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## Euthanasia: An Inclusive Definition

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We continue to share with our remotest ancestors the most tangled and evasive attitudes about death, despite the great distance we have come in understanding some of the profound aspects of biology. We have as much distaste for talking about personal death as for thinking about it; it is an indelicacy, like talking in mixed company about venereal disease or abortion in the old days. Death on a grand scale does not bother us in the same special way: we can sit around a dinner table and discuss war, involving 60 million volatized human deaths, as though we were talking about the weather; we can watch abrupt bloody death every day, in color, on films and television, without blinking back a tear. It is when the numbers of dead are very small and very close that we begin to think in scurrying circles.<sup>1</sup>

Lewis Thomas, *The Lives of a Cell*

We might attribute the scurrying circles to many factors. The concerns and fears related to our personal death and to that of near friends and relatives are centered both on the process of dying and on a consideration of what we might or might not encounter after the process is complete.

When reasoning about the fact of death as we encounter it in the daily news of world and local affairs, we must maintain a degree of emotional detachment in order to process the information and its implications and to make judgments about it. If we were to permit emotion to surface to the extent justified over, for instance, the atrocities recently experienced in the Persian Gulf, the anger would render sensitive people incapable of fruitful

action in any part of their lives. But, when reasoning about the fact of our personal death or that of someone close, it is more difficult to maintain detachment. Our very deepest fears and concerns are touched, and reasoning is unavoidably influenced by those considerations. The questions are the same for everyone, with, perhaps, different ones having top priority:

Is death the end of consciousness or of personal identity?

Will there be anyone who will care lovingly for me as my control over life wanes?

Will my psychological suffering be too great as I gradually lose control over my life?

Will I suffer unbearable pain?

In response to these concerns, the issue of euthanasia has aroused great interest. It has arisen in order to deal with the loss of autonomy during the dying process as physical, and sometimes psychological, competence wanes. It is also a proposed remedy for the physical and psychological pain experienced during this sometimes difficult passage.

The term "euthanasia" is derived from Greek roots which mean good or happy death. Current usage has brought us to an interpretation of "good" as meaning quick or painless or assisted, or all three. The pros and cons of euthanasia have been argued in relation to the two common branches of this definition — active and passive which are qualified by whether the decisions to proceed are voluntary or involuntary. In this paper, I will present these arguments briefly, including the one proposed by the Hemlock Society that "self-deliverance," a euphemism for active euthanasia, is good for both the individual and society. I will answer them from the perspective that neither of the common definitions in any of their interpretations develop the most inclusive understanding of the term "euthanasia." Neither do, in fact, allow for an interpretation of "good" which is wide enough to encompass all of the relevant particular goods which are in the patient's best interest without bringing harm to others in his or her personal or social network. The definition of euthanasia which I propose is one which provides benefit to the individual while at the same time expanding the common good in ways that are universally acceptable. Although this "new definition" — actually an ancient one — may include what is termed passive euthanasia, it is wider. It accounts for long term effects as well as short. Very simply, it is the good that is found in being surrounded and assisted during the dying process by a network of familiar, caring persons.

### **Ethical Significance of Distinctions**

Does this seem too simple? Or unrealistic? Perhaps it will not seem so after we examine the philosophical structure of this proposal. But first, it is important to look briefly at the ethical significance of the sets of distinctions mentioned earlier. The distinction between active and passive euthanasia is also described as the difference between killing and allowing to die. There are some who say that there is never any moral relevance between killing and allowing to die. They propose that the rightness or wrongness is in the end intended (that end being to save the person suffering), that both are

voluntary choices honoring the person's autonomy, and that both involve performing an act that affects the timing of the dying process.

Those who argue that there exists a significant moral difference base their considerations on the place that causality holds in those actions. To explain this, I would like to give you a simple graphic representation which was first brought to my attention by the philosopher Philippa Foot. In the case of active euthanasia, there is an intervention in a process which is moving from A to D. By adding B, a lethal injection, we are changing the process and causing it to move to D1. If A is birth on March 13, 1927 and D is death on September 27, 1990, the cause of death would be a lethal injection at D1, June 10, 1990.

In the case of passive euthanasia, whether it is a decision to withdraw life-support or not to treat, for instance, with antibiotics, the action is not a matter of intervention in the process which will, if unimpeded by any other causal event, move from A to D. We are not adding B, which would be a new factor in the equation, but rather removing C, a temporary barrier added at some point to retard the ongoingness of the process. A person born at A might live to D on September 27, 1990 without any interventions such as life support systems which we will call C. With the help of C, he might live to October 30, 1990. And so the removal of C more or less brings D, the time of death, back to the original end of the process in September, 1990. The point of this argument, then, is clearly that the new cause of death is not the disease or the process itself, but the actions of the person administering the injection or whatever.

### **Long and Short Term**

A less theoretical set of considerations lies in an evaluation of the effects of each approach. As in all ethically significant actions, there are short and long term effects, both direct and indirect. The short term effects influence both the dying person and his or her immediate network. In the case of active euthanasia, all possibilities are cut off. For the individual, there is no possibility of benefitting from a newly discovered treatment or cure, no possibility of participation in research, no possibility of changing one's mind. For the dying person's close network, there is the likelihood of lowering the morale of those who perform the act, or of those who are aware of this act. If the person is hospitalized, there can be — with acceptance of active euthanasia — a diminishing of the sensitivities of the staff who are dedicated to preserving life.

The long term negative effects are of two types: the slippery slope and the formation of cultural norms and consequent public policy. Decisions on the slippery slope proceed downhill morally from those which are made voluntarily by persons in terminal stages of incurable illness to decisions made for themselves by those who are nonterminal, as we saw in the Kevorkian case. Finally, the slide progresses to decisions made by others for those who are nonterminal and/or unable to make informed, rational decisions about their lives. This group may include handicapped and

so-called non-productive members of society of all ages. Such a move, called "crypthanasia" is well-documented in the Dutch experience.<sup>2</sup> The second long-term effect is the normalizing of a practice within a cultural, national, or international community. Once a practice is accepted, it tends to become the popular measure against which "the good" or good actions are measured. Members of that society then experience internal and external pressures to conform to that newly established norm. When active euthanasia is legalized in a culture, felt obligations to spend time, money and energy taking care of the dying are minimized (unless countered by other understandings of "good"). The result is that individuals may come to feel that they are burdensome to family and society and that they are obligated to spare others from having to care for them. And the important others who might be willing to form an ongoing support system are encouraged by the popular norm to expect that they will not be called on to give in any costly or time-consuming way. Terminal care could then become an efficient process, not to be extended beyond the boundaries set by the community.

Another foreseeable abuse arising from the policy of active euthanasia lies in the possibility of encouraging this decision for the purpose of increasing organ procurement. Euthanasia, in this case, is described as a benevolent act which can aid others by donation of body parts. Organ donation may be a good and altruistic act, but it ought not to be factored in any decision to hasten death. Even using a utilitarian calculus with a positive outcome, it would be difficult to determine the psychological capacity of a dying person to overcome the subtly coercive argument that hastening one's death to donate organs somehow increases one's worth.

On the other hand, for those who are experiencing dying as a very traumatic experience, active euthanasia would shorten the period of suffering (and suffering is a highly subjective experience). Scarce resources would be freed for use by those with a good prognosis, and there might be a general lessening of anxiety related to the concerns of pain, loss of autonomy, and prolongation of the dying process. As I have argued, however, the benefit does not outweigh the burdens. There are better ways to counter the trauma and to alleviate the fears.

In the case of passive euthanasia, or allowing to die, the practical factor that differentiates it from active euthanasia is that the possibilities are not cut off. No finality is engineered. This procedure is subject to the same abuses, such as being motivated by organ procurement, and similar slippery slope problems, such as nontreatment of treatable defects in handicapped newborns. However, when such abuses are avoided, euthanasia described as "allowing to die" has the effect of honoring the person's wishes, and so autonomy, without introducing an additional factor which is the cause of death. It preserves scarce resources only incidentally, not as an intended result of a culturally sanctioned act of killing. This, of course, is not the primary intended result of active euthanasia, but when "crypthanasia" begins, the balance has begun to weigh in that direction.

Lewis Thomas also says in his wonderful book:

Perhaps we would not be so anxious to prolong life if we did not detest so much the sickness of withdrawal. It is astonishing how little information we have about this universal process.<sup>3</sup>

What many people do not know about this universal process is that almost all physical pain can be alleviated. It is the psychological pain that is so individual and subjective. It depends on a person's worldview, beliefs about whether death is the end of all subjective awareness and identity, on the psychological strengths and weaknesses of the person — perhaps there has always been a struggle with suicidal tendencies and this is a welcome release. But the most important factor in psychological pain is often the existence and quality of the support network which is surrounding the person during what Lewis terms the withdrawal process. In our society we want to turn away from the unpleasant, to be upbeat and winners. Dying is seen as losing, unpleasant, a burden on those who would get on with their lives. So dying is isolating, losing contact with all one loves and values. Many friends and family members tend to turn away so as not to be reminded of the inevitability of their own mortality.

There are some who argue that active euthanasia is a compassionate response to this discomfort with the dying process. As I have mentioned, they propose that it is a kindness on the part of a dying person to spare others the burdens of caring for him or her. But, again, would it not be the case that once this is established as a norm it would have attendant duties to ask for euthanasia? Those who want to live on and be cared for to the natural end of the process would begin to feel guilty for imposing their needs on reluctant others. And so the psychological pain and isolation of many dying persons would be increased.

Compassion, I propose, lies not in the removal of oneself from the network, but in the dual role, experienced at different times in one's life, of caring and of allowing oneself to be cared for. By a consistent giving of oneself in love and support to others in one's personal network who are in the process of dying, it might then be reasonably expected that the period of one's own dying will be comfortably attended by members of an accepting network who consider that process a part of, not an intrusion into their life. The inclusive definition of euthanasia, then, is one which incorporates passive euthanasia, for the reasons mentioned, but encompasses a notion of "good" which is not limited to just that beneficent act. Compassion and caring in the ways indicated are the measures for a wider set of criteria by which we can evaluate the kinds of "good" in what we term "good death". It benefits the individual by preserving fully the option to be cared for as a reasonable personal and societal expectation. It helps to prepare each individual for personal death by allowing him or her to have experience through personal participation in the dying process of others. And it develops the virtues of compassion and caring in each man and woman who actively participates in daily assistance of his or her friend or relative. Such

physical and emotional support is not always comfortable for the inexperienced — or for the experienced, for that matter. But, just as men and women learn to care for infants because of love and responsibility, the same learning process is possible for the personal care of elders who have contributed so much to our lives. Would anyone consider it a state or medical profession responsibility to provide for infant care during that first, sometimes difficult year of life with crying during the night and total dependence? Lewis Thomas comments:

It used to be the hardest and most important of all the services of a good doctor to be on hand at the time of death, and to provide comfort, usually in the home. Now it is done in hospitals, in secrecy (one of the reasons for the increased fear of death these days may be that so many people are totally unfamiliar with it; they never actually see it happen in real life). Some of our technology permits us to deny its existence, and we maintain flickers of life for long stretches in one community of cells or another, as though we were keeping a flag flying.<sup>4</sup>

As for a preservation of the common good, such an inclusive understanding of good death avoids the slippery slope which leads to involuntary euthanasia and to the subtle psychological coercion for donation of organs. In addition, it has no place for the establishment of legal and practical norms which are based on the honoring of the autonomy of some while eliminating the support systems which would facilitate the exercise of autonomy by others who think differently. Most importantly, however, it prevents the desensitization of the community as a whole to the short and long term effects of the establishment of such a norm.

This definition is based on an old practice, as you may have noted. The foundations are rooted in a philosophical perspective called an ethic of care, which is a morality based on the assumption that all persons are dynamically interconnected in a personal and social network of relations.<sup>5</sup> Aristotle was aiming at this when he stressed the social embeddedness of persons. It counters the notion of a human being as an “economic man” or a social contractor equal in all ways and entitled primarily to noninterference. But the dying are not equal in many ways. One significant difference is that they are dependent on caretakers and interact in their social network from a position of unique vulnerability. I am proposing that this dependence, if accepted with graciousness, generosity, and compassion, benefits both the individual and society in the ways I have discussed. The dying are not “economic men” to be valued according to their social contributions, past and potential. They are members of a community who are bound by sets of attachments. From a care perspective, to detach and “not interfere”, as one does in honoring the request for active euthanasia, is to abandon, to separate, to provide for the seeds of isolation in the neglected.

An ethic of care stresses the honoring of attachments, those which are personal and those which are formed as common members of a human community. This is shown in availability and responsibility, often, perhaps usually, when it is inconvenient and not paid for. The model of economic man stresses impartiality and noninterference with an individual's liberty to

choose. The ethic of care stresses that partiality and involvement are a gift of the chosen and unchosen attachments that are unavoidably formed by members born into the world community. It is only by allowing oneself to fully experience such caring that one learns how to give it to others. And it is only by giving such caring that others learn how to continue the process which strengthens human bonds. In the situations of attachment which are a natural part of our social embeddedness, the impartiality advocated by proponents of the economic man model<sup>6</sup> is not possible because one's self is at least partially defined by these relations with others.

Good death, then, is a return to the ancient custom of death as attended by the community. Edmund Pellegrino writes that ". . . sorrow and death are part of the tragic condition of man. They are not transcended by medicine so much as made bearable."<sup>7</sup> Good medicine can alleviate the pain and, perhaps, some of the psychological suffering. Compassion and caring properly expressed can do the rest.

### References

1. Lewis Thomas, *The Lives of a Cell: Notes of a Biology Watcher*, New York: Bantam Books, 1975, p. 55.
  2. Robert G. Twycross, Assisted death: a reply. *The Lancet* September 29, 1990; 336; 796-8.
  3. Thomas, *op. cit.*, p. 57.
  4. Thomas, *op. cit.*, p. 58.
  5. For further study of the ethic of care, see articles by Virginia Held, Carol Gilligan, and Annette Baier.
  6. For further reading on the economic man model, consult ethical writing by Kant, Locke, and Nozick.
  7. Edmund D. Pellegrino and David C. Thomasma. *A Philosophical Basis of Medical Practice*. New York: Oxford University Press, 1981, p. 118.
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