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'Euthanasia' and Dying Well Enough*

Paul Ramsey

In order to think straight about the question of the morality of "euthanasia," I want first of all to convince you that:

1. It is better if you do not know the Greek language, or the root meaning of the word.
2. You do not need to learn how to demonstrate that, while to kill someone directly (or with direct intention) is damnable, you are excusable if you kill someone only indirectly (or with indirect voluntariness).
3. You do not need to deploy subtleties like saying you are accountable for another's death if you were the *active* agent of it, but not accountable if you were *passive* while the death occurred.
4. You do not need to prove to the waiting world of philosophers or theologians that there is a crucial moral distinction to be

drawn between acts of *omission* and acts of *commission* even though the consequence is the same.

5. You do not need to puzzle for very long over the meaning of the distinction between "ordinary" and "extraordinary" medical means of saving life — the first supposed to be morally mandatory and the second supposed to be dispensable, both in past Christian medical ethics and in the views of most physicians.

These distinctions may be important to take up in other connections — I happen to believe some are — but neither separately nor together do they serve to solve or dissolve or even to clarify the question of euthanasia. In particular, to frame the question in terms of omission and commission, passive or active euthanasia, direct versus indirect killing, ordinary versus extraordinary means — and even our wobbly use of the term "euthanasia" — only serve to confuse moral discourse. Yet it seems nearly impossible to dislodge such language.

The title of this article is taken from a recent study pamphlet issued by the General Synod (Church of England) Board of Social Responsibility.¹ "Man should be enabled to 'die well,'" is the theme of that pamphlet. It

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goes on to say: "This is the literal meaning of the word 'euthanasia' and, if we were starting afresh, there would be a good case for using this word to express our common concern for the welfare of the dying. But this is no longer possible, since the word has now become established in popular usage with a more precise meaning."

That "more precise" — and corrupted — meaning, I suggest, is that human beings should sometimes choose death as an end. The choice of one's own death as an end is now the meaning packed into the word "euthanasia." Therefore, it occurs to us, when discussing the morality of the matter, to attach certain predicates that describe the manner and means to death as a chosen and choice-worthy end. We speak of "active" or "passive" euthanasia, of "directly" or "indirectly" disposing a patient to death, of whether death came by acts of omission or by acts of commission, by action or by refraining.

I would get rid of all those terms. We are misled to them by our popular and irreformable usage of the word "euthanasia" — for choosing death as an end. Since we cannot restore the word to its original meaning, I think we simply must speak of the immorality of euthanasia and of the morality of "dying well" — or, more soberly, of "dying well enough." That may be to beg the question, or at least to anticipate a conclusion. But there is little

wrong with that among readers who are even now on the watch.

It is often said that ceasing to oppose death and letting die are "indirect euthanasia," which is to intervene, to start or hasten the dying process would be "direct euthanasia." It is important that we entirely reject this language, and not solely because of the subtle suggestion frequently introduced that an apology for the morality of letting die is only a reluctant euthanasiast. The alternatives are simply between "dying well enough" (death itself never chosen either as end or as means) and choosing death as an end (and in that, he who chooses the end chooses the means also).

The language of direct and indirect was carefully honed in traditional moral analysis in order to sort right from wrong in quite different kinds of dilemmas than the one we are now considering. That language is properly used in the case of *indirect* therapeutic abortion (where a physician removes a cancerous uterus in order to save a woman's life, knowing full well that he also kills the unborn child within) and in the case of collateral civil damage in acts of war targeted upon legitimate military targets. In those cases, direct and indirect intentionality of direct and indirect effects have to do with the twofold (or manifold) effects flowing from a single action, or from a single act of the will, targeted upon some good while the agent foresees (and so "indirect-

ly" wills or permits) some evil side-effects.

The only instance in which such language and its moral meaning need be invoked in discussing the question of euthanasia is a minor one. It is also very obscure how factually to analyze what is being done in that instance. I refer to the use of pain-relieving drugs which are supposed also to be life-shortening. That, indeed, is an instance in which from a single volition and action two effects are (ambiguously) foreseen to follow.

Clear Moral Analysis

The *moral* analysis is clear enough. Any physician knows whether he is *trying* to relieve suffering or *trying* to bring on death. His *aim* is the former, even if he knows that he is also *doing* the latter. No one doubts that he should relieve pain and suffering, even if a shorter life for the patient is an "indirect" result of the medical care he initiates.

Once in an interdisciplinary discussion a scientist friend of mine — a proponent of euthanasia on utilitarian grounds, who believes we should comparatively evaluate human lives in their declining trajectories, slowing some, hastening others — was poking fun at the "absurd" distinction between the direct and indirect results of pain-relieving drugs. I asked him what he would think if we had drugs to relieve suffering that certainly *did not* shorten lives or hasten death. He replied that he'd op-

pose funding the research to discover any such way to deal with the suffering of the dying. My rejoinder was, "Then you *can* tell the difference between the direct or intended and the indirect or unintended of the twofold effects of medication!" As between the two, he simply wanted physicians sometimes to bring on death, and incidentally, of course, relieve the suffering of the dying.

In the case of pain-relieving drugs, the moral grounds for approving their use even if death comes sooner is clear enough, and, I believe, convincing. As stated in the Anglican pamphlet:

There is a clear distinction to be drawn between rendering someone unconscious at the risk of killing him and killing him in order to render him unconscious. . . . There is a decisive difference between the situation of a medical practitioner whose patient dies as the result of an increased dosage of a pain-killing drug and who would use a safer drug had it been available, and that of a public executioner, in states which employ this means of carrying out the death penalty, who chooses drugs for their death-inducing properties. Two rivers may take their rise at a very little distance from one another on a mountainous plateau, but this slight difference may determine that the one flows north and the other south.²

What is in doubt is the factual situation. To suffer unrelieved pain is also debilitating and life-shortening. "Giving the right drugs is not tantamount to killing the patient slowly. *The relief of pain itself may well lengthen life: it will certainly enhance it.*"³ "This is not 'protracted

euthanasia' . . . as it has been called, but a way of enabling someone to live actively up to the moment of death."⁴

My point, however, is to urge that we jettison the expressions "direct" and "indirect" from discussions of euthanasia unless it is very clear that we are talking about this single issue: the use of pain-relieving drugs. Except for this sort of medical decision, the alternatives are choosing death as an end and the means thereto also (to add "deliberately" or "directly" says no more than already stated by the word "choose") or to let die and to help the dying to die well enough (and that entails no choice of death, direct or indirect, as end or means).

The remaining verbal distinctions — the alleged difference between "passive" and "active" euthanasia, between acts of omission and acts of commission, between action and refraining — can be taken together for comment. Again, those may be the right-making or wrong-making features in the analysis of some moral questions, but not of the treatment of terminal patients. Of course, euthanasia is an active choice of death as an end and of the means thereto. Death is brought about by commission, by an action. For Jews and Christians — and for other religious outlooks as well — euthanasia is wrong because it is wrong to choose death (to say "deliberately" or "directly" adds nothing).

But the alternative policy is

not correctly characterized as "passive" euthanasia (a passive choice of death as an end or by negative means). Death's cause is not advanced by acts of omission or by refraining. Death's cause is advanced by the disease state itself, which it is now useless to fight.

It is rather another case that is advanced by choosing an alternative course of *action*. When a doctor says, "There's nothing more to be done," he means, in context, "There's nothing more to be done to cure or to save this particular life," not "nothing more to be done" absolutely, except to switch to inaction, passivity, omission, refraining. "It is entirely misleading," the Anglican pamphlet correctly affirms, "to call decisions to cease curative treatment negative euthanasia"; they are part of good medicine, and always have been."⁵ The switch from curative treatment is followed immediately by an exceedingly active practice of medicine — "commissions" of many sorts — in caring for the dying. In words drawn from a Protestant hymn, from trying to "rescue the perishing" one turns to "care for the dying." Not even the "turn" from what was formerly the indicated treatment is an inaction, much less the care and treatment to which one then turns. Still that turn is not a turn toward death as a goal of human actions. No one chooses death as end or means. We choose rather to care for the still-living dying. That is "affirmative action" of

the highest order. One refrains, of course, from what was formerly the needed curative treatment, but that is promptly replaced by the now needed caring treatment. The latter policy is as active as the former. Both serve life and neither chooses death as end or as means.

Hospice a 'Way-Station'

Cicely Saunders, M.D., is the leader of the Hospice movement in Great Britain. The word Hospice, used in place of Hospital or Sunset Village, means a way-station for pilgrims. She once remarked:

"I am in the happy position of not being able to carry out drastic life-prolonging measures because we just do not have the facilities at St. Joseph's. Other people have made the decision, at a prior stage, that this is a patient for whom such procedures are not suitable or right or kind. This makes it very much easier for us than for the staff of a busy general ward. I think that it is extremely important that the decision be made by a person who has learned all he can about the family, about the patient himself, and about the whole situation. The further we go in having special means at our disposal, the more important it is that we stop and think what we are doing. . . . I have had much correspondence with the former chairman of the Euthanasia Society in Great Britain, and I took him round St. Joseph's after I had been working there some eighteen months. He came away saying, "I didn't know you could do it. If all patients died something like this, we could disband the Society." And he added, "I'd like to come and die in your Home." I do not believe in taking a deliberate step to end a patient's life — but then, I do not get asked.

If you relieve a patient's pain and if you can make him feel like a wanted person, which he is, then you are not going to be asked about euthanasia. . . . I think that euthanasia is an admission of defeat, and a totally negative approach. One should be working to see that it is not needed."⁶

A reporter asked Dr. Saunders why, even for emergencies, they did not have an "intensive care unit" at St. Joseph's or St. Elizabeth's. She replied, "Why, all we have here is *intensive care!*" That says better than I can why we should resist calling the practice of dying well enough by such names as "passive" or "negative" euthanasia, and why we should never let ourselves be put in the position of having to prove that refraining is somehow better than acting, and be less accountable if evil comes about only through our omissions.

II

The immorality of choosing death as an end is founded upon our religious faith that life is a *gift*. A gift is not given if it is not received as a gift, no more than a gift can be given out of anything other than kindness or generosity (to give out of flattery or duplicity or to curry favor is not a gift).⁷ To choose death as an end is to throw the gift back in the face of the giver; it would be to defeat his gift-giving. That, I suppose, is the reason suicide and murder were called "mortal sins," deadly states of the soul as surely as is despair over God or despair in face of the forgiveness of sin.

So also, religious faith affirms that life is a *trust*. And not to accept life as a trust, to abandon our trusteeship, evidences a denial that God is trustworthy, or at least some doubt that He knew what He was doing when He called us by our own proper names and trusted us with life. We are stewards and not owners of our lives.

Or again, if, as Christians, we believe that death is the "last enemy" that shall be destroyed, then to choose death for its own sake would be a desertion to the enemy, and a kind of distrust in the Lord of life and the Lord over the death of death.

Many people today think it odd to believe that illness unto death or the gradual decay of our mortal frames are signs that God is calling his servant home. That seems to make nature God. "Vitalism" is the usual charge. I suggest, to the contrary, that such a view is no more an oddity than to believe that the birth of a child is God's gift of life and a sign of hope. Both are, to the seeing eye, biological processes. Both are capable of being "rationalized," and as faith recedes, humankind seizes dominion: babies made to order, death by choice. To the eyes of faith, however, God gives and God takes away. And it is no novel conclusion of religious philosophy that God always works through "secondary causes." If that is true, then some current assaults on "vitalism" or "physicalism" are liable

(if successful) to run God entirely out of the world.

Medical-Moral Policy

What, then, does one choose in a medical-moral policy of allowing to die or refusal of further treatment — if that is not dominion over human life instead of trusteeship or stewardship, if that is not based on a fundamental denial that life is a gift and a trust? What, then, does one choose in a medical-moral policy of "dying well enough" if he does not choose death as end or means? No one has answered this question better than Prof. Arthur Dyck of Harvard University. A person "does not choose death but how to live while dying." Physicians decide now a patient should live while dying, be-tubed or as comfortable as possible. Such choices about "how the last days of the dying patient are to be spent" Dyck goes on to say, 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 or how much medical intervention we will seek or tolerate, and the like."⁸ Or, I would add, like choosing orange or apple juice for breakfast, to smoke or not to smoke, or between the shore or the mountains for a vacation.

These are life-choices. They are indeterminate decisions in that it is difficult to say how we make them, or to justify one option rather than another. But none is a choice between life or

death, or who shall live and who shall die. Indeed, that choice is now out of our hands. The dying patient is, of course, in a narrow passage no longer thinking of going to the shore or to the mountains. His choices indeed are limited. Still, his choice of how to live while dying is a life-choice; it need never be a choice of death as end or means. One compares a certain state or condition of dying with another, one treatment with another, or treatment with no treatment. All such decisions are consistent with accepting life as a gift and a trust. None seizes dominion over human life and death. We may be mistaken; indeed, we may be bad trustees and exercise our stewardship of God's gift of life *wrongfully*. Still, worthy or unworthy, we remain *trustees* making choices among the good of and for life and do not lay claim to dominion over human life. As Dyck puts it, "choosing how to live while dying" stands in diametrical contrast to actions that "have the immediate intention of ending life (one's own or another's)." Only the latter "repudiates the meaningfulness and worth of one's own life." Only the latter "irrevocably severs any actual or potential contact with others and shuts them out of one's life." Only the latter usurps dominion or throws back the gift in the face of the giver. Only the latter chooses death as means or end. The former is a life-choice, one among the choices of a life still received.

III

There was a final point listed at the beginning of this article, namely, you do not need to puzzle for very long over the meaning of the distinction between "ordinary" and "extraordinary" means of saving life.

Past moralists used the term "ordinary means" to save life as an ethical category; it *meant* imperative. They used the term "extraordinary means" as a term of moral permission; it *meant* electable or morally dispensable means. Like all other offense-terms or terms of approval, these terms are, as classifications, incurably circular until filled with concrete or descriptive meaning.

So, "forgery" means *wrongfully* writing someone else's name, not simply writing someone else's name. "Lying" means *wrongfully* vocalizing an untruth, not singing "I die! I die!" if one is a Wagnerian opera singer. "Murder" means *wrongful* killing, not just any killing. We still have to ask, what *sorts* of cases count as these wrongs?

A discussion of what constitutes ordinary or extraordinary medical means is like debating which cases of writing someone else's name constitute forgery, what killings are wrongful, or which words uttered, inconsistent with the mind's apprehension, are to count as lying. In all these cases, we have to ask, "What counts? What are the morally relevant features?" when we judge a specific situa-

tion or action to fall under one of these terms.

When we ask this question, I suggest that the morally significant meaning of ordinary and extraordinary medical means can be reduced almost without remainder to two components. I further urge that the older language be abandoned, and that instead we should speak of (1) a comparison of treatments that are medically "indicated" and expected to be helpful, and those that are *not* medically indicated. In the case of the dying, that includes in all cases, or in most or many cases, a judgment that further curative treatment is *no longer* indicated.

Right to Refuse Treatment

Instead of the traditional language, still current among physicians, we should talk about (2) a patient's right to refuse treatment. Indeed, this entire language about ordinary and extraordinary means was developed by past moralists specifically to apply to conscious patients who are certainly not in the "process of dying."⁹ So they spoke of not leaving home and traveling great distances to obtain life-saving treatment, of a justified revulsion to disfigurement, etc.

Why do I say that the meaning of "ordinary/extrordinary" can be reduced "almost" without remainder to these two components? Why some hesitation in recommending that we drop the traditional language? Certainly not because of any doubt about

the rightfulness of stopping further curative treatments in the case of the dying.

Still there was an important nuance in the older language that may be lost in the foregoing translations, especially in our contemporary talk about a patient's right to refuse treatment. The terms "ordinary/extrordinary" — however cumbersome, opaque and unilluminating — directed the attention of physicians, patients, family members, and moralists to *objective* considerations in the patient's condition and in the state of the art of medicine's remedies which determined whether decisions to allow to die or to continue to try to save were morally right or wrong decisions.

The translation "a patient's right to refuse treatment" enthrones, to the contrary, an arbitrary freedom. It ascribes to subjective decisions the power to *make* medical interventions right or wrong. Choosing or refusing treatment is submitted to voluntaristic determination. In contrast to that, the distinction between ordinary and extraordinary means was a way of referring to refusals that are simply suicidal and those that may not be. The search for the specific meaning of imperative or electable means of saving life (objectively relative to a patient's *medical* condition or to his *human* circumstance) excluded a patient's right to choose death as end or means. He chose to remain at home, not to travel far away; he

chose against disfigurement. These were all *life*-choices; none, a choice of death as end or means.

Certainly no patient has a right arbitrarily to refuse treatment *with medical assistance*. Physicians, too, have consciences, and integrity in their professional judgments. Therefore, I add that the search for *objective* grounds for describing a treatment as ordinary or extraordinary (*objective*, even when relative to the patient's dying condition) had also the virtue of not turning physicians into "animated tools" (if someone prefers Aristotle's definition of a slave, over the words "technician" or "instrument") who simply assist a patient to attain anything he wishes. Instead, a patient's need and real claims upon our care were to be read off the human and medical reality of his case, not from his expressed wishes alone. His freedom and dignity do not encompass the right to do wrong, a right to assault the value of his own life with medical assistance. Treatments are not electable because elected, desirable because desired.

If there is a right to die (a right to choose death as an end), then that implies "as is normal with rights, a correlative duty on the part of others to secure to the individual the exercise of his right."¹⁰ Not yet have we assigned the right to die, the right to choose death as an end (if that is the meaning of "a patient's right to refuse treatment"), the same moral status as the right to

life. If the claim were verified that an individual has a right of arbitrary self-determination in the matter of life and death, then if he chooses to live, there is a duty upon others to protect his life and, equally, if he chooses to die there is a duty upon others to assist his dying. I, therefore, fear that the translation "a patient's right to refuse treatment" moves too far in the direction of subjective voluntarism and automated physicians. Having gone to that state of affairs in the matter of abortion, let us not do so as we approach medical euthanasia.

After this excursus, return to the first component meaning and translation of "ordinary/extrordinary," namely, treatment indicated or no further curative treatment indicated in the case of the dying. We should now be prepared to see that this wording does not mislead. It rather directs attention to the objective condition of the patient, and not to the wishes of any of the parties concerned — not even the previously expressed opinion (as reported) of Karen Ann Quinlan. Treatment indicated or no further treatment indicated are not such by anyone's stipulation. Within whatever margin of error, these are objective medical determinations. That means that disagreement — for example, between physicians and the family of a comatose patient — may be *real* disagreements over an objective medical situation and about what should be done in a particular case.

At the same time, a comparison of treatments, or of treatment with no further curative treatments, is objectively relative to the patient's *present* condition—not to some notion of “standard medical care” in a physician's mind. A routinized understanding of “ordinary/extraordinary” is the “security blanket of some physicians who nevertheless have been known to call some ethicists “absolutists”!

In this article I have been concerned simply with the clarification of terms, to the end that the prohibition of euthanasia can be more fully understood. This is a firm principle or moral norm that should govern medical care. I myself have suggested that there may be “exceptions” to the rule against hastening or causing or choosing death.¹¹ A little flurry of debate once swirled around those exceptions. I do not now enter the lists to defend them. My point has rather been a far more important one, against the trend that is clearly evident in contemporary discussions to weaken the principle prohibiting choosing death. Loose language, I believe, is its source.

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