Annotated models of disciplinary essays

3. Annotated Philosophy essay

The essay question
The third year Philosophy essay on the following pages was written in response to this question:

“Although we are sometimes justified in withdrawing or withholding life-sustaining treatment from someone who is terminally ill and suffering, we could never be justified in killing such a person.” Critically discuss this claim.

Essay outline
This outline forms the basis of the Philosophy essay

Thesis
Statement of issue and definition of terms
1. outline of first argument for passive euthanasia
2. outline of counter argument

Argument
For the issue: passive euthanasia is already an acceptable medical practice
• supporting information: due to limited resources; end the suffering of terminally ill patients

Argument
For the issue: for passive euthanasia but against active euthanasia
• supporting information: examples
• explanation of doctrine of ‘double effect’
• the moral importance of differentiating between ‘killing’ and ‘letting die’

Argument
Transition to counter argument: there is no real moral difference between killing and letting die
• examine previous evidence from the perspective of motivation
• sub argument: agent’s motivation should decide the morality, not the method. (refute counter argument)

Argument
Argument against the distinction between killing and letting die
• example (include counter argument and refutation)

Conclusion
Summary of arguments for and against. Conclusion: there does not seem any real distinction between active and passive euthanasia recommendation (validity of maintaining distinction)
Essay annotations

Annotations are provided in the right hand column. These annotations highlight significant features of the essay, such as structure and how evidence for the argument is built up and incorporated. The annotations in ‘text boxes’ comment on other features such as academic language and referencing conventions. For further information on these features see the relevant self access module available at the Learning Resource Centre.

<table>
<thead>
<tr>
<th>Student essay</th>
<th>Comments</th>
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<tr>
<td>Withdrawing or withholding life-sustaining treatment from a terminally ill and suffering patient seems more easily justified than killing such a patient. This appears to be accepted by the majority of the medical profession, and is reflected by present laws in NSW. These prohibit the killing of a terminally ill and suffering patient (active euthanasia). However, they sometimes permit withdrawing or withholding life-sustaining treatment (passive euthanasia), something which is already practised in many cases. There are two ways of arguing that passive euthanasia can be justified while active euthanasia cannot. The first relies on the intuition that killing someone is morally worse than letting him or her die. It is argued that a doctor who kills a patient directly causes the death, but a doctor who withdraws or withholds treatment merely allows that death. The doctor is differently responsible for the two deaths, and this justifies viewing the methods differently. However, many argue that there is not any real morally significant difference between the two. Choosing not to act is itself an action, and we are equally responsible for this. Indeed, as there is no morally significant difference, active euthanasia may sometimes be preferable. The second way of arguing that active euthanasia is never justifiable involves conceding this point. However, it is said to be in our best interests to maintain this fallacious distinction. Permitting active euthanasia would undermine our belief in the sanctity of human life, and start us sliding down a “slippery slope” that would end with a Nazi-like policy of ‘euthanasing’ anyone seen as a threat to or burden on society. In its most sensational form, this argument is easy to rebut, but we must carefully consider possible negative consequences of justifying active euthanasia, and the respect for personal autonomy that it displays is sufficient justification for such a program.</td>
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<tr>
<td>thesis statement of issue brief definitions of terms outline of first argument for justifying passive euthanasia supporting argument example conclusion to this argument: passive euthanasia is justifiable outline of counter argument conclusion: active euthanasia may be justifiable outline of second main argument for the issue conclusion and recommendation</td>
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LANGUAGE FEATURES OF ACADEMIC WRITING:
discipline specific language (bio-ethics): e.g. euthanasia; terminally ill patient; withdrawing or withholding life-sustaining treatment
complex nominal groups, which allow information to be condensed: e.g. ([Withdrawing or withholding life-sustaining treatment from a terminally ill and suffering patient]) seems ... (here a non-finite clause is functioning as the nominal group)
evaluative language in conclusion and recommendations: e.g. we must carefully consider possible negative consequences of justifying active euthanasia, and the respect for personal autonomy that it displays is sufficient justification for such a program.
Passive euthanasia refers to withholding or withdrawing treatment that might have delayed the death of a terminally ill and suffering patient.1 Active euthanasia refers to intentionally bringing about the death of such a patient, for example, by administering a lethal injection. It is often argued that doctors are justified in allowing their patients to die, by withdrawing or withholding treatment, but not justified in killing them. This difference in attitudes in active and passive euthanasia seems generally accepted by the medical profession. Neurosurgeon Wilder Penfield, for example, reflects that: “Positive action to take a life is not permitted. But the negative decisions that ease and shorten suffering have always been ours to make.”2 This distinction is also reflected in the law of NSW, suggests Catherine Armitage, who says:

The Profession is guided by legal opinion – from the NSW Crown Solicitor, among others – which holds that a doctor must never do anything actively to kill a patient, but nor is he/she bound to fight for the patient’s life forever.3

Passive euthanasia, already an acceptable medical practice in some situations,4 and permissible by the law of NSW, seems obviously justifiable in some circumstances. Practical considerations of limited resources, if nothing else, warrant this. There will always be people who die because resources are inadequate to save them. And it seems logical to divert resources from people who have no hope of surviving to those who might. There is no need for a doctor to invest heroic amounts of time and effort trying to prolong the life of someone whose injuries or illnesses are so severe they will be dead after merely an hour, or day, or week. We do not continue chemotherapy on a patient dying of the last stages of cancer, for example. Passive euthanasia prevents us futilely wasting resources, and frees them to be reallocated where they can do more good. However, passive euthanasia is also advocated as a means of reducing the suffering of the terminally ill patient because it, if properly regulated and administered, expresses respect for individual autonomy. It is hard to see how one could argue that this is never justified.

Proponents of active euthanasia, however, often meet fiercer opposition. We seem to intuitively believe that killing is worse than merely letting die. We feel stronger condemnation for a background information restatement of definitions establishing the context of essay question quote quoting an authority to support point quoting legislation to support point argument for the issue (simultaneously topic sentence for paragraph) a) supporting information: due to limited resources example: one circumstance of limited resources b) supporting information: another circumstance is when passive euthanasia would reduce the suffering of the terminally ill argument for passive euthanasia but against active

1 Some philosophers (J. Gay-Williams, for example) object to the use of the term “passive euthanasia” in this context. These objections will be discussed later in this essay; however, for ease of expression I will be adopting this terminology.
3 Catherine Armitage, ‘Dead or Alive? Deciding the fate of the brain injured,’ The Sydney Morning Herald, April 1922.
murderer than we do for someone who refrains from acting to prevent a murder, even when they could have saved the victim. Kitty Genovese was stabbed to death on a New York street while 38 people heard her screams and failed to act. We condemn them for their cowardice and selfishness, and find their failure to act reprehensible, but we do not bring murder charges against them, and we do not view their actions as morally equivalent to those of her killer.5

This “intuitive” difference between killing and allowing to die can be explained in many different ways. The former involves actually initiating the sequence of events that leads to someone’s death. The latter, however, only involves refraining to intervene in an already established course of events leading to death.6 And death is not necessarily guaranteed. The patient might still recover, if they were given an incorrect prognosis. We are merely “letting nature take its course”. Gay-Williams argues that refraining to treat a patient, when the treatment cannot reasonably be expected to save his/her life, is not euthanasia at all. The patient is not killed, but dies of whatever disease s/he is suffering from. And the patient’s death is not aimed at by the person who does not treat them. Instead, the decision is a medical judgment about the value of continuing a course of treatment that aims to avoid further pain, indignity and expense for the patient and his/her family and friends.7

This sort of argument revolves around the doctrine of double effect. This distinguishes the intended result of an act from any foreseen but undesired consequences it may have. A decision to increase literacy rates is generally a good thing. However, this is often accompanied by increased suicides. This does not mean that it is bad to increase the literacy rate, or that anyone attempting to do this wants to, or is responsible for, increasing the frequency of suicides.8 Likewise, there is a difference between merely foreseeing the death of a patient, and actually intending that death. Refraining from continuing with a pointless course of treatment, to avoid further pain and suffering for the patient, has unfortunate consequences, in that the patient dies. But the doctor is not held responsible for this.

Indeed, not accepting there is a difference between killing and allowing to die could lead to some very strange results. By neglecting to send donations to World Vision, we may be

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as responsible for the deaths of those dying of famine as we would be if we had sent them poisoned grain.\textsuperscript{9} The difference between killing and allowing to die is “morally important” because it “sets limits to an agent’s duties and responsibilities to save lives.”\textsuperscript{10} It is argued that it would be wrong to hold someone as responsible for what they allowed to happen as for what they made happen. It is relatively easy to live your life without killing anybody. It takes an effort to save lives. The former is the basic minimum required of decent people. People who do the latter, however, are often seen as saints. We are generally not as responsible for allowing a death as we are for killing. Consequently, while we may be justified in withdrawing or withholding treatment from a terminally ill and suffering patient, we could never be justified in killing them. The explanations detailed above are said to reflect significant moral differences between active and passive euthanasia that make the latter permissible, and the former impermissible.

However, it can also be argued that while we may sometimes intuitively sense a moral difference when offered examples of “killing” and “allowing to die,” this is due to other morally relevant features:

“Intuitions…are inevitably subjective and unreliable simply because it is impossible to consider it (an act) apart from its context…We are…liable to jump to conclusions about differences by failing to take it into account.”\textsuperscript{11}

We can concede that Kitty Genovese’s murderer is more morally responsible for her death than those who failed to help her. However, there are other significant differences in this case. The motivations of the murderer and the bystanders are completely different. Likewise, the motivations of the person who fails to save the life of someone dying of starvation in Africa are completely different to those of the person who sends them poisoned grain. Perhaps these, or other differences, account for the differences in our moral judgments. Phillipa Foot, for example, suggests that the difference between the two is that they are both contrary to different virtues. The murder of Kitty Genovese, she might say, goes against justice. She had a right to life, and this was violated. Refraining from assisting her, however, only violates charity.\textsuperscript{12} These examples do not illustrate differences in the way we judge killing and letting die differently. Rather, they are examples of killing that happen to be morally wrong, and examples of letting die that are, merely coincidentally, not so morally wrong.

\textsuperscript{10} Helga Kuhse, ‘Euthanasia’, A Companion to Ethics, p. 297
\textsuperscript{11} John Ladd, ‘Positive and Negative Euthanasia,’ Ethical Issues Relating to Life and Death, p. 167.
\textsuperscript{12} Phillipa Foot, ‘Euthanasia,’ Ethical Issues Relating to Life and Death, p.25.
James Rachels presents us with a more relevant example involving two shady characters, Smith and Jones. Both will gain a large sum of money if their 6-year-old cousin dies. Smith drowns his cousin in the bathtub. Jones, however, walks in just as his cousin slips, hits his head, and falls facedown into the water. He would quite happily have drowned him, but has no need to. If we see Jones' and Smith's actions as being equally morally reprehensible, then, Rachels argues, we should likewise see no moral difference between the actions of a doctor performing active euthanasia and a doctor performing passive euthanasia.  

However, Rachels' opponents argue that this example, also, contains other morally relevant differences that cloud his case. It is not clear that our views about the similarity of the actions of Jones and Smith should be applied to the Euthanasia debate. To these people I offer an alternate example. It involves a doctor, who is the only person able to treat a patient who, while not terminally ill, requires medical care to recover. In scenario one, they refuse to treat the patient, and gleefully watch as they die. In scenario two they administer a lethal injection to the patient. I do not believe there is a morally significant difference between the two cases. Only the means by which they cause their patient's death is different, and both should be seen as guilty of murder. In this example the doctor is just as culpable for an omission as for an act. As Beauchamp argues:

> Killing is sometimes right, sometimes wrong, depending on the circumstances, and the same is true of letting die. It is the justifying reasons which make the difference to whether an action is right, not merely the kind of action it is.

Where doctors believe they are acting in their patient's best interests, and the end result is the same (the death of the patient), I do not believe the methods used make any difference to the morality of euthanasia. This seems to be compatible with our intuitions in the case outlined above. I think the arguments of people like Gay-Williams are sheer sophistry. A doctor who discontinues a course of treatment because it is not believed to be in the patient's best interests, and foresees the patient will die because of this, does not intend his/her patient's death. Yet the doctor ceases treatment knowing that the patient will die. And the doctor has made an informed decision that this is the better course of action. The doctor who knows this, and nevertheless ceases treatment has hastened the death of the patient just as much as the doctor administering a lethal injection. It is unreasonable to separate the decision to stop treatment from the realisation

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that a patient will die when it is ceased. Often unwelcome consequences prevent us doing something we want to do, and we are unable to avoid responsibility for these by saying we wanted only the positive effects. Why should we accept such excuses in the euthanasia debate, when we do not elsewhere?

This distinction is not only irrelevant, but it can also lead to some terrible results. Being allowed to die can be an incredibly painful process. A lethal injection, however, is less painful. Assuming a terminally ill patient decides he or she does not want to continue to suffer, and a doctor agrees to assist the patient terminate his/her life, surely consistency demands that the least painful form of euthanasia, intended to reduce suffering, is used.

Finally, Rachels argues that accepting that there is a distinction between active and passive euthanasia will result in decisions about life and death being made on irrelevant grounds. He offers the example of two Down’s Syndrome babies, one born with an obstructed intestine, and one born perfectly healthy in all other respects. In many cases, babies born in such a condition are refused the simple operation that could cure this, and die. It does not seem right that an easily curable digestive ailment should determine whether the baby lives or dies. If a Down’s Syndrome baby’s life is judged to be not worth living, then both babies should die. If not, they should both be given medical treatment sufficient to ensure their survival. Accepting a distinction between active and passive euthanasia results in unacceptable inconsistencies in our treatment of such babies, and it should thus be abolished.

Some philosophers who accept the arguments outlined above nevertheless believe that this distinction, however fallacious, should be maintained in public policy and law. They believe that consequentialist arguments justify this. If we permitted active euthanasia, it is argued that this would undermine our belief in the sanctity of human life. This would begin our slide down a “slippery slope” that would end with us “euthanasing” anyone seen as a threat or burden to society, as happened in Nazi Germany. If we look at this argument logically, it seems difficult to see how permitting voluntary active euthanasia, for compassionate reasons, and respect for individual autonomy, could change attitudes to killings that do not demonstrate these qualities. As Beauchamp argues, if the principles we use to justify active euthanasia are just, then any further action inspired by these principles must also be just. And if we examine what really happened in Nazi Germany, the facts do not seem to support this sensational claim.

17 Ibid.
18 Tom Beauchamp, ‘A reply to Rachels…’, Contemporary Issues in Bioethics, p.251
totalitarian system and racial prejudice were more responsible for those tragic events than was any acceptance of euthanasia. In any event, we qualify our moral prohibitions of killing by allowing the exceptions of self-defence and wars. Why not accept euthanasia as another exception? Beauchamp replies by saying that the difference with euthanasia is that it entails making the judgment that a life can be not worth living, whereas the others only justify retaliating against a morally blameworthy aggressor. However, the ancient Greeks and Romans practised infanticide, while Eskimos killed their aged parents. And despite their apparent acceptance that there were lives not worth living, they do not appear to have less respect for other lives in general. In any event, if there really is no difference between passive and active euthanasia, views incorporating this distinction must be wrong. Rather than maintaining such incorrect attitudes, we should try to find a less vulnerable position that more accurately reflects our attitudes.

However, possible negative consequences to justifying active euthanasia should be considered. It might have negative effects on health care workers who see their duty as preserving life, not destroying it. It might result in widespread use of active euthanasia, pressuring unwilling patients to accept it because it is expected of them. Patients who might have recovered could be killed. Doctors might try to hide their mistakes by claiming they merely ‘euthanased’ patients. People might use euthanasia to get rid of burdensome relatives. However, I believe that some of these objections are unwarranted, and legislative safeguards can be implemented to minimise other negative consequences. Health care workers who disagree with euthanasia should not be obliged to perform it. However, many doctors are amongst those advocating active euthanasia. 43% of South Australian doctors admitted in a 1992 survey that they had already actively assisted patients to die.

Surely justifying active euthanasia, with adequate legislative safeguards, would be better than allowing such actions, presently illegal, to continue behind closed doors. Furthermore, the empirical evidence does not seem to support arguments that euthanasia is likely to become the norm. In mid 1991 it was reported that an American Federal Statute was introduced, obliging health care workers to inform their patients about “living wills,” because legislation enabling passive euthanasia had not been used as widely as expected. I believe that requiring more than one doctor to diagnose the patient as terminally ill and give his/her approval, and stringent consent procedures will minimise the risks of permitting active euthanasia. And I believe that the suffering it prevents, and the respect for

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19 ibid pp.252-253.
This unit is from material developed for R. Woodward-Kron, E. Thomson & J. Meek (2000), Academic Writing: a language based guide (CD-ROM), University of Wollongong.