Euthanasia In The Society Today

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Euthanasia is one of the most difficult issues in contemporary bioethics because it involves suffering, autonomy, dignity, professional duty, vulnerability, family relationships, and the meaning of medical care at the end of life. The original essay approaches the issue through utilitarianism and Jeremy Bentham's felicific calculus, arguing that ending life may reduce the pain of a terminally ill patient and the distress of the family. That framework can support a serious philosophical analysis, but several claims require correction. Financial burden should never become a reason to end a person's life, a family cannot simply request euthanasia for a patient in a coma, and euthanasia must be distinguished from refusing treatment, withdrawing medically ineffective treatment, palliative sedation, and physician-assisted dying. Laws differ sharply among jurisdictions, while major professional organizations remain divided or opposed. A responsible utilitarian analysis must count not only immediate relief but also risks involving coercion, disability discrimination, unequal healthcare, diagnostic uncertainty, professional trust, and the availability of palliative care. (American Medical Association, 2026)

Defining Euthanasia

Euthanasia generally refers to one person intentionally administering a lethal intervention to end another person's life for the purpose of relieving suffering. The American Medical Association defines it as administration of a lethal agent by another person to a patient to relieve intolerable and incurable suffering. The defining features are intention, causation, and the direct act by another person. Everyday discussion often uses the word loosely for any decision after which a patient dies. This creates confusion. Accurate definitions are essential because ethically and legally different actions should not be evaluated as though they are identical. (American Medical Association, 2026)

Physician-Assisted Suicide or Medical Aid in Dying

In physician-assisted suicide, the physician provides the means or information, while the patient performs the final life-ending act. Some jurisdictions use the term medical aid in dying for a legally defined process involving terminally ill, decision-capable adults who self-administer prescribed medication. Supporters may prefer this language because they distinguish the act from impulsive suicide associated with mental-health crisis. Opponents argue that the moral reality remains assistance in intentionally ending life. Whatever terminology is used, it should not be confused with euthanasia, where another person administers the lethal agent. ("World Medical Association", 2019)

Withholding and Withdrawing Treatment

A decision not to start or to stop a burdensome treatment is ethically and legally distinct from euthanasia when the intention is to respect the patient's refusal or recognize that treatment no longer achieves agreed goals. A competent patient can refuse ventilation, dialysis, chemotherapy, artificial nutrition, resuscitation, or other interventions, even when refusal may shorten life. The underlying disease then causes death. Withdrawing an intervention is not automatically morally different from never starting it. Clinicians must provide symptom relief and continue caring for the patient rather than treating refusal as abandonment.

Palliative Sedation

Palliative sedation may be considered for severe symptoms that remain refractory despite appropriate treatment, especially near the end of life. Medication reduces consciousness to relieve otherwise intolerable distress. Its intention is symptom relief, and dosing is proportionate to that purpose rather than designed to cause death. The AMA recognizes sedation to unconsciousness as a last-resort option for terminally ill patients with severe symptoms unresponsive to aggressive palliation. Ethical use requires informed consent, specialist involvement where possible, continued monitoring, and clear documentation. It should not be mislabeled euthanasia simply because death may occur during sedation.

Utilitarianism

Utilitarianism evaluates actions according to their consequences for wellbeing. Bentham's classical formulation emphasizes pleasure and pain, while later utilitarians differ about preferences, rules, justice, and the quality of welfare. A simple act-utilitarian argument may support euthanasia when it ends severe suffering, respects a settled request, and reduces distress without causing greater harm. However, consequences extend beyond one moment. The analysis must include the patient's future possibilities, family effects, clinician wellbeing, public trust, social inequality, safeguards, and how legal rules influence vulnerable people. A narrow calculation of current pain is not enough.

Bentham's Felicific Calculus

Bentham proposed evaluating pleasure and pain through features such as intensity, duration, certainty, proximity, fecundity, purity, and extent. Applied to end-of-life decisions, the calculus asks how severe the suffering is, how long it is expected to continue, how certain the prognosis is, whether relief is available, and how the action affects all concerned. The method highlights relevant questions but does not produce a mechanical answer. Human suffering cannot be measured with complete precision, and the interests of different people cannot be added without moral judgment. A patient's

fundamental rights should not be overridden merely because relatives or institutions would experience financial or emotional convenience. (Bentham, n.d.)

The Argument From Relief of Suffering

The strongest utilitarian argument for voluntary euthanasia concerns a decision-capable patient experiencing intolerable, irreversible suffering that cannot be relieved acceptably. If continued life offers only severe distress and the patient repeatedly requests death, ending life may appear to minimize suffering. Supporters argue that medicine already respects bodily autonomy and that forcing a person to endure unwanted dying can be cruel. The strength of this argument depends on the accuracy of diagnosis and prognosis, the quality of palliative options, the stability of the request, freedom from coercion, and the patient's ability to decide.

Suffering Is Broader Than Physical Pain

End-of-life suffering can include breathlessness, nausea, weakness, loss of function, fear, loneliness, dependence, and loss of meaning. Modern palliative care can relieve many symptoms, but not every person considers available relief acceptable. Some value alertness and may reject sedation; others fear complete dependence more than pain. Clinicians should explore the specific source of a request rather than assume that "I want to die" has one meaning. It may express untreated pain, depression, fear of burden, poor communication, lack of support, or a stable value-based decision. Each possibility requires a different response.

Autonomy

Autonomy supports the right of capable adults to make informed decisions about their own bodies and medical treatment. Supporters of assisted dying argue that a person facing an unavoidable terminal decline should control the timing and manner of death. Yet autonomy is not simply the ability to state a preference. The choice must be informed, voluntary, stable, and free from coercion. Social conditions affect autonomy. A patient who lacks pain care, disability support, housing, or family assistance may choose death under constraints that society could change. Respect for autonomy therefore requires expanding meaningful alternatives as well as honoring decisions.

Decision-Making Capacity

Capacity is decision-specific and generally requires understanding relevant information, appreciating how it applies personally, reasoning about options, and communicating a choice. Illness, medication, delirium, brain injury, or severe psychiatric symptoms can impair capacity. A diagnosis alone does not prove incapacity, and an unusual choice does not automatically invalidate it. For a life-ending

decision, assessment should be careful and repeated where uncertainty exists. Requests made during temporary crisis should not be treated as settled choices.

Patients in a Coma

The original essay includes patients in a coma as candidates for euthanasia because treatment may be expensive. This is ethically unacceptable. A patient without capacity cannot make a current voluntary request. Decisions about life-sustaining treatment should follow an advance directive, previously expressed wishes, or the patient's values and best interests through an authorized surrogate. A surrogate does not gain the moral right to request death because care is costly or emotionally difficult. Withdrawal of burdensome or medically ineffective treatment may be appropriate, but it is not equivalent to intentionally administering a lethal agent for financial relief.

Dignity

Supporters sometimes argue that euthanasia preserves dignity when terminal disease causes severe dependency, disfigurement, or loss of bodily control. Dignity should be handled carefully. Human worth does not disappear with disability, incontinence, cognitive decline, or need for care. If society describes dependence as undignified, vulnerable people may feel pressure to die. A patient may still experience a personal loss of dignity that deserves serious attention. The response should include privacy, respectful care, control where possible, and exploration of what dignity means to that individual. Death should not be presented as the only route to dignity.

Beneficence and Nonmaleficence

Beneficence requires clinicians to promote wellbeing, while nonmaleficence requires avoidance of harm. Supporters of euthanasia argue that prolonging intolerable suffering can be a greater harm than death. Opponents argue that deliberately killing a patient violates medicine's foundational commitment and removes the possibility of error correction. Both positions take suffering seriously but define harm differently. Ethical discussion should avoid portraying one side as compassionate and the other as indifferent. Thoughtful people can share commitments to dignity and relief while reaching opposing conclusions about professional participation.

The Physician's Role

The AMA opposes euthanasia and physician-assisted suicide as incompatible with the physician's role as healer and warns of societal risk, while acknowledging that morally serious people disagree about assisted suicide. Opponents fear that changing the role from relieving suffering to intentionally ending life may alter patient trust. Supporters argue that healing sometimes means respecting a competent

choice when cure and acceptable palliation are impossible. Conscience protections are relevant for both sides: no professional should be forced to participate contrary to deeply held ethical obligations, and patients should receive accurate information about lawful options and continuity of care.

Palliative Care

Palliative care addresses pain, symptoms, communication, psychosocial needs, spiritual concerns, and family support alongside or apart from curative treatment. Hospice focuses on end-of-life care under defined eligibility systems. Access is unequal, and some patients receive specialist help too late. A request for euthanasia should prompt an offer of high-quality palliative assessment, but palliative care should not be presented as a debate tactic or as a guarantee that all suffering can be eliminated. Patients should be able to receive palliative care regardless of their view about assisted dying.

Depression and Demoralization

Depression can affect hopelessness and desire for death, but terminally ill people should not be assumed mentally ill because they discuss dying. Clinicians should assess mood, cognition, trauma, anxiety, and demoralization while respecting the patient's reasoning. Treatable depression may change a request, which makes assessment important. Psychiatric evaluation should not become a method of declaring every unwanted decision incompetent. The purpose is to identify reversible suffering and protect voluntary choice.

The Financial-Burden Argument

The original essay argues that euthanasia can relieve families from medical debt. This is one of the most dangerous arguments because it converts unequal healthcare into pressure on the patient. A person may feel obligated to die to preserve an inheritance, reduce hospital cost, or protect relatives. Utilitarianism should not count financial savings as a straightforward benefit without considering coercion, distributive injustice, and damage to trust. Society should address unaffordable care through insurance, social support, palliative services, and fair policy—not by making death the cheaper treatment offered to vulnerable people.

Family Interests

Families experience anticipatory grief, caregiving burden, conflict, love, fear, and exhaustion. Their perspectives matter, but the patient's interests and wishes remain central. Preparing for a planned death may allow farewell and practical arrangements, yet it can also create trauma, disagreement, or guilt. Family members should receive counseling and support. They must not be allowed to coerce the decision or make the patient feel like a burden. When the patient requests privacy from family,

clinicians must balance confidentiality with appropriate support.

Utilitarian Arguments Against Euthanasia

Rule utilitarianism asks which general rule is likely to produce the best consequences over time. Opponents argue that a rule allowing clinicians to end life may create fear, normalize death as a solution to dependency, expose marginalized groups to subtle pressure, and make errors irreversible. It could weaken investment in palliative care or disability support. Supporters respond that a tightly regulated rule can reduce clandestine practices and protect autonomy. The debate therefore depends heavily on empirical evidence about safeguards, reporting, inequality, and practice in jurisdictions where assisted dying is legal.

Slippery-Slope Concerns

A slippery-slope argument claims that allowing a narrow practice will lead to broader and unacceptable cases. This concern should not be accepted or dismissed without evidence. Laws can expand through legislation, court decisions, interpretation, or changing social values. Safeguards can also remain stable. Ethical evaluation should examine actual eligibility changes, compliance, reporting, and cases of concern. The possibility of expansion is relevant because death is irreversible, but speculation alone cannot settle the issue.

Disability Rights Criticism

Some disability advocates warn that society already devalues lives involving dependency, pain, or assistance. A request to die may be treated as rational in a disabled person while a nondisabled person expressing similar despair receives suicide prevention. Supporters of assisted dying argue that excluding disabled people categorically can also deny autonomy. Policy should avoid assumptions in either direction. People need accessible housing, personal assistance, communication support, healthcare, and freedom from discrimination so that choices are not produced by neglect.

Justice and Equal Access

Justice asks whether benefits and burdens are distributed fairly. A system in which affluent patients receive excellent palliation while poor patients are offered a faster route to death would be unjust. Rural patients may lack specialist assessment. Language barriers may weaken consent. Cultural communities may distrust healthcare because of historical abuse. Safeguards must therefore include accessible alternatives, independent review, interpretation, documentation, and monitoring for disparities. Formal equality on paper may not produce equal freedom in practice.

Prognostic Uncertainty

Terminal prognosis is probabilistic. Clinicians can estimate but cannot always predict exactly how long a person will live or how symptoms will develop. Some patients outlive expectations or respond to new treatment. This uncertainty supports caution and repeated assessment. It does not mean every terminal diagnosis is meaningless. Eligibility rules that depend on a specific expected lifespan may produce inconsistent decisions. Patients should understand the limits of prognosis before making irreversible choices.

Advance Directives

Advance directives allow people to express preferences for future treatment and appoint surrogates. They can guide decisions about resuscitation, ventilation, artificial nutrition, and comfort care after capacity is lost. Whether a prior request can authorize euthanasia after incapacity is one of the most controversial issues and depends on jurisdiction. The ethical difficulty is that the person's earlier values may conflict with the apparent interests of the later incapacitated person. Clear discussion and documentation improve treatment decisions even where euthanasia is not permitted.

Safeguards in Permissive Systems

Common safeguards include adulthood, decision-making capacity, voluntary and repeated request, serious or terminal illness, informed consent, independent medical review, waiting periods or reflection, reporting, and the ability to withdraw at any time. Some systems require self-administration, while others allow clinician administration. Safeguards should be evaluated through compliance and outcomes, not their existence in statute alone. Oversight needs access to complete records and authority to investigate concerns.

The Difference Between a Moral Argument and a Legal Policy

A person may believe euthanasia morally permissible in an exceptional case while opposing legalization because rules must govern many cases. Another may oppose the act personally while supporting legal choice under safeguards. Ethical analysis concerns values and consequences; law must create definitions, procedures, enforcement, and review. The utilitarian question for legalization is not only whether one patient benefits but whether the entire policy produces more wellbeing and justice than available alternatives.

A Balanced Utilitarian Assessment

A defensible utilitarian analysis begins with the patient's suffering and autonomous wishes but extends outward. It asks whether suffering is refractory, whether alternatives are accessible, whether capacity is secure, whether coercion is absent, and whether the rule protects vulnerable populations. It excludes family financial benefit as a legitimate primary reason. It recognizes that death ends future suffering but also every future possibility. Depending on facts and assumptions, utilitarians can reach different conclusions. The framework does not automatically endorse euthanasia.

My Position

The original essay supports euthanasia too broadly. I would narrow the conclusion. Compassion requires aggressive relief of suffering, honest communication, respect for treatment refusal, and access to palliative care. Voluntary assisted dying may be defended philosophically in rare circumstances involving a capable, informed adult with enduring and intolerable suffering, but legal permission requires strong safeguards and continuous evaluation. Nonvoluntary euthanasia, decisions based on family finances, or treating coma as sufficient justification should be rejected. The patient must never be made to believe that death is owed to relatives or society.

Conclusion

Euthanasia cannot be evaluated responsibly through a simple calculation that death ends pain and saves money. Utilitarianism requires attention to every consequence, including autonomy, relief, error, coercion, disability stigma, healthcare inequality, professional trust, and the effects of legal rules. Euthanasia differs from physician-assisted dying, treatment refusal, withdrawal of ineffective treatment, and palliative sedation. Patients without capacity require decisions based on prior wishes and best interests, not financial convenience. A compassionate healthcare system should provide palliative care, communication, emotional support, and respect for lawful choices. The moral disagreement remains genuine because dignity and harm can be interpreted differently. Any policy must protect the individual patient while ensuring that vulnerability never becomes a reason to regard death as cheaper or more socially useful than care.

References

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