Arguments Against Active Euthanasia
By Doctors Found At Medicine’s Core

By Leon R. Kass, M.D.

(This article was adopted from a longer paper dealing principally with how medical ethics should treat the question of active euthanasia by physicians. The full paper will appear in the winter issue of The Public Interest)

One way to define medicine—or anything else—is to delimit its boundaries, to draw the line separating medicine from nonmedicine, or its ethical from its unethical practice. Another way to define medicine—or anything else—is to capture its center, to discern what it is most essentially. In the best case, the two kinds of definitions will be related: the outer boundary will at least reflect, and at best will be determined by, what is at the center. Some practices will be seen to be beyond the pale precisely because they contradict what is at the center.

To seek the center, one begins not with powers but with goals, not with means but with ends. In the Hippocratic Oath, the physician states his goal this way: “I will apply dietetic measures for the benefit of the sick according to my ability and judgment. I will keep them from harm and injustice.” Elsewhere, in a more thorough explication of the oath, I have argued that this little paragraph, properly unpacked, reveals the core of medicine. For example, from the emphasis on dietetics, I argue that medicine is a cooperative rather than a transforming art, and the physician an assistant to the immanent healing powers of the body. And, because a body possessed of reason is a body whose “possessor” may lead it astray through ignorance or self-indulgence, the physician, as servant of the patient’s good, must teach, advise and exhort to keep him from self-harm and injustice. Let me focus here only on the modest little phrase, “the benefit of the sick.”

The physician as physician serves the well-being only of the sick. He does not serve the well-being of the relatives or the hospital or the national debt inflated due to Medicare costs. Moreover, the physician serves the sick not because they have rights or wants or claims, but because they are sick. The benefit needed by the sick, qua sick, is health and wellness. The healer works with and for those who need to be healed, in order to make them whole.

Healing is thus the central core of medicine: to heal, to make whole is the doctor’s primary business. The sick, the ill, the not well, present themselves to the physician in the hope that he can help them become well. The physician shares that hope and that goal; his training has been devoted to making it possible for him to serve it. Despite enormous changes in medical technique and institutional practices, despite enormous changes in nosology and therapeutics, the center of medicine has not changed: it is as true today as it was in the days of Hippocrates (1) that the ill desire to be whole; (2) that wholeness means a certain well-working of the enlivened body and its unimpaired powers to sense, think, feel, desire and move; and (3) that the relationship between the healer and the ill is constituted, essentially, even if only tacitly, around the desire of both to promote the wholeness of the one who is ailing.

The wholeness and well-working of a human being is, of course, a rather complicated matter, much more so than for our animal friends and relations. Because of our powers of mind, our partial emancipation from the rule of instinct, our self-consciousness, and the highly complex and varied ways of life we follow as individuals and as members of groups, health and fitness seem to mean different things to different people, or even to the same person at different times of life. Moreover, departures from health have varying importance depending on the way of life one follows.

Constant and Organic

Yet not everything is relative and contextual; beneath the variable and cultural lies the constant and organic, the well-regulated, properly balanced, and fully empowered human body. Indeed, only the existence of this natural and universal subject makes possible the study of medicine. The cornerstone of medical education is the analytical study of the human body, universally considered: anatomy, physiology, biochemistry and molecular biology, genetics, microbiology, pathology and pharmacology—all these sciences of somatic function, disorder and remedy are the first business of medical schools, and they must be learned before one can hope to benefit particular human beings in need of help.

But human wholeness goes beyond the kind of somatic wholeness abstractly and reductively studied by the various (continued on page 2)
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sciences. Whether or not doctors are sufficiently prepared by their training to recognize it, those who seek medical help in search of wholeness are not to themselves just bodies or organic machines. Each person intuitively knows himself to be a center of thoughts and desires, deeds and speeches, loves and hates, pleasures and pains, but a center whose workings are none other than the workings of his enlivened and mindful body. The patient presents himself to the physician, tacitly to be sure, as a psychophysical unity, as a one, not just as a body, but also not just as a separate disembodied entity that simply has or owns a body. The person and the body are self-identical. To be sure, the experience of psychophysical unity is often disturbed by illness, indeed, by bodily illness; it becomes hard to function as a unity if part of oneself is in revolt, is in pain, is debilitated. Yet the aspiration of the patient is to have the disturbance quieted, to restore the implicit feeling and functional fact of oneness with which we freely go about our business in the world. The sickness may be experienced largely as belonging to the body as something other; but the healing one wants is the wholeness of one’s entire embodied being. Not the wholeness of soma, not the wholeness of psyche, but the wholeness of anthropos as a (puzzling) concretion of soma-psyche is what medicine is finally all about.

Logical Difficulty

Can wholeness and healing, thus understood, ever be compatible with intentionally killing the patient? Can one benefit the patient as a whole by making him dead? There is, of course, a logical difficulty: how can any good exist for a being that is not? “Better off dead” is logical nonsense—unless, of course, death is not death indeed but instead a gateway to a new and better life beyond. But the error is more than logical: in fact to intend and to act for someone’s good requires their continued existence to receive the benefit.

This is not to say that certain attempts to benefit may not in fact turn out, unintentionally, to be lethal. Giving adequate morphine to control pain might induce respiratory depression leading to death. But the intention to relieve the pain of the living presupposes that the living still live to be relieved.

Hard Cases

Against this view of healing the whole human being, someone will surely bring forth the hard cases: what of a patient so ill-served by his body that he can no longer bear to live? What of a body riddled with cancer and wracked with pain, against which its owner protests in horror on from which he insists on being released? Generally speaking, it just isn’t true that we are psychophysical unities; rather, we are some hard-to-specify duality (or multiplicity) of impersonal organic body plus supervening consciousness, what the professionals dub personhood: awareness, intellect, will. Cannot the person “in the body” speak up against the rest, and request death for personal reasons?

However sympathetically we listen to such requests, we must see them as incoherent. Strict person-body dualism cannot be sustained. “Personhood,” whatever it may be, is manifest on earth only in living bodies; our highest mental functions are held up by, and are inseparable from, lowly metabolism, respiration, circulation, excretion. There may be blood without consciousness, but there is never consciousness without blood. The body is, to say the least, the living ground of all so-called higher functions. Thus, to call for death in the service of personhood is like a tree seeking to cut its roots for the sake of growing its highest fruit. No physician devoted to the benefit of the sick can serve the patient as person by denying and thwarting his personal embodiment.

To say it plainly, to bring nothingness is incompatible with serving wholeness: one cannot heal—or comfort—by making nil. The healer cannot be an annihilator if he is truly to be a healer. The boundary condition, “No deadly drugs,” flows directly from the center, “Make whole.”

The reasonableness of this approach to medical ethics is encouraged by finding analogies in other professions. For example, we can clearly discover why perjury and contempt of court are taboos for lawyers, why falsifying data is taboo for a scientist, or why violation of the confessional is taboo for a priest, once we see the goals of these professions to be respectively, justice under law, truth about nature, and purification of the soul. Let me expand two other analogies somewhat closer to our topic.

Being a Teacher

Take the teacher. His business: to encourage and to serve as the occasion for learning, for understanding. Recognizing this central core, we see that the teacher ought never to oppose himself to the student’s effort to learn, or even to his prospects for learning. This means, among other things, never ridiculing an honest effort, never crushing true curiosity or thoughtfulness; it also means opposing firmly the temptations of students to scramble their minds, through drugs, etc. (continued on page 3)
Are Found in Core Definition of Medicine

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And even when the recalcitrant student refuses to make the effort, the teacher does not abandon his post, but continues to look for a way to arouse, to cajole, to inspire, to encourage. The teacher will perhaps not pursue the unwilling student, but as long as the student keeps coming to class, the true teacher will not participate in or assist him with his mental self-neglect.

Finally, let us look at the parent. These days only a fool would try to say what the true business of father or mother is, qua father or mother. Yet it must be something like protection, care, nurture, instruction, exhortation, chastisement, encouragement and support, all in the service of the growth and development of a mature, healthy, competent, and decent adult, capable of an independent and responsible life of work and love and participation in community affairs—no easy task, especially now. What will the true parent do when teenagers rise in revolt and try to reject not only the teachings of their homes, but even the parents themselves, when the sons and daughters metaphorically kill their parents as parents by un-sonning and un-daughtering themselves? Should fathers acquiesce and willingly unfather themselves; should mothers stand against their life work of rearing and abandon the child? Or does not the true parent “hang in there” in one way or another, despite the difficulty and sense of failure, and despite the need for perhaps great changes in one’s conduct? Does not the true parent refuse to surrender or abandon the child, knowing that it would be deeply self-contradictory to deny the fact of one’s parenthood, whatever the child may say or do? Again, one may freely choose or refuse to become a parent, but one cannot fully choose what it means. The inner meaning of the work has claims on our hearts and minds, and sets boundaries on what we may do without self-contradiction and self-violation.

I have argued that the work of professionals, and parents like professionals, has a core meaning. The physician’s work centers on the goal of healing and he is bound not to act in contradiction to that goal. But there is a difficulty. The central goal of medicine—health—is in each case, a perishable good: inevitably, patients get irreversibly sick, patients degenerate, patients die, medicine or no medicine. Unlike—at least at first glance—the activity of teaching or rearing the young, healing the sick is in principle, i.e., in the best possible case, a project that cannot succeed indefinitely, a project that must fail. And here is where all the trouble begins: How to deal with “medical failure”? What to seek when restoration of wholeness—or much wholeness—is by and large out of the question?

There is much that can and should be said on this topic, which is, after all, the root of the problems that give rise to the call for mercy killing. I have addressed this issue elsewhere, arguing for the primacy of easing pain and suffering, along with supporting and comforting speech, and more to the point, the need to draw back from some efforts at prolongation of life that prolong or increase only the patient’s pain, discomfort, and suffering. Though mindful of the dangers and aware of the impossibility of writing explicit rules for ceasing treatment—hence the need for prudence—I argued that considerations of the individual’s health, activity and state of mind must enter into decisions of whether and how vigorously to treat if the decision is indeed to be for the patient’s good. Ceasing treatment and allowing death to occur when it will seem to be quite compatible with the respect that life commands for itself. For life is to be revered not only as manifested in physiological powers, but also as these powers are manifested in the form of a life, with its beginning, middle, and end. Thus, life can be revered not only in its preservation, but also in the manner in which we allow a given life to reach its terminus. For physicians to adhere to efforts for indefinite prolongation not only reduces them to slavish technicians without any intelligible goal, but also degrades and assaults the gravity and solemnity of a life in its close.

Is killing a patient, even on request, compatible with respecting a life that is failing or nearing its close? Obviously, the euthanasia movement thinks it is. Yet one of the arguments most often advanced by proponents of mercy killing seems to me rather to prove the reverse. Why, it is argued, do we put animals out of their misery, but insist on compelling fellow human beings to suffer to the bitter end? Why, if it is not a contradiction for the veterinarian, does the medical ethic absolutely rule out mercy killing? Is this not simply inhumane?

Perhaps inhumane, but not thereby inhuman. On the contrary, it is precisely because animals are not human that we must treat them (merely) humanely. We put dumb animals to sleep because they know not that they are dying, because they cannot live deliberately—i.e., humanly—in the face of their own suffering or dying. They cannot live out a fitting end of their existence. Compassion for their weakness or dumbness is our only appropriate emotion, and, given our responsibility for their care and well-being, we do the only humane thing we can. But when a conscious human being asks us for death, he by that very fact displays the presence of something that precludes our regarding him as a dumb animal. Humanity is owed humanity, not humaneness; humanity is owed the bolstering of the human, even or especially in its dying moments, in resistance to the temptation to ignore its presence in the sight of suffering.

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Books

Recent Acquisitions

(New additions to the collection of the National Reference Center for Bioethics Literature.)


DeMarco, Donald. IN MY MOTHER'S WOMB: THE CATHOLIC CHURCH'S DEFENSE OF NATURAL LIFE. Manassas, VA: Trinity Communications, 1987, 234 p. Catholic teachings on abortion, genetics, and reproductive technologies are explained as they are determined by the Vatican Instruction on Life in Its Origin.

Edwards, Rem B. and Graber, Glenn C., eds. BIOETHICS. San Diego, CA: Harcourt Brace Jovanovich, 1988. 755 p. Ten chapters present basic issues in bioethics, such as medical resource allocation, reproductive technologies, abortion, euthanasia, care of the mentally ill, the concept of health, medical experimentation, informed consent and the patient-physician relationship.

Feinberg, Joel. HARMLESS WRONGDOING. New York, Oxford University Press, 1988. 380 p. Volume 4 of the series "Moral Limits of the Criminal Law" considers whether certain activities that do not harm consenting participants should be criminalized by the state.


Horn, Carl, ed. WHOSE VALUES? THE BATTLE FOR MORALITY IN PLURALISTIC AMERICA. Ann Arbor, MI: Servant Books, 1985. 205 p. (Shriver Collection of Christian Ethics.) The debate of secular versus religious values as determiners of public policy is discussed by 10 authors from different fields. Infanticide, parental control over minors, abortion, moral education and "secular humanism" are some of the issues examined.


Levine, Carol. TAKING SIDES: CLASHING VIEWS ON CONTROVERSIAL BIOETHICAL ISSUES. Guilford, CT: Dushkin Publishing Group, 1987. 360 p. (Second edition.) Twenty chapters treat bioethical controversies ranging from abortion to surrogate motherhood, euthanasia to treating the mentally ill, human and animal experimentation, organ donation and costs for health care.

Mathieu, Deborah, ed. ORGAN SUBSTITUTION TECHNOLOGY: ETHICAL, LEGAL AND PUBLIC POLICY ISSUES. Boulder, CO: Westview Press, 1988. 340 p. Dilemmas in organ transplantation and substitution are examined by major authors in the field of bioethics. Twenty-one essays discuss problems of organ procurement, recipient selection, costs and funding of the technology, allocation of resources, and artificial heart experimentation.


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New Books Added to Bioethics Collection

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... techniques are described as they have been used in combat. Future applications of biotechnology, regulating new life-forms, and international biological weapons treaties are considered.


Rouner, Leroy S., ed. FOUNDATIONS OF ETHICS. Notre Dame, IN: University of Notre Dame Press, 1983. 237 p. Constraints occurring between cultures due to the differences between Christian ethics, Western and Eastern ethical values, and philosophical ethics are explained.


Spicker, Stuart F., et al., eds. THE USE OF HUMAN BEINGS IN RESEARCH: WITH SPECIAL REFERENCE TO CLINICAL TRIALS. Boston: Kluwer Academic, 1988. 291 p. The history and reasons for human experimentation are reviewed, and the ethical and epistemological issues in randomized clinical trials are discussed before obligations of the subjects are considered in these 14 essays presented at the 14th Trans-Disciplinary Symposium on Philosophy and Medicine.


Wass, Hannelore; Berardo, Felix M.; and Neimeyer, Robert A., eds. DYING: FACING THE FACTS. New York: Hemisphere, 1988. 472. (Second edition.) Within the three broad areas of perspectives, facts and issues, the subject of death and dying is explored by discussing topics such as life preservation, the right to die, hospice care, definition of death, suicide, and the sociology of death.


(By Marlene Johnson)

Scope Notes Issued; Keyword Guide Is Out

Two new papers in the Scope Notes Series were issued in the fall of 1988. Scope Note 9 is titled "Bioethics Audiovisuals 1892 to Present" and Scope Note 10 is called "Ethical Issues in In Vitro Fertilization." Each has been sent to members of the Kennedy Institute as a regular benefit of membership. Extra copies are $3 each, prepaid.

The new Bioethics Thesaurus 1988 containing all keywords currently used in BIOETHICSLINE is now available and costs $5, prepaid. The thesaurus contains succinct definitions for bioethics terms as well as information about subject captions and simple search suggestions. The thesaurus is printed in full as part of the Bibliography of Bioethics, where it is found following the subject entry section of the volume.
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What humanity needs most in the face of evil is courage, the ability to stand against fear and pain and thoughts of nothingness. The deaths we most admire are those of people who knowing that they are dying, face the fact frontally and act accordingly: they set their affairs in order, they arrange what could be final meetings with their loved ones, and yet with strength of soul and a small reservoir of hope, they continue to live and work and love as much as they can for as long as they can. Because such conclusions of life require courage, they call for our encouragement—and for the many small speeches and deeds that shore up the human spirit against despair and defeat.

Many doctors are in fact rather poor at this sort of encouragement. They tend to regard every dying or incurable patient as a failure, as if an earlier diagnosis or a more vigorous intervention might have avoided what is, in truth, an inevitable collapse. The enormous successes of medicine these past 50 years have made both doctors and laymen less prepared than ever to accept the fact of finitude. Doctors behave, not without some reason, as if they have god-like powers to revive the moribund; laymen expect an endless string of medical miracles. It is against this background that terminal illness or incurable disease appears as medical failure, an affront to medical pride. Physicians are today little likely to be agents of encouragement once their technique begins to fail.

It is, of course, partly for these reasons, that doctors will be pressed to kill—and many of them will, alas, be willing. Having adopted a largely technical approach to healing, having medicalized so much of the end of life, doctors are being asked to provide a final technical solution for the evil of human finitude and for their own technical failure: if you cannot cure me, kill me. The last gasp of autonomy or cry for dignity is asserted against a medicalization and institutionalization of the end of life that robs the old and the incurable of most of their autonomy and dignity: intubated and electrified, with bizarre mechanical companions, helpless and regimented, once proud and independent people find themselves thrust in the roles of passive, obedient, highly disciplined children. People who care for autonomy and dignity should try to reverse this dehumanization of the last stages of life, instead of giving dehumanization its final triumph by welcoming the desperate good-bye-to-all-that contained in one final plea for poison. The present crisis that leads some to press for active euthanasia is really an opportunity to learn the limits of the medicalization of live and death and to recover an appreciation of living with and against mortality. It is an opportunity for physicians to recover an understanding that there remains a residual human wholeness—however precarious—that can be cared for even in the face of terminal and incurable illness.

Should doctors cave in, should doctors become technical dispensers of death, they will not only be abandoning their posts, their patients, and their duty to care; they will set the worst sort of example for the community at large—teaching technicism and so-called humaneness where encouragement and humanity are both required and sorely lacking. On the other hand, should physicians hold fast, should medicine recover the latent anthropological knowledge that alone can vindicate its venerable but now threatened practice, should doctors learn that finitude is no disgrace and that human wholeness can be cared for to the very end, medicine may serve not only the good of its patients, but also, by example, the failing moral health of modern times.

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