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Correspondence

Euthanasia, letting die and the pause

SIR

Euthanasia, Letting Die and the Pause, by Grant Gillett in the June 1988 issue of the journal is an intriguing effort to note some important features of practical morality and to apply them to the issue of active euthanasia. While I share Dr Gillett's basic viewpoint, that philosophical argumentation alone is inadequate to capture all dimensions of practical morality, I do not believe that he has succceeded in giving an account of why what he calls 'the pause' ought to weigh against a policy of active euthanasia. While the essay is quite complex and deserves point by point commentary, I will have space in this communication to make only a few brief remarks.

First, it is important to note that 'the pause', while a phenomenon that I think most physicians would readily recognise, cannot be said to be peculiar either to life-and-death matters or to the medical profession. I would argue that it is a feature of any moral deliberation when sensitive people anticipate significant consequences from their actions. It is worth recalling that Julius Caesar, before he crossed the Rubicon, paused at least long enough to utter a Latin epigram which we had to memorise in our high school Latin courses centuries afterwards. I would suggest that 'the pause' is best interpreted as 'I am about to take an action which has grave consequences. What if I am wrong? What if there are important factual or moral considerations that I have, in my need to feel decisive and in control, failed adequately to think about?' If this is an adequate interpretation, then the fact of 'the pause' simply means that morally sensitive agents are dealing with difficult problems, and that cannot be used by itself as an argument for one side or the other of the argument. Indeed, Dr Gillett notes this himself, as both the physicians he mentioned opted for death of the patient after 'the pause'.

Second, it is also important to note, as alluded to just now, that 'the pause' can cut both ways in the euthanasia debate. An American psychiatrist, Stuart Youngner, encountered a very difficult patient with advanced multiple sclerosis, who requested active euthanasia to end what he took to be a miserable and helpless existence. Dr Youngner courageously made a videotape of one interview with this patient and showed it to selected medical audiences. Eventually, the patient died in precisely the state of helpless dependency that he most feared after Dr Youngner continued to withstand his requests for assistance for active euthanasia. It is quite clear that Dr Youngner shares Dr Gillett's feeling that the moral physician will not kill patients directly. I believe, however, that it is also highly likely that Dr Youngner must have experienced 'the pause' many times in wondering whether or not he was truly helping this patient in his misery. Thus, the decision to withhold active euthanasia can be just as likely to generate the same gut-level emotional reflection as does its performance. Neither fact seems adequate to establish the morality or immorality of active euthanasia.

Dr Gillett ends his article by addressing a point that he believes has not adequately been covered in the existing literature on active euthanasia. I will repay his favour by raising a point which I do not believe has been adequately addressed either. At an earlier point in his essay, Dr Gillett refers to the impact of a policy of killing on the agent. The presumption is that one cannot engage in killing without being morally corrupted in some way, or without coming to regard the object of one's attention as less worthy of effort to prolong life. The point that I think has been generally neglected in most of the literature on active euthanasia is that this is a grave insult to all veterinarians. Veterinarians of my acquaintance (and our programme is actively engaged with them in teaching a course in veterinary medical ethics) regard active euthanasia as a legitimate tool of their professional trade. However, they give every evidence of having a deep and broad commitment to pursuing the welfare of animals whenever they can achieve this, and often go to great lengths to try to preserve the life and health of their individual animal patients. I believe they would take great offence at the idea that the inclusion of active euthanasia in their therapeutic armamentarium reduces their commitment to the welfare of their patients who can be helped by other means.

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Reply to Brody: 'The pause' and killing

In response to Howard Brody's astute and succint critique of 'The pause' I would offer the following remarks.

On his first point; I did not argue that 'the pause', in and of itself, ought to tell against euthanasia (and throughout I will mean by this active voluntary euthanasia) but rather noted, as indeed Brody acknowledges, that the pause characterises decisions which reach deep into the structure of our moral thought. I then argued that the intuitions which feed the pause in euthanasia are generally stacked heavily against the active killing of persons (even if they sometimes urge the withdrawal of intrusive and dehumanising treatment). Thus 'the pause' indicates that something

important is at stake and the argument rests on the fact that what is at stake touches the deepest roots of our moral sensitivity in general but also, and particularly, our moral sense as doctors. I therefore do not argue that a 'gut level reaction is adequate to establish the morality or immorality of active euthanasia'.

The second point which needs to be raised is the unique and complex nature of human death, a subject on which I spent some time in 'The pause'. I argued that where we face such an event and the decisions which surround it then our intuitions are sensitive guides to the right choice of action in the situation. This is because they reflect a holistic method of problem-solving characteristic of biological organisms (and 'neural networks') which is particularly adept at dealing with multiple interacting and informal considerations highly unique to an individual situation and difficult to capture in a codified form. We are able to cope with such problems in the natural and moral sphere because we do not always allow apparently complete rational reconstructions of issues to cloud our perfectly sound judgements about them. In support of this rather hazy appeal to holistic thinking in interpersonal and moral dilemmas, I adduced facts about the psychology of death and dying designed to highlight the nature of the euthanasia decision in rather more subtle terms than are normally to be found in moral argumentation.

The uniqueness of human life and death (the distinctiveness of tokens of those types) is also pertinent to the appeal Brody makes to veterinary practice. We treat animals largely as instances of certain types whereas we recognise that each human individual is a distinct entity. That is not to say that we do not react to cats and dogs and so on as individuals, but just to recognise that much of this individuality is attributional. A human being is, however, distinguished primarily by things sharply relevant to his mode of living and dying. Human beings, as Kubler-Ross notes, 'create and live a unique biography and weave ourselves into the fabric of human history'. When a vet puts an animal down he makes a decision which is similar in all its essentials to every other decision for an animal with the same condition and at the same stage of development. But a human death is unique with respect to all of those things that make a human being what she essentially is (as a rational and social being). There are many meanings, aspects of relationships and unspoken words that may be disrupted by a technological hijack of this area of human life. For this reason an external viewpoint or even a viewpoint reacting to extreme contingencies of pain and perceived worthlessness may not evince the same delicacy when 'the final solution' is waiting in the wings. I believe we accept euthanasia as such a solution at our peril because the decisions here are not as simple as they are in the case of non-human animals.

I mentioned in my piece the need for caution about 'misguided paternalistic beneficence'. This requires a firm commitment to the intent to relieve distress and a firm resolve not to inflict insensitive and intrusive treatment on human beings. At times, and for patients like the one with multiple sclerosis mentioned by Dr Brody, this means that we just have to stay our hand, having discussed the situation with the patient, when it comes to the use of physiotherapy and antibiotics designed to cure an otherwise terminal pneumonia or when we are tempted to thrust naso-gastric tubes down patients who have neither the will to go on living nor any hunger or thirst which ought to be relieved for the sake of their comfort. It is characteristic for the dying patient to stop experiencing any need for food and water and, when the patient clearly realises what this means, I do not think we should assume the god-like role of overruling this abstention. This is an equal deference to the refusal to assume the god-like role of intervening to end a persons's life at a time determined by some arrangement made with the patient. I do not believe that I would ever have the wisdom to be able to do this despite a fairly active and extensive clinical career which has involved me in the treatment of many patients dying from a variety of distressing diseases. The same disclaimer is to be found emanating from others, such as Cecily Saunders, Elisabeth Kubler-Ross and Tom West, whose voices speak with much greater experience and wisdom than my own.

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