

Giving the Terminally Ill Access to Euthanasia Isn't Discriminatory: A Response to Reed

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Pre-print: Please cite published version when available

Reed argues that laws that grant people access to euthanasia on the basis of terminal illness are discriminatory. In support of this claim, he offers an argument by analogy: it would be discriminatory to offer a person access to euthanasia because they're a woman or because they're disabled, as such restricted access would send the message "that life as a woman or as a disabled person is (very often) not worth living" [1]. And so it must also be discriminatory to offer people access to euthanasia because they're terminally ill.

Arguments by analogies are only as good as the analogies upon which they are built. Having a terminal illness, I'm going to suggest, is not relevantly similar enough to either being disabled or being a member of an oppressed social group to make Reed's argument compelling.

Let's explore each branch of the analogy in turn. Why think that terminal illness is relevantly unlike disability, in a way that makes offering access to euthanasia in the latter case discriminatory, but not the former? For one thing, terminal illness is necessarily time-limited. When my father was dying, he found himself in constant pain and incapable of independent self-care. Had these experiences been the result of a spinal cord injury, he would have had time to adapt to, and come to terms with, them. Indeed, there is evidence to suggest that depressive symptoms abate significantly in the years following a spinal cord injury [2]. Here, we can see why offering people access to euthanasia because they're disabled is discriminatory. We don't normally offer to help people die simply because they're going through a difficult time, so why should we make such an offer in cases where their tough time is due to an acquired disability? But this line of reasoning breaks down in the terminal illness case: my father didn't have years to adjust – he knew he would be dead within two months. His current suffering wasn't going to be outweighed by future goods. It was just going to be eclipsed by more suffering.

Now, is being terminally ill relevantly like being oppressed? Oppressed people are badly off because of unjust social organization. And so, we can see why offering oppressed people access to euthanasia is discriminatory. We should combat oppression by changing society, not by allowing or encouraging the oppressed to permanently disappear.

To some extent, the badness of terminal illness *is* connected to social injustice: inadequate healthcare makes dying a lot worse. But we can't fully ameliorate this badness by changing society for two reasons. First, some people will experience their impending deaths as intrinsically bad. Second, dying is often bad

simply because it's extremely painful – and medicine's tricks for alleviating pain often come with dire tradeoffs. Palliative sedation, for instance, is the only empirically vindicated strategy for managing end-of-life delirium [3] I think it's reasonable to want to avoid having to choose between psychosis and unconsciousness at the end of one's life. And it's also reasonable to think that these end-of-life tradeoffs won't be ameliorated simply by allocating more resources to palliative care: the dying process is just messy in a way that makes symptom-management difficult. And so, we're not discriminating against the dying by offering them access to euthanasia. Rather, we're responding to a situation that many people reasonably view as intolerable.

Of course, not everyone finds dying intolerable. And this raises an important concern that Reed's definition of discrimination brings out. To discriminate against a class of persons is, roughly, to “treat them worse than they would expect to be treated if they were not in that class on account of their being members of that class” [1]. So merely treating a class of people differently isn't sufficient for discrimination – we aren't discriminating against people with mobility issues, for instance, when we give them wheelchairs.

I've so far suggested that, while offering the terminally ill access to euthanasia does treat them *differently* than the non-terminally ill (because it gives them access to an option that the non-terminally ill lack), it doesn't treat them *worse*. This is because certain facts about terminal illness (it's time-limited, it's often accompanied by immense pain) make it appropriate to grant the terminally ill access to euthanasia. But an objector might point out that many terminally ill people don't suffer intolerably. Perhaps offering access to them is discriminatory, insofar as it communicates to them that their life isn't worth living.

This is where the disability analogy *is* fruitful. Sometimes being offered access to particular accommodations or forms of medical care (like mobility aids, catheters, or disability leave) can make people feel like they're being signaled out, and discriminated against. But doesn't mean that such offers are themselves discriminatory – it just means that we need to work harder to destigmatize such offers, and that we must learn to have open conversations about them. People might be less reluctant to use wheelchairs for instance, if we start conversations about the use of mobility aids long before they're needed, and if we recognize that many people move fine (albeit 'non-standardly') without them. And people might be more comfortable saying *no* to certain options if they have a doctor who is willing to explore alternative treatments with them.

I think we can have such conversations about euthanasia. Euthanasia is not a panacea; it doesn't replace adequate end-of-life care, and it isn't right for every dying person. But it does have a role to play, insofar as it responds directly to some of the very real horrors that can accompany the end of life.

References

- [1] Reed, P. (2023). Discrimination against the dying. *Journal of Medical Ethics*.
- [2] Dorsett, P., & Geraghty, T. (2004). Depression and adjustment after spinal cord injury: a three-year longitudinal study. *Topics in Spinal Cord Injury Rehabilitation*, 9(4), 43-56.
- [3] Bramati, P., & Bruera, E. (2021). Delirium in Palliative Care. *Cancers*, 13(23), 5893.