapy. The plausible objection that can be made against this line of reasoning, however, is that the self-respirating comatose individual should not be considered a patient in the strong sense of the term because he necessarily and permanently is completely indifferent to anything being done to or for him, and some marginal response or realistic hope of a marginal response from the patient is necessary for caring therapy to exist at all. How, for example, can comfort and pain alleviation be administered to a patient who neither feels pain nor suffers discomfort? In what sense is a person being treated as a patient if the treatment is administered to his

biological body alone?[22] But if this is true, then it seems that the self-respirating irreversibly comatose patient is simply beyond receiving patient treatment in any professional sense, and a physician would have no more moral justification for terminating the life of this kind of person than he has for terminating the life of the conscious patient discussed earlier in the paper who is accessible to caring therapy, but desires termination instead.

If the arguments in the paper are substantive then a physician could act morally when injecting a lethal dosage of a pain-alleviating drug into a terminally ill patient's body during the process of caring therapy. This allowance, however, would seem to have little practical significance for the actual practice of patient treatment, since pain generally appears to be controllable in caring therapy without requiring lethal drug dosages. Patient termination then, is not necessarily incompatible with patient treatment, but it virtually continues to be unwarranted in medical practice.

REFERENCES

1. Cf. M. B. Etziony, *The Physician's Creed* (Springfield, Ill.: Charles C. Thomas, 1973).
2. *Ibid.*, p. 13.
3. Cf., for example, James Rachels, "Active and Passive Euthanasia," *The New England Journal of Medicine*, Vol. 292 (Jan. 9, 1975), pp. 78-90.
4. *Ibid.*, p. 79.
5. *Ibid.*
6. *Ibid.*
7. Beauchamp, Tom, "A Reply to Rachels on Active and Passive Euthanasia," in *Social Ethics*, ed. by T. Mappes and J. Zembaty (New York: McGraw-Hill, 1977), p. 71.
8. For additional arguments for distinction between "withholding" and "terminating," cf. Richard L. Trammell, "Saving Life and Taking Life," *The Journal of Philosophy*, Vol. LXXII (March, 1975), pp. 131-137.
9. *The Humanist*, July/August, 1974, pp. 4-5.
10. Cf. Richard A. McCormick, S.J., "To Save or Let Die," *America*, July 13, 1974, pp. 9-10.
11. Cf. Paul Ramsey, *The Patient as Person* (New Haven: Yale University Press, 1970), p. 151.
12. McFadden, Charles J., *Medical Ethics* (Philadelphia: F. A. Davis, 1967), p. 227. Also, Thomas O'Donnell, S.J., *Medicine and Christian Morality* (New York: Alba House, 1975), pp. 42-43.
13. Beauchamp, *op. cit.*, p. 73.
14. Sullivan, Joseph V., "The Immorality of Euthanasia," in *Beneficent Euthanasia*, ed. by Marvin Kohl (Buffalo, N.Y.: Prometheus Books, 1975), p. 24.
15. Cf., for example, Philippa Foot, "Euthanasia," *Philosophy and Public Affairs*, Vol. 6 (Winter, 1977), pp. 85-112.
16. Philippa Foot also admits this point; cf. *ibid.*, p. 112.
17. Saunders, Cicely, "A Death in the Family; A Professional View," *British Medical Journal*, Jan. 6, 1973, pp. 30-31.
18. Cf., for example, John M. Freeman, "Is There a Right to Die — Quickly?", *Journal of Pediatrics*, Vol. 80 (1972), pp. 904-905.

19. Maguire, Daniel, *Death by Choice* (New York: Doubleday, 1974), p. 67.
20. *Ibid.*
21. Recent developments in medical philosophy which recognize a need for more patient input in the patient treatment decision-making process do not deny the appropriateness and value of medicine's long-standing goals. These developments simply suggest that the physician and patient together should determine how these goals are to be made concrete in the individual patient.
22. "Never hasten the dying process except when it is entirely indifferent to the patient whether his dying is accomplished by an intravenous bubble of air or by the withdrawal of useless ordinary natural remedies." Ramsey, *op. cit.*, p. 161.
