Euthanasia, letting die and the pause

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Author’s abstract

There is a marked disparity between medical intuitions and philosophical argument about euthanasia. In this paper I argue that the following objections can be raised. First, medical intuitions are against it and this is an area in which judgement and sensitivity are required in that death is a unique and complex process and the patient has many needs including the need to know that others have not discounted his or her worth. Also, part of the moral constitution of a good doctor is a devotion to the protection and preservation of life whatever reasons are produced to dissuade her. Finally, we do not know what the final events of a person’s life might hold.

In the debate over euthanasia there is a curious tension between the intuitions of doctors, which are almost always against active voluntary euthanasia, and the arguments of philosophers which are almost universally for it. It is also striking that any doctor who is asked is convinced that there is a clear difference between active and passive euthanasia – killing and letting die – yet a defensible ethical difference is hard to find. A deontologist might well argue that individuals have a right to life but can waive that right and ask for a merciful death should events bring them to the point where that is their preference (1). The physician might, with some justification, argue that he has a right not to be asked to kill but this does not seem an insurmountable problem (2). Consequentialists are apt to claim that where the remainder of a human life is likely to hold a negative balance of goods and bads and the individual prefers not to struggle through it, then euthanasia is the only kind thing. They also dismiss the difference between killing and letting die (‘letting nature take its course’) except where the former is kinder and involves less suffering (3). We kill animals to put them out of their misery so why be harder on human beings? Indeed, Thurston Brewin, a doctor involved in the care of terminal patients, conceded

‘... it is very illogical of us to make this distinction between active and passive. Well, so it is. Logically there is little or no difference. But our gut instinct tells us that there is. And, like it or not, we are not going to be browbeaten into changing our minds by mere logic; nor even by the remarkable fact that, whereas in the case of human beings passive euthanasia is widely regarded as a civilised and humane compromise, in the case of animals the same thing is considered an inexcusable cruelty’ (4).

But in medical ethics we are concerned to provide a more secure basis for ethical decisions than the intuitions of doctors and nurses. In this paper I will draw on three claims to argue that such medical intuitions are a central part of our moral reasoning in this area even though they cannot be captured in formalisable ethical principles. The first claim is that medical ethics as much as in more general ethics we are dependent upon the moral competence of the agents involved (5). The second is that a crucial element in the moral competence of a doctor is a tendency to hesitate, have misgivings or feel a ‘pause’ about certain principled medical decisions involving life and death. The third is that a calculus of moral weightings (whether deontological or consequentialist) will never comprise an adequate basis for medical ethics. I shall illustrate the argument by appeal to clinical examples and attempt to show that the moral constitution of a doctor is and should be such that he see the difference between killing and letting die. I will close with a short argument which is often overlooked in the debate concerning active euthanasia.

I. Moral competence

A one-day-old child was admitted to the hospital with a large defect between its eyes from which a considerable quantity of brain tissue was extruding (such a defect is called an encephalocele). A brain scan (CT scan) was performed which showed that this was not an isolated brain abnormality but that the brain was also abnormal in other ways. The senior neurosurgical resident on duty, who knew that his recommendation would probably be supported by the consulting surgeon on call, examined the child. He inspected the child’s head with the formed intention to recommend non-intervention and let the child die. As the child’s head was being examined, its normal (and attractive) face screwed up and the child emitted a cry (which,
course, as right in his action as the first doctor described. Nevertheless, I believe that his lack of 'pause' at such moral junctures betrays a moral insensitivity which calls into question his grasp of the moral content normally present in the relevant principles. The phenomenology of this pause and what it reveals about the moral constitution we should bring to ethical decisions in medicine needs to be illuminated. When the requisite light is shed it suggests that philosophical argument has its limits in medical ethics in just the way that Williams has recently suggested that it might in other areas of ethical practice and theory (8). We might get a glimpse of the approach to be taken if we note that moral reasoning constitutively involves 'reactive attitudes' (in Strawson's sense) (9). If that is the case then the elements of moral reasoning would be inseparable from reactions like the pause which often seem to intrude upon it.

II. Moral sensitivity

Moral terms and their associated concepts, like all other terms, need to be learned. In the acquisition of ordinary concepts a person depends upon her interactions with others who have mastered those concepts and can introduce her to their use and conceptual relations. Davidson supports such a construal in taking mutual interpretation as the source of meaning (10). Wittgenstein also, scrutinising the roots and nature of meaning, notes that human beings and the practices in which we find them participating are the milieu in which thought and our concepts find their life: '6... children are brought up to perform these actions, to use these words as they do so, and to react in this way to the words of others.' (10). What do the words of this language signify? – What is supposed to show what they signify, if not the kind of use they have?' (43. For a large class of cases – though not for all – in which we employ the word "meaning" it can be defined thus: the meaning of the word is its use in the language.' (432. Every sign by itself seems dead. What gives it life? – In use it is alive. Is life breathed into it there? – Or is the use its life?' (11). These sketchy outlines of an approach to meaning are all that I will offer in support of the thesis that meaning and understanding are intersubjective phenomena which have their roots in the use of language.

The implications of such a view for the meaning of those terms which are essential to moral reasoning have been discussed by McDowell (12). He has suggested that the capacities involved in grasping the use of moral terms depend upon 'a congruence of sensitivities' (13). Moral terms centrally concern persons and what happens to them. A child learns terms such as 'kind', 'cruel', 'nice', 'hate', 'right', 'bad' and so on as what matters to him and others with whom he is in close contact. This is illuminated by conversation and the actions of others. The unequivocally and deeply ethical members of this set of terms engage his personal feelings and commitments in throwing the events and

incidentally, was abnormal in quality and confirmed the judgement that the child had a severe congenital brain defect). This event gave the examining doctor pause in delivering the opinion he otherwise thought to be right. With a deepened sense of the moral significance of his act and reminding himself both of the prolonged suffering that mars the lives of such children and of the destructive effect they tend to have if they are allowed to live (6), he called his consultant who endorsed the decision that no treatment should be offered.

Our moral reasoning may commend this decision to us but it is interesting that, at a certain point, the agent concerned took pause to reconsider, even though he had already discussed the ethical pros and cons with other staff involved with the child and its parents. I will argue that his momentary pause was morally significant rather than being the result of an irrational and distracting emotional reaction which should be put to one side in moral reasoning and that it furnishes a clue as to why we feel misgivings about active euthanasia.

Elsewhere I have argued that if a person has suffered severe and irreversible brain damage there is good moral reason to let him die as a result of his injury or disease, and that such reason does not appeal to social utility but rather to the fact that the human life concerned has ceased to have the features that justify the special status we confer on persons (7). Nevertheless a decision not to treat a young person admitted from a road accident with a severe head injury gives one the same kind of pause as the doctor in the example above.

When one considers active euthanasia one could envisage a doctor approaching a suffering patient (who has asked to be put out of his misery) with this intent. Let us say that the patient has disseminated cancer, cannot move in his bed for pain, cannot eat because of nausea and has difficulty breathing because of the restrictive effect of a large quantity of intra-abdominal fluid. He has expressed the firm resolve that he does not want to linger on, that life is unbearable and that he feels that nothing is left to him save the prospect, if the doctor will only comply, of a merciful and welcome death. The doctor carries a syringe containing a lethal dose of medication and inserts a drip into one of the few remaining veins in the patient’s arm. She must then administer the drugs and kill the patient. She too may well feel 'the pause'. What weight should she give to it? The decision as to whether the pause should be resolutely disregarded or reflectively respected turns on its moral rather than its psychological or emotional significance and thus on a possible conceptual connection between this reaction and a reflective judgement as to whether and how a life should end.

Imagine that the young doctor in the first situation made the decision not to treat the child and evinced no reaction when the child cried. If asked whether the cry had affected him he would have said ‘Not at all, I knew what I should do so that was irrelevant’. He is, of
situations that he encounters into an evaluative relief. Our concepts of right and wrong in which evaluative meanings are expressed and articulated are therefore personal and interpersonal in the sense that they involve beings who share with us in the exploration and understanding of our own mental and moral attributes. Many of these attributes and the terms in which we understand them directly emerge from our natural reactions, our relationships with others and our emotional responses to those others. Interactive learning situations (or ‘language-games’) in which we use attitude words such as ‘hurt’, ‘mean’, ‘kind’ and so on define and refine the ‘reactive attitudes’ which come into play in our later exchanges with other persons; they are, as it were, the currency of moral understanding. By mastering exchanges in this currency we come to a grasp of morality and its place in the life of persons, and here we are not merely noting certain empirical or genetic features but exploring the criteria or essential features of use by which we confer meaning on moral terms (and thereby content on moral concepts). Williams implies just such a construal in certain recent remarks: ‘We must also see that our reactions and relations to other groups are themselves part of our ethical life, and we should understand these more realistically in terms of the practices and sentiments that help to shape our life’; and: ‘This discussion suggests a conclusion about the future of ethical thought and practice. . . . The process would involve a practical convergence, on a shared way of life. . . . In the practical ethical case convergence would need to be explained in terms of basic desires or interests, and this also requires the process to be uncoerced. . . . If the agreement were to be uncoerced it would have to grow from inside human life.’ (14). He also remarks:

‘This is why it is a misunderstanding to ask, in the way that ethical theorists often ask, “what alternative” one has to their formulations. They mean, what formulation does one have as an alternative to their formulations, either of the answer or of some determinate heuristic process that would yield an answer, and there is none. There might turn out to be an answer to the real question, and this would indeed be an alternative to their formulations; but it would not be an answer produced in the way that their demand requires an answer, as a piece of philosophy. To suppose that, if their formulations are rejected, we are left with nothing is to take a strange view of what in social and personal life counts as something’ (15).

His arguments tend towards the conclusion that there is a clearcut way neither to inform nor to capture our moral judgements by appeal to argument alone. In moral thought a certain sensitivity is also required which only emerges in engagement with others who reciprocate our reactions and attitudes. If moral concepts do have meaning in virtue of the way they are interwoven with our emotional involvements with and commitments to others (who define our universe of discourse and among whom we learn to understand human nature) then they are not only informed but essentially informed by our natural human responses and emotional reactions (much as Hume noted). This is not to say that natural responses – our moral and personal reactions – constitute a principled and therefore adequate morality but one can locate the material which gives moral concepts their content within those aspects of human ‘forms of life’ that involve relationships and feelings. Moral arguments do not stop with the way that moral agents feel but much of their suasion derives from an origin in those feelings and principled reflection upon them. In such a construal moral sensitivity becomes a significant feature of moral thought. One could say that certain reactions are part of one’s engagement or ‘agreement in judgements’ within the meaning structure that is constituted by moral discourse. Thus, without accepting that the good merely requires to be recognised for what it is (16) nor that it is, in some sense, ‘nonrepresentable and indefinable’ (17), nor that ‘all one can do is to appeal to certain areas of experience, pointing out certain features and using certain metaphors and inventing certain concepts where necessary to make those features visible’ (18), one can still see a grain of truth in these observations. Discerning the moral thing to do does involve being sensitive to the ways in which aspects of a situation impinge upon the needs, hopes and identities of others. In that sensitivity an agent draws heavily on mutual experience with others where he has learnt to appreciate and understand human feelings in general and his own as one case of them. If he does not have the requisite sensitivity, then attempting to point out to him some moral aspect of a situation you may well fall back on a hapless ‘But don’t you see?’ (19) as argument would not avail in attempting to overcome his defect.

III. Moral thought about human organisms

Moral competence is, of course, both a matter of making certain moral observations and of acting in a moral way, as Aristotle noted (20). On the view that I have urged it becomes clear that moral thinking will be action-guiding but not solely in terms of rules which can be weighed one against another. The rules or principles will draw force from the sensitivities to which they appeal. The context in which a person acquires her moral concepts is a context in which she is acting and interacting with other persons who mean something to her. This implies that, in acquiring a grasp of a word like ‘hurt’, ‘suffer’, ‘sympathy’, or ‘wrong’, feeling the force of what matters to another (or imaginative identification with the sufferer) and sympathetic action will naturally grow together (21). Such active responses will sometimes be encouraged and sometimes discouraged and will form part of the language game in which the concepts in question come into play through the use of relevant terms. Even though, under the influence of reflection, one abandons the narrow frame of interests and
involvements that have given rise to moral awareness and responses, there remains a sense in which ‘full’ moral engagement in a situation will be most clearly felt and most powerfully elicited where the moral thinker has entered some personal relationship in which the problem surfaces. That is perhaps why Peter Winch remarks ‘In moral as in other branches of philosophy good examples are indispensable: examples, that is, which bring out the real force of the ways in which we speak and in which language is not ‘on holiday’ (to adapt a remark of Wittgenstein’s)’. In the euthanasia debate the voices of those whose language is informed by practice with the situations involved are instructive. Karen Gyllenskold, a Swedish psychologist involved in the counselling of dying patients, identifies one of the central concerns in facing one’s death as the need to feel that one is no longer worthless and thus suitable for doing away with. ‘When my patient felt absolutely worthless, she would introduce the topic of active euthanasia to me, to her doctor, to her family and to the ward staff. But this did not create an ethical problem for any of us; we have never known patients to persist with such wishes after receiving psychological counselling and after an analysis of their situation’.

Mother Frances Dominica, the director of a children’s hospice also has some pertinent observations.

‘Despite society’s fear of death and ineptitude in the face of death, I believe that every individual has the potential to meet death with a severe beauty which in no way denies grief. Being alongside such families you absorb some of their grief. But you also share some of the good things – learning to think in time of terms of depth rather than length; enjoying the swift growth of real friendship; bypassing the usual obstacles of class, creed, colour, age, education; having ‘all one’s sensitivities heightened’ as one father put it. And you begin to recognise and reverence the beauty in every man, woman, and child because tragedy lifts the mask of pretence and truth is revealed’.

We do not know what will happen to this unique situation if it becomes another object of medical technology, the preserve of, say, ‘telostricians’ whose job is to smooth it out and make it as subject to preference as are many of our other decisions. It is the intuitions and conceptions informed by actual experience that must be given especial weight in moral reasoning in this area.

IV. The ‘pause’

We can now look at ‘the pause’ – and the reaction of medical agents generally – and ask whether there is a conceptual link to moral competence such that an agent who acts in a principled way but does not experience this pause must be regarded as morally deficient in some sense. I have argued that the principles one uses should allow one to put reflective weight upon the propensities that one feels but should not, one would hope, completely replace or suppress them. A morally sensitive doctor will and does formulate principles which translate physical and mental prognosis into guidelines for treatment. But his reactions to the person whose prognosis he is considering become part of the actual and imaginatively conceived experience and inform his reasoning. This fact not only reflects a natural human tendency but also should be fostered by a doctor’s training.

In training a doctor there is a curious tension. He is encouraged to have a certain detachment from the emotional impact of the conditions that he treats and their effect upon those that suffer them, and yet this is held in delicate balance with a much more morally and personally loaded approach to his patients. Very early on in his training the tension comes into focus in the dissecting room (where some of the most stable friendships in a doctor’s life are forged). Here he is taught to dissect and yet maintain a deeply respectful attitude to the human body within a framework of decorum. This conveys the attitude that one is dealing with something of high ethical importance which is not to be treated lightly. One could say that it deepens our natural propensity to regard the human body or form as the focus of a complex of moral attitudes. The attitude of respect fostered in the anatomy room is just the beginning of a process in which the patient is seen as an ethically significant being and not merely as ‘clinical material’.

In most medical courses there is a period of study at the beginning of the clinical years in which one comes to appreciate ‘the practice of medicine’ and learns to marry the biological facts learned in preclinical courses with the concern for the suffering of others that will dominate subsequent practice. This latter represents the ‘normative’ attitude which gives medicine its impetus – the intention to put right that which is interfering with or causing a wrong within the life of another. The normative concern is sharpened by the encouragement one receives to develop and establish satisfactory ‘doctor-patient relationships’ in one’s clinical practice. In such a relationship the patient is encouraged to exercise trust and responsibility and the doctor care and support. The whole nature of the relationship is such that empathy for the suffering being borne by the patient is implicit and essential. It is this implicit and desirable feature of clinical practice that helps to avoid the mentality in which the disease is to be combated at no matter what cost in pain and distress to the patient. In fact the doctor focuses on the patient as a person and implicitly asks ‘How would I like to be treated?’ or ‘What would I want in this situation for someone I loved?’. This can never be a totally detached reflection as it is fuelled by the sensitivity which gives content to the understanding of moral and interpersonal language and the place that such language holds in our life and
thought. But this means that just those moral reactions which give us pause when they are evoked by the child with the encephalocoele, the severely brain-injured patient in coma or the terminal cancer patient are inextricably interwoven with the principled moral reasoning which may tend to a more detached conclusion (28). The springs of our moral concern involve an attitude which is extremely sensitive to the presence, bodily form, activity, and feelings of another human being and thus will respond to certain potent (even symbolic) cues – a child’s cry, the peaceful and helpless face of the comatose, the dependence and vulnerability of those who are in great pain – which we cannot blot out nor even down-play if we wish to retain our moral integrity. It will be symptomatic of having the sensitivities involved in grasping the import of the moral dilemmas in medicine that one will evince certain reactions, or feel ‘the pause’ when confronted by such cues.

V. Necessary discomfort

Where then should we turn? It is clearly not right to neglect the potentially harmful effects and very real human suffering that will result if ‘the pause’ is allowed to determine our decisions in all or even a majority of cases. However, we do need to realise the importance of just this reaction in evincing the kind of moral constitution fundamental to the caring professions in particular but, in fact to our common humanity in general. The pause is also important in that it warns us when we are straying near the borderline where wisdom and circumspection are required because our moral sense is signalling the inadequacy of ‘formulations’. The pause marks the area where our ethical acuity needs to be awakened because the human features of the situation matter a great deal and our full moral sensitivity needs to get purchase. We must accept therefore that not only can nothing be done to make this kind of decision easier but also perhaps nothing should be, if we wish to avoid just those slippery slopes that often loom large in medical ethics (29). Where we are acutely aware of a tug ‘uphill’ towards inconvenient and costly involvement we are less likely to slide down to the point where persons are disposable and convenience is all. What is more we cannot hope to replace our very human sensitivity by a system of guidelines which will spell out the correct thing to do in all situations as Williams has suggested in his reservations about ‘alternative formulations’. We must, in short, condemn ourselves to moral agonising on the basis of what counts to us as morally sensitive beings. Therefore, the reserve we feel when we pause is important and not to be shrugged off although in many circumstances we will override it with a resolute moral decision guided by certain general principles. That decision is, in fact, motivated by a wider and more critical application of just those sensitivities brought to the surface by the saliency that has drawn our poignant moral reaction in the cases in question. Thus ‘the pause’ takes on dual significance; it reveals the presence of those elements of nature and training that constitute an informed moral sense, and it allows us to reflect upon the weight of the decision we are making, to experience the moral saliencies ‘refresh’ and so keep our sensitivities sharp and informed in the face of repeated exercise and the danger of forming a ‘blunted’ appreciation of what we are about. I have thus argued that the moral discomfort we feel about these situations is not regrettable and revisable but, in fact, indispensable. Only by appreciating the intransigence of the problem of acting morally in these situations can we be assured that we have the requisite moral sensitivities to address such problems in anything like an informed way.

Unlike many problems with which modern medicine has come to deal, moral conflict is not a disease awaiting a cure, indeed it should be seen as a symptom of moral health.

VI. Euthanasia

I now want to venture beyond what some might regard as the rather elusive and unsystematic remarks I have made and offer some definite objections to active euthanasia.

First, the fact that medical intuition tells against it is to be taken as serious moral evidence that there may well be something wrong with what is being contemplated. Medical intuitions are trained to produce the correct responses where a careful and sensitive weighing of life and death issues is required. Doctors accept this role and must do if they are to function at the cutting edge of our ethical concern for the afflicted. It is not open to a doctor to ask, with Cain, ‘Am I my brother's keeper?’; in fact so deep-rooted is the opposite attitude that it can lead to that tragic and misguided paternalistic ‘beneficence’ that sometimes results in an unenviable prolongation of what has become a travesty of human life. In such situations it may well be the patient who asks for release. This bears on euthanasia in two different ways. On the one hand it suggests that if there is reason to think that the problem of euthanasia does require careful and sensitive judgements to be made in highly particular circumstances then we ought to take careful note of medical intuitions. It also underlines the fact that by involving the medical profession in this issue we recognise that there is a central place for just that caring ethos which medicine represents. But this means that there is unlikely to be a formulation which prescribes the right balance to strike and obviates the need for action informed by the values fostered in that ethos. One might say that the medical profession has a right to stand by its powerful but informal central tenets in an uncertain situation even where a patient wishes to waive his right to life (30).

Second, we can adduce a worry about death and its unique, central and complex place in our attitude to human life (31). This worry is strengthened by Mother Frances’s remarks about nobility, beauty and truth even where a child must face death. We worry that a
"quick and merciful" death will "spare" us the last events that are so unique and valuable and that a climate in which death is seen as the ultimate treatment for discomfort will create the expectation that at a certain point one ought to consent to be disposed of. That this is a real and not a fanciful possibility seems the irresistible conclusion of Karen Gyllenskold's observations and brings us to a third worry.

If it is possible that any given request for euthanasia is a test to see if one is still worth something despite being distressing, ugly, helpless and doomed, then death is a clear and forthright answer to that question, but we might question whether it is the right one.

Fourthly, what we do sometimes tends to become an item in our repertoire of acts. In this case it is killing, albeit for the best reasons and surrounded by checks and balances of a highly ethically and personally demanding kind. But the human mind has a perennial tendency to simplify and categorise and thus the finer points of many situations become overlooked, particularly when those points themselves are a little hard to specify. For instance, it is much easier to see Beethoven as plainly romantic than to realise how much his work is charged with classical elements and even involves certain impressionist features. Or again we tend to think of the ancient Greeks as noble, rational, democratic and cultured but often forget the extent of their callousness, cunning, dishonesty, and depravity. The reasons given for a euthanasia decision may saliently feature pain, disability and suffering and therefore, by silence, encourage a relatively impoverished assessment of the worth of a human life. If human well-being and quality of life is as difficult to define as it seems to be, it is understandable that 'hard' facts like disability and discomfort will bear the brunt of justification for what must essentially be an interpersonal decision with all the tacit content characteristic of such somewhat suppressed in the overt moral reasoning. The effect of such a constriction of reason-giving and assessment may well be to foster the spread of a shallow, basically hedonistic conception of a life worth living in discussion of medical decision-making and thus to encourage a totally inadequate framework for ethical thinking in medicine. It is particularly in those cases of life and death decisions that Victor Frankl's remarks about meaning become sharply relevant to our moral thinking (32). If our focus is subtly and insensibly narrowed to fall under a hedonistic type of calculus then those rather elusive ethical underpinnings that I have sought to stress will be lost and a vital ingredient of the 'caring' ethos of medicine will go with them.

So, were we to decide to kill or create a place in our ranks for medical killers, how would we come to think of medical practice and of ourselves, its practitioners? Would we still think of ourselves as under that vocation or noble compulsion to protect and improve human life where it is afflicted, or would we rather see ourselves as being in the business of dispensing remedies which may bring life or death according to certain unstated, or worse, simplistic, standards and pragmatic considerations? What is more, how would we safeguard against the human propensity for error, our tendency to take the easy way out, the possibility of subtle coercion, and our capacity for self-deception under the influence of interest or convenience? Our acts and the potential acts which we see as being in our repertoire partially constitute what we are; to borrow from Peter Winch: 'I am thinking here of a conceptual link between the commission of the offence and what its committer thereby becomes' (33). I think that, as Winch claims, the act of killing in and of itself changes the killer and those who condone his action. The momentous import which we attach to each human life must be mitigated to preserve the moral and psychological integrity of a killer and some ideology or ideal, or psychological subterfuge must displace human life from its central place in our moral system. In this I can only see harm to our doctors and ultimately their patients. Medicine has an ethical stance in which a single human life, without justification, has a value which confers upon it a certain dignity and inviolability - almost amounting to sanctity - and which conditions the ultimate end to which our therapeutic efforts are aimed. An important part of medical training is a deeply ingrained respect for and jealous husbandry of human life. It is this ramifying and compulsive attitude that grips one in medical practice, that one brings to the acceptance of clinical responsibility, and that refuses to allow one to weigh self-interest or economic factors against the welfare of one's patients. The intensity of the moral conflict doctors feel about life and death decisions is fuelled by this pervasive obsession. We hold the mastery of the tools and techniques which modern medicine has delivered to us as servants of human life but not as its judges (at present) and we have collectively resolved always to heal and never to harm, always to put our patient above the pressures upon us or the social and economic considerations which may tend to a more calculating conclusion. Philippa Foot remarks: 'Apart from any special repugnance doctors feel towards the idea of a lethal injection, it may be of the greatest importance to keep a psychological barrier up against killing' (34). To sanction medical killing is to take a first tentative step from the ethical stance which has delivered to us medicine as we know it.

Perhaps we have lost ground already. Elisabeth Kubler-Ross speaks of the attitude often conveyed to the patient in modern medical practice. 'He slowly but surely is beginning to be treated like a thing. He is no longer a person' (35). It is instructive that those in hospice medicine do not report frequent requests for euthanasia despite the fact that they see a huge number of dying patients with distressing diseases. They more than anyone else have made the pain-wracked slide towards death a thing of the past.

'Those who have the strength and the love to sit with a dying patient in the silence that goes beyond words will
know that this moment is neither frightening nor painful. . . . To be a therapist to a dying patient makes us aware of the uniqueness of a human being in this vast sea of humanity. . . . few of us live beyond our threescore and ten years and yet in that brief time most of us create and live a unique biography and weave ourselves into the fabric of human history’ (36).

So, finally, I must demur from an acceptance of euthanasia and raise a fifth and oft overlooked reason for so doing. The future is always unknown to us and until the moment of death the biography that a given human being creates is unfinished. No one can know what events will precede that moment. Perhaps those last events will yield some profound good such as a reconciliation, reaffirmation or realisation which brings the autobiography to its proper end. I am sure that many of us feel unwilling to go where angels fear to tread when and how it might be regarded from our limited perspective as ‘in the best interests of all concerned’.

Thus I think Dr Brewin does himself a disservice. His reservations are not irrational merely because they do not have an easily surveyable underpinning in ethical ‘formulations’; they are as rational as, although different in quality from, many other judgements we make with personal content or where knowledge cannot be formalised (as both Williams and McDowell have noted). They engage that moral sensitivity which informs but is not completely formulated in terms of moral principles and thus they indicate that in medical ethics (as in ethics generally), philosophy has its limits. These limits and ‘what in social and personal life counts as something’ mean that a moral calculus will never displace the informed moral engagement and judgement of those in the caring professions. The pause, like much in philosophy, is one of those reminders to be assembled when we have a philosophical purpose in hand (37).

Certain compacts between patient and doctor will be of such private and deeply personal significance that the law cannot intrude without distortion of their essential dynamics. I believe that euthanasia is one such and that there is a difference between killing and letting die which I have tried to bring out by a detailed analysis of what is involved in active euthanasia. The question of intent is of prime importance as it is what reflects and gives expression to our constitution as morally sensitive physicians. It is right to relieve pain, even where the tacit understanding between doctor and patient is that this may hasten death or at least weaken one’s biological tenacity for life. It is also right to discontinue a medical treatment, such as life-sustaining intensive care, for a person who will not recover meaningful life. But it seems that to approach a patient with an intent to kill is at fundamental odds with what we ought to sanction. I occupy that position because I feel that the act involved is of such deep, widely ramifying and intensely personal significance that the law has no way to provide a context for it. Our official ethic, enshrined in our statutes as firmly as it is graven in our character, and thus proclaimed with all the gravity which justice can lend to any moral conviction, must be, and be seen to be, that human life is inviolate. Any doctor who feels bound by conscience to contravene this sanction must, I think, be prepared to submit his action to the deepest scrutiny that society can undertake and be vindicated by the overwhelming humanity of his act and that alone. Only in this way will we remain faithful to that magnificent obsession which is the sole adequate guarantee of continued medical excellence.

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References
(5) This remark relates to those claims of John McDowell and Bernard Williams which I discuss below.
(18) See reference (17): 74.
(20) Aristotle. Nicomachean ethics. Bk II (1103a ff)
(23) Gyllenskold K. In: Case studies for a conference on non-treatment decisions. Lawrence University, Wisconsin (note yet published).

(25) See reference (2). Crisp R has coined the term using 'telos' – end.

(26) It might be regarded as some kind of reaction to this milieu of sustained ambivalent concern that causes medical students to achieve their reputation for somewhat uproarious off-duty behaviour.


(28) It also means that these situations are apt for moral reasoning in just the way that Winch recommends because in entering into them in thought we are engaged and moved.


(31) A place recognised by Heidegger in his discussion of human finitude as an essential feature of human being.


(33) Winch P. Trying. In: Ethics and action (see reference (22)), but the point is familiar from J P Sartre.


(36) See reference (35): 276.

(37) See reference (11): 129.