Dr. James S. Spiegel, Christian Ethics, Session 14, Euthanasia and Physician-Assisted Suicide

This is Dr. James Spiegel in his teaching on Christian ethics. This is session 14, Euthanasia and Physician-Assisted Suicide.

Okay, the next issue we will discuss has to do with terminal care issues, euthanasia, and physician-assisted suicide.

When, if ever, is it appropriate to hasten the death of someone in their own interests? So, we'll begin by talking about some basic definitions. One is the phrase termination of life support. This refers to the allowing of someone to die by either withdrawing or withholding medical treatment.

Physician-assisted suicide is when a medical professional, says a physician, instructs someone on how to end their own life with some sort of means of a lethal injection. And then euthanasia, which literally means easy death; in that case, a physician takes direct action to hasten the death of a patient. This is also known as mercy killing.

So, when, if ever, is it appropriate to either assist someone in their own death or to directly hasten someone's death through lethal injection? Here's a little bit of legal background. I remember the Karen Ann Quinlan case of 1975, when I was a little kid, in the news in the mid-70s for months, if not years. In this case, the court ruled that the patient's interests overruled the professional integrity of health care professionals.

There was conflict over whether this woman, Karen Ann Quinlan, should be kept alive even though people in her family wanted her to be allowed to die. Then, in the Cruz Ann case in 1990, the court ruled that a patient has a right to decline life-saving medical treatment, including food and water. In Washington versus Clucksburg, and Vacco versus Quill in 1997, the court ruled that no constitutionally protected right to die exists.

So, in this case, the court did not declare physician-assisted suicide to be illegal. However, they left this to the states to decide. And since those cases, nine different states, at least as of last year, nine U.S. states have legalized physician-assisted suicide. California, Oregon, Vermont, Montana, Colorado, Hawaii, Washington, Maine, and New Jersey, as well as DC.

And over the last several years, we've seen a significant increase in the number of Americans who favor legal physician-assisted suicide. According to a 2017 Gallup

poll, about three-quarters of Americans favor physician-assisted suicide being legal. Here are some important distinctions.

These are often appealed to or applied in various terminal care issues. One is the distinction between ordinary and extraordinary means. By ordinary means, we're talking about treatment that offers reasonable or significant benefits without an excessive burden on the patient or financial burden.

Here, we're talking about things like antibiotics, blood transfusions, and feeding tubes. Those are ordinary means. At least now, in the history of medical technology, these things change because what is extraordinary or exotic over time becomes routine and ordinary.

So today, blood transfusions and feeding tubes, for example, are considered ordinary when, at one time, they were extraordinary. But today, extraordinary means include things like organ transplants or respirators. Maybe respirators are becoming ordinary.

But in this case, we're talking about the relatively little benefit or the excessive burden. In the case of organ transplants, of course, you do have significant benefits. But that certainly creates a significant financial burden.

This is extremely expensive. Another distinction is that between withholding and withdrawing life-saving treatment. This is the distinction between abstaining from giving a particular treatment on the one hand as opposed to stopping or ceasing a treatment that has already been initiated.

And then there's a distinction between killing and letting die. This is the distinction between actively bringing about or causing the death of someone as opposed to allowing the disease or the injury or the natural course of nature to kill the person. So, those are all important distinctions that we will be noting from time to time throughout this discussion.

When it comes to making terminal care decisions, this is extremely important from not just a moral standpoint but also from a legal point of view. And we can distinguish the different possibilities or scenarios from best case to worst case. And beginning with something called legal advanced directives.

These are the best-case scenarios where you don't have significant legal complications ensuing, such as when you have a living will. This is a legal document where the patient states his or her wishes in advance regarding terminal care. If I am in a situation where I cannot make the decision for myself, here is what I want done.

And the person can stipulate along a spectrum of possibilities how much effort they want to put forth in order to preserve their life. So, you have a living will. Another legal option is what's called durable power of attorney, where the patient designates someone to make terminal care decisions for them, whether it's their primary care physician, a spouse, or some other family member.

So those are best-case scenarios. Next, we have verbal advanced directives, which are a little problematic, or they can be from a legal standpoint. Here, the patient makes his or her wishes known informally to friends or family.

And on the basis of that, the health care professionals can make the decision, or at least let that inform their decision as to how to proceed with the patient. And then, finally, if none of those options have been pursued and we don't know what the patient stated or what they would have wanted, then it has to revert to a judgment of proxy where someone is designated to make the decision on behalf of the patient. So those are the different possibilities in terms of terminal care decisions.

I always recommend that everyone make a living will or at least create a durable power of attorney. In any case, particularly as one gets well into their adult years, and especially in their advanced years, to have some sort of written document that stipulates how one wants to be handled in a terminal care situation. You can save your family and loved ones a lot of difficulty and stress.

Now, let me talk briefly about some of the basics of brain anatomy, which comes into play a little bit in our discussion here. So, the brain's three general anatomic divisions include the cerebrum. This is also called the higher brain.

This is the part of the brain that controls consciousness, cognition, thinking, memories, feelings, and perceptions. Then, the cerebellum controls coordination, body movements, posture, balance, and so on. Then, the lower brain, the brain stem, is what governs what we call vegetative functions, breathing, respiration, heart rate, and sleep cycles.

When it comes to major definitions of death, these anatomical distinctions come into play. So, you have whole-brain definitions of death, where the standard or the criterion for death is complete cessation of the function of the entire brain. That's what's necessary for death.

The whole brain has to stop functioning. Whereas in higher brain definitions of death, it's just cessation of the function of the cerebrum, the cerebral cortex, which is sufficient for death. There are non-brain definitions that have been used throughout history, but at least in Western culture, they aren't used or applied as much.

Non-brain definitions understand death in terms of body function that's external to the brain, such as breathing and blood flow, or in terms of a metaphysical event, most prominently the idea of the soul or spirit leaving the body. Now, one can combine a non-brain concept like the metaphysical reality of the soul leaving the body with one of the other brain definitions, either whole brain or higher brain. And so when it comes to the distinction between brain death and what's called a persistent vegetative state, or PVS, you can see how these definitions of death come into play.

Brain death refers to, again, when the entire brain has stopped functioning, which is indicated by a flat electroencephalogram. But a persistent vegetative state is when the higher brain has stopped functioning, but brain stem function remains. A person is still breathing, their heart's still beating, and there's still blood flow, but there's no consciousness, no awareness, and no thinking going on.

And this is where it becomes very tricky from a terminal care point of view because, in many cases, it's just very difficult to know if the person can emerge from this comatose state. And there have been people who have lingered in PVS for years and years and years, including Karen Ann Quinlan, the case I mentioned earlier. I think she had had some sort of drug overdose.

And the question was whether her feeding tube should be removed or whether she'd be taken off a respirator. I think that's what it was. And finally, after a lot of legal wrangling, they did that.

And they thought she would die, but she just kept on breathing on her own for, I believe, about eight or nine years but remained comatose. But there have been people who have remained comatose for 15. Even the longest I've heard is 19 years. This individual has been in, I want to say, Eastern Europe, I think Poland, for nearly 20 years.

And this was about 15 years ago when he emerged from his coma. And this was just considered impossible, that he was in a permanent vegetative state, it was thought. And that his wife was really being irrational in her hope that he would come to.

Well, he did. And it turned out he was in great cognitive shape. And so, last I heard, you know, not long after, a few months after he came to, they were spending most of every day just in conversation.

And she was filling him in on the last nearly 20 years of history, all that he had missed while he was asleep. So, you just don't know. And depending upon the extent of the damage to a person's brain, physicians can be confident that, you know, a person, if they do become conscious again, there won't be much, if any, cognitive ability.

But in many, many cases, that's just not known. And whether the person is going to wake up from their coma, even the most informed and experienced physicians can be mistaken in their prognosis. So, PBS that's a source of a lot of controversy and difficulty when it comes to these terminal cases or apparently, terminal care cases.

So, let's look at now, some of the arguments, pros, and cons when it comes to euthanasia. And specifically, what used to be called active euthanasia, as opposed to passive euthanasia. That used to be a distinction that medical ethicists often made in discussion of these issues.

But passive euthanasia refers to withholding or withdrawing life support. The way that the discussion has proceeded, it's recognized that that really isn't euthanasia. In order for something to be true euthanasia, it has to be active, or you're doing something to hasten the person's death.

So, now, euthanasia generally is understood to refer to what used to be called active euthanasia. But, sometimes, it's helpful, just to be clear, to call it active euthanasia, to clearly communicate we're talking about a situation where something is done actively to hasten a person's death. So, James Rachels wrote a classic, now classic, article many years ago defending euthanasia, or active euthanasia.

He argues that once it's decided that a patient should be allowed to die, killing the patient may be a morally appropriate or preferable thing, hastening the person's death when we know that death is inevitable. So, he talks about some examples where killing the person seems preferable to letting the person die, where you have, say, a person suffering with terminal cancer, stage 5 pancreatic cancer. I've known people, I've had colleagues who've died of pancreatic cancer, which is one of the more severe, aggressive forms of cancer.

I've not known of anyone who's recovered from that. I'm sure it's happened in some cases if it's caught early enough. But in all the cases I've known, the person eventually died, and towards the end, in many cancer cases, it's excruciating suffering.

And you know the person is going to go; it's just a matter of time. Maybe we know it's days or even hours away. Why allow the person to suffer in agony when you know they're going to be gone very soon is the point.

So, isn't it more humane to hasten the person's death? There's the old phrase: I think there was a movie with this title: They kill horses, don't they? We do this to be merciful and humane to an animal, so why not when it comes to fellow human beings? So, Rachel uses a thought experiment, an illustration, to reinforce his argument here. Between Smith and Jones, there are two people in each case. They have a nephew from whom they stand to gain a significant inheritance if this little kid

dies. And Smith is babysitting his nephew when he hears his nephew fall in the tub, bumping his head, falls face down into the water; and he knows that if his nephew drowns, he's going to gain a huge inheritance.

As the kid is starting to get up from the water, Smith holds his head down and drowns him. Now, Jones, he's in the same situation. His nephew also falls, bumps his head in the bathtub, and falls face-first into the water.

In this case, Jones has his hand poised above his nephew's head such that if the kid starts to come to, he'll be ready to push his head down, but the kid never comes to and drowns without any intervention from Jones. So, the question is, who did something worse? And Rachel argues that they both did something equally bad. Jones didn't do any better just because he didn't keep his nephew's head under the water or touch him in any way.

He did not do anything actively to kill his nephew, but it was still just as wrong because he was still ensuring that his nephew died. So, there's a kind of parity in terms of moral assessment here between two situations that are identical, except in one case, there's activity going on, and in the other, it's passive. So, if killing and letting die are morally equivalent in this case on the evil side, then why wouldn't they be equivalent morally on the good side when you're either killing or letting die for a good reason? So that's how James Rachel is trying to pump our intuitions here regarding active and passive insurance that a person in a terminal care situation dies.

Why is it, though, that we tend to think of killing as worse than letting die? He recognizes that that's a general attitude that people have. We tend to see active killing as worse than allowing somebody to die. His answer to that is that it's usually done less responsibly.

When we hear cases of people being killed, it's nearly always in a context where the killing is wrong and it's murder. But here we're talking about contexts where the killing would be morally okay, and the intention is good. It's for the sake of the person who dies.

It's not against their will, in contrast to how it usually works when we hear cases in the news of people being killed. So, our attitudes need to adjust according to the context, the intentions, and the purposes involved. In many cases, being aligned with the will of the person who is dying or is in a terminal care situation.

When that's what they want and excruciating suffering is what will attend their continued existence if their death is not hastened, we need to view this in a more sympathetic light according to Rachel's and other defenders of euthanasia. So, he buttresses his argument with a couple of other points. These are just general arguments that Rachel and others have used to defend euthanasia.

The active hastening of someone's death for their own sake. There's a utilitarian argument that points out that euthanasia results in greater happiness and less pain overall. In many cases, again, it's a merciful thing to do in terms of maximizing pleasure and minimizing pain for the person who is dying.

And for friends and family members who don't want to see their loved ones relieved from pain, especially excruciating pain and agony. Then there's the argument from the Golden Rule. If you ask yourself, if you were in a terminal condition, it was certain or nearly certain that you were going to die, and you're writhing in agony, wouldn't you prefer to be killed? Sometimes, in casual conversations, people raise that question.

Would you rather die like this or like that? If you could control your destiny, what would be the way that you would prefer to die? And universally, people's response is, you know, I'd like something very quick and as painless as possible. So, if that's any indication of personal preference, then as we apply the Golden Rule to people who are in situations of terminal care, doesn't that imply the appropriateness, in some cases, of euthanasia? Rachel goes on to respond to the argument about possible recovery. We just don't know for sure, in many, many cases, whether a person may recover.

And, after all, a diagnosis may be incorrect. Physicians are fallible. They make prognoses and even diagnoses that are not accurate at times.

So, doesn't that point in favor of the wiser course of action being to try to keep the person alive for as long as we can? So, Rachel's response to that is that just because physicians are sometimes mistaken, it doesn't follow that they never know when a case is hopeless. And we just have to look at it on a case-by-case basis. And if the physicians say multiple physicians, who are attending to a particular patient are confident that no recovery is possible, then that would be a situation that would be morally appropriate to consider euthanasia, according to Rachel.

On the negative side, a number of arguments can be made in defense of the view that euthanasia is always wrong. Many years ago, an article was written under a pseudonym, J. Gay Williams, by a medical ethicist named Ronald Munson, who takes a view that personally is more in line with Rachel's view. But when he was putting together this anthology, I think it was a medical ethics anthology, he couldn't find a suitable article defending the anti-euthanasia view, so he wrote one himself, and then he chose to use this pseudonym probably because he didn't want to be so identified with arguments against euthanasia.

Which is interesting. I've seen plenty of arguments and articles that are very well done by people like Leon Kass that are anti-euthanasia, but this is the article that is

most well-known, and this has been anthologized dozens, if not scores, of times. I've used multiple ethics texts in teaching ethics classes over the decades, and this Gay Williams article and this Munson article are in every one of them.

But it is succinct, and he does communicate the arguments clearly and, for the most part, with a certain amount of strength. But according to Munson, we'll call him by the pseudonym Gay Williams; euthanasia is wrong; it's inherently wrong and wrong from the standpoint of self-interest and practical effects. So choosing not to administer life-saving treatment, he notes, even to a dying patient who is being killed or is dying because of some injury or disease, that is not euthanasia because it's the injury or the disease that's killing the person.

So, he's affirming what I noted earlier, that euthanasia, we don't need to make an active-passive distinction when we're talking euthanasia. We're talking about the active acceleration of the person's demise. So, first, we have an argument from nature. He says every human being has a natural inclination to continue living, and our bodies are structured for our survival.

This is basically the natural law argument, which we've already talked about. According to natural law theory, the notion of a telos, or a particular design plan, is evident in all things that we see in nature, including our own bodies, our bodies are structured for survival, and the various organs that work within us, and all the things that they do, their functions, preserve our lives, everything about us, anatomically, physiologically, demonstrates this inclination to keep living. And euthanasia does violence to that, and it contradicts that telos that is so evident in every living thing, including human beings.

Euthanasia does violence to this natural goal of survival. As he puts it, it is against nature and our dignity. And there's an argument from self-interest, which pertains to the fact that when one is euthanized, that rules out the possibility of recovery. It's a permanent decision, and there's no going back.

So, for this reason, euthanasia can work against our own interests. If there's been a mistaken diagnosis, if there's some sort of new treatment that could emerge while the person is lingering on, or if there's some sort of spontaneous recovery that could happen, or even a miracle of God, then by hastening the person's death, we've kept them from potentially living on for months or years. This kind of thing comes up in the context of the death penalty, which we'll talk about, as an argument against the death penalty.

Because it's always possible in any given case that the ruling was mistaken, this is actually an innocent person, so people who are anti-death penalty often bring this up as a reason not to have capital punishment. Here, some similar kind of logic is involved. It's always possible you could be wrong in the diagnosis or the prognosis.

So, why not make a decision that is in the person's best interest, in terms of at least keeping open the possibility that they could live on, even for many years? A third argument is an argument from practical effects that refers to the impact that the widespread practice of euthanasia could have on the medical community. The idea is that the routine practice of hastening the death of patients for their own good or to get them out of their misery could dull healthcare professionals' commitment to saving lives.

They know that this is always an option. They see a person in intense pain. It looks hopeless.

So, if this option is always available, they might turn to this in fact, not just routinely, but in situations where it really isn't warranted and where a person has a much better chance of survival than they think. So, the worry is that healthcare professionals might not work as hard to heal patients who are severely ill, and this could have a deleterious effect on the healthcare industry generally.

So, J. Gay Williams worries about a kind of causal, slippery slope here, and he works in the concept of physician-assisted suicide in this causal slope. From taking one's own life, if we approve of that, suicide, which is less controversial than these cases of physician-assisted suicide and euthanasia, because in the case of suicide, you just have the person doing it to him or herself. But from there, if we approve of that, that will make us more likely to approve of physician-assisted suicide and deputizing others to do this for oneself or to instruct oneself to self-euthanize.

The next step is for other people to do it for the patient, in conjunction with or consistently with that patient's own desire or choice. From there to involuntary euthanasia, where a person's own choice or preference is unknown, or maybe even going against the person's wishes. If it's for their own good, then how much does their own preference matter? And then from there, finally, to a duty to die, just not the option or the moral acceptability of euthanizing, but a person having a duty to die, where the worry is that this would become so widespread and common in our culture, that people who are of a certain age, who are a particular burden financially on a family, that there will be a kind of attitude among the family or throughout society that those people are, as the Nazis used to say, useless eaters.

Grandma, Grandpa, it really is time for you to go. You've lived a long time, and you're basically a burden to us. Not that that would ever be said, but the assumption is, do yourself and the rest of us a favor and let us take this route.

You have a moral obligation to go. That's the worry. Let's put pretty stark terms here, but that's a general concern that many anti-euthanasia scholars have noted.

In response to that, we'll move on to the Bible and euthanasia. In response to that, someone like James Rachels would say that if we do this carefully, and if we're sensitive to these kinds of concerns, we can keep from rolling down this slippery slope and maintain proper regard and respect for people's own desires and wishes. If we keep the focus on the autonomy of the person who is dying, then we won't have to worry about cases of involuntary euthanasia going against the person's wishes, much less the duty to die.

These are some pretty standard arguments against euthanasia. Okay, so the Bible and euthanasia. Let's look at some arguments both for and against euthanasia.

Some argue that it's morally significant that the Bible advocates relief of suffering and mercy, that this is a fact that creates a presumption in favor of hastening a person's death, that there's extreme suffering, that it's just fulfilling a general biblical norm to show mercy to people and to try to relieve pain. Also, death in Scripture is viewed as desirable. A psalm says Precious in the sight of the Lord is the death of his saints.

And Paul says in Philippians 1, For me to live is Christ and to die is gain. So, do these biblical passages also create a presumption in favor of euthanasia or physician-assisted suicide in some cases? Thirdly, the point is sometimes made that the sixth commandment against killing is not absolute. It allows for exceptions.

We know, at least most would say, that one exception to this is killing in self-defense, certainly from a biblical standpoint, capital punishment, which was practiced widely in Old Testament times in ancient Israel. This was commanded by the same God who said, Do not kill. He said, Do kill those who kill.

Apply the death penalty to murderers, rapists, and so on, as well as just war. In many cases, Israel was commanded to go out and kill whole people groups, in fact. There's a lot of killing that's mandated by God in the Old Testament.

So clearly, the command not to kill in the Decalogue is qualified. So, the question is not just killing or no killing, but when is it appropriate to kill? So, the defender of euthanasia can argue this is another one of those exceptions.

Just as it may be okay to kill in cases of self-defense and just war or capital punishment, it may be okay to kill and hasten a person's death when they are in excruciating pain in a terminal case. Those are biblical arguments that are sometimes made in defense of euthanasia. In terms of arguments against euthanasia, the most central principle that's appealed to here is the sanctity of life, the idea that human life is sacred, we're created by God and in God's image, and God is the one who gave us life.

He endowed us with life. He sustains our life, and he preserves our lives. We are God's property.

We do not own ourselves. Paul says as much. So, the idea is that the right to life is not ours to waive.

We talk about the right to life. God gave you this right to life, but it is not your right to disregard it because God owns you. You are God's property.

This argument was made by Socrates in one of Plato's dialogues that it's an offense to God to commit suicide, and by extension, Socrates, I'm sure he would say that euthanasia, I suppose he would say this, or physician-assisted suicide, because you're destroying God's property. But at least the basic idea is there in Socrates. If not in Plato, who was actually a proponent of infanticide in some cases.

So, there would be some disagreement there, assuming that Socrates and Plato would disagree. Secondly, the intentional taking of an innocent human life is prohibited in scripture. The argument is made that unless explicit exceptions are made in scripture, this is a prohibition that needs to be respected.

No exception is recognized in the Bible in the case of mercy killing. Whereas these other exceptions I noted in terms of just war and self-defense, capital punishment, are explicitly noted. You don't have these kinds of exceptions stipulated in scripture with regard to what a person is suffering from a deadly disease or a serious life-threatening injury.

And finally, that there is value in suffering. This is emphasized in a number of different places in scripture. In the first chapter of James, in 1 Peter, and elsewhere, we need to keep that in mind.

There is value in suffering in terms of character building and opportunities for others to comfort the person who is suffering, as well as just the general biblical perspective on life, death, and the afterlife. The idea is that death is unnatural.

It's an enemy to be overcome. It's something to be fought and resisted. In numerous places in scripture, that is emphasized.

There's the old Dylan Thomas poem, Do not go gentle into that good night. Rage, rage against the dying of the light. The poem goes on to say that we should resist death.

Dylan Thomas was distraught by his father's own demise and how he was not resisting or fighting to stay alive. That caused a lot of distress for Dylan Thomas because he wanted his dad to live. That is a natural thing to try to stay alive.

A lot of people talk about death with dignity. Those who use that phrase tend to use it on the pro-euthanasia side. Somehow, that's the more dignified thing to do, is to willingly succumb to death.

The argument can be made on the other side as well. To go down fighting, that's the dignified thing. That's the essence of this argument.

We should resist and fight against death. It's an enemy to be resisted. This was the case with my own father.

He had euthanasia. He had emphysema. He personally wanted to be euthanized at one point.

He said to call Jack Kevorkian, the doctor of death, so he could apply his suicide machine to my dad. His emphysema was complicated by pneumonia. This was back in 1997.

My family was somewhat divided. He had been brought home and put on hospice care, basically waiting for my dad to die. I had spent enough time in the medical community, five years working for a veterinarian.

I was of that tech of sorts. Also, I spent a couple of years working as an insurance clerk for some pulmonary doctors. I spent a lot of time in hospitals and seeing people in various stages of demise.

Many would recover unexpectedly. I knew that it was possible for a patient whose situation looked hopeless to rally. I thought it might happen with my dad.

He'd been sent home. He was on morphine just to kill the pain. Most of my family members had basically given up hope he was going to die in just a matter of time.

I thought, particularly, if we could get him to eat better. He was not eating anything in the hospital. He had lost a lot of weight.

I thought he needed to regain his strength. I told him, I'll give you anything. Whatever you want to eat, I'll get it for you.

We need to get you stronger, and you have a shot here. I started pumping the groceries into him and keeping the morphine coming, which was killing the pain enough that he could regain his appetite. My mother and one of my brothers sat down with me and said, you know, you are lying to yourself.

Your dad's going to die. There's no way he can recover. I said, well, I've seen it happen before. They said, no, your father is dying. They were quite adamant with me. I said, just let me do this. He's hungry. I'm going to keep feeding him. What happened? Well, he got stronger and stronger, and he recovered. He lived another four years. In the meantime, his faith really grew. He was reading the Gospels.

It was an amazing thing to watch, just his kind of slow emergence spiritually. Those were valuable years. My mother and my brother later admitted, well, you were right, Jim.

We thought there was no chance. His physicians thought there was no chance. Frankly, I thought there was very little chance.

But on that 1% possibility, I acted to try to make the possibility as strong as it could be. In God's providence, my dad rallied and lived four more years. As I mentioned, it was very significant for him spiritually.

You never know. It can seem like hoping against hope. It can even seem foolish to hope for that.

But God can do some amazing things. The key, in that case, was morphing. In fact, to this day, whenever I hear that word, I associate it with something good.

Because that was key for keeping the pain at bay and up to where my dad's appetite could remain so he could eat and get stronger, I don't remember him having serious withdrawals from that. I don't know how addicted, if at all, he was to that.

But the use of narcotics, even though we live in a time where our nation has a problem, a significant problem with opiate addictions, can be a great blessing for people in excruciating pain—using opiates, strong narcotics, to reduce pain. But what about a situation where the use of narcotics can actually accelerate death? Here's another personal situation I was in.

A year or two before my dad became gravely ill, in 1997, my mother's aunt was dying. She was about 91 or 92. She was in the final throes, and her kidneys were shutting down.

That really is when you, if ever you know the person's about to die, that's it. The physician asked my mother a question about giving my aunt some pretty strong narcotics that would speed up her demise. My mom was at a loss to really give a response because she just didn't know what was best in that case, so she referred the physician to me, who asked me if we could do this. We just need your permission.

We asked because this would accelerate her death. I said, by how much? He said, I don't know, 8, 10, 12 hours. So I thought about it and said, go ahead.

So, they did it, and my great-aunt died later that day. What I did when I was asked that question is I applied something called the principle of double effect, which has a long history in Christian ethics, particularly in the natural law, Roman Catholic tradition, as being useful to make decisions in situations where a particular course of action may have good and evil or bad effects. When, if ever, is it okay to take such a course of action, knowing there are going to be mixed results in terms of good and evil? And that was surely the situation here with my great aunt.

According to the principle of double effect, such actions are justified only if they meet certain conditions. So, in the first case, evil must not be the means of producing a good effect. Secondly, the evil may not be directly intended.

And thirdly, there must be a proportionate reason for performing the act in spite of its evil consequences. So, the foreseeable benefits must be at least as great as the foreseeable harms. So that's the principle of double effect.

As applied to my great aunt, giving her these strong narcotics, which would accelerate her death, meets the first condition that evil must not be the means of producing the good effect. The good effect is her pain is reduced. The evil is her dying more quickly, but that's not the means of producing the good effect.

The means is the narcotic itself. The evil of her dying a bit earlier is a co-consequence. Secondly, it is not directly intended.

The aim of giving her these narcotics was to kill the pain or to reduce that drastically. It was not... The aim was not to kill her or kill her more quickly. So, it was not directly intended.

Thirdly, there was the proportionate reason for performing this act of giving her the narcotics in that her pain would be dramatically reduced. And we're only talking about a few hours here. We're not talking about taking her life or accelerating her death months or years in advance of when she would otherwise have died.

And since she was barely conscious anyway, really just moaning and groaning and writhing there to the extent that she was conscious, it was just purely the experience of pain. Accelerating her death by a few hours is very clearly offset by the good of taking her out of pain. So, that was a judgment I made based on the principle of double effect.

Someone might challenge that. But in any case, it's a very useful principle that applies in many terminal care cases as well as in other contexts. In fact, when we talk

about animal welfare and animal rights in a separate lecture, we'll note how the principle of double effect is useful in that context.

So, that concludes our discussion of euthanasia and physician-assisted suicide.

This is Dr. James Spiegel in his teaching on Christian ethics. This is session 14, Euthanasia and Physician-Assisted Suicide.