Euthanasia is one of the most acute and uncomfortable contemporary problems in medical ethics. Is Euthanasia Ethical? The case for euthanasia rests on one main fundamental moral principle: mercy.

It is not a new issue; euthanasia has been discussed-and practised-in both Eastern and Western cultures from the earliest historical times to the present. But because of medicine's new technological capacities to extend life, the problem is much more pressing than it has in the past, and both the discussion and practice of euthanasia are more widespread.

Euthanasia is a way of granting mercy-both by direct killing and by letting the person die. This principle of mercy establishes two component duties:
1. the duty not to cause further pain or suffering; and
2. the duty to act to end pain or suffering already occurring.
Under the first of these, for a physician or other caregiver to extend mercy to a suffering patient may mean to refrain from procedures that cause further suffering-provided, of course, that the treatment offers the patient no overriding benefits. The physician must refrain from ordering painful tests, therapies, or surgical procedures when they cannot alleviate suffering or contribute to a patient's improvement or cure. Perhaps the most familiar contemporary medical example is the treatment of burn victims when survival is unprecedented; if with the treatments or without them the chances of the patient's survival is nil, mercy requires the physician not to impose the debridement treatments , which are excruciatingly painful, when they can provide the patient no benefit at all. Although the demands of mercy in burn contexts have become fairly well recognized in recent years, other practises that the principles of mercy would rule out remain common. For instance, repeated cardiac resuscitation is sometimes performed even though a patient's survival is highly unlikely; although patients in arrest are unconscious at the time of resuscitation, it can be a brutal procedure, and if the patient regains consciousness, its aftermath can involve considerable pain. Patients are sometimes subjected to continued unproductive, painful treatment to complete a research protocol, to train student physician, to protect the physician or hospital from legal action, or to appease the emotional needs of family members; although in some specific cases such practises may be justified on other grounds, in general they are prohibited by the principle of mercy. Weather a painful test or therapy will actually contribute to some overriding benefits for him or her, they should not be done.

In many such cases, the patient will die whether or not the treatments are performed. In some cases, however, the principle of mercy may also demand withholding treatment that could extend the patient's life if the treatment is itself painful or discomforting and there is very little or no possibility that it will provide life that is pain-free or offers the possibility of other important goods. For instance, to provide respiratory support for patient in the final, irreversible stages of a deteriorative disease may extend his life but will mean permeant dependence and incapacitation; though some patients may take continuing existence to make possible other important goods, for some patients continued treatment means pointless imposition of continuous pain.

The principle of mercy may also demand letting die in a still stronger sense. Under its second component, the principle asserts a duty to act to end suffering that is already occurring. Medicine already honours this duty through its various techniques of pain management, including physiological means like narcotics, nerve blocks, acupuncture, and neurosurgery. In some cases pain or suffering is severe but cannot be effectively controlled, at least as long as the patient remains sentient at all. Classical examples include tumours of the throat, tumours of the brain or bone, and so on. Severe nausea, vomiting, and exhaustion may increase the patient's misery. In these cases, continuing life- or at least continuing consciousness- may mean continuing pain. Mercy's demand for euthanasia takes place here: mercy demands that the pain, even if with it the life, be brought to an end.

Ending the pain, though with it the life, may be accomplished through what is usually called "passive euthanasia", withholding or withdrawing treatment that could prolong life. In the most indirect of these cases, the patient is simply not given treatment that might extend his or her life. For example, radiation therapy in advanced cancer. In the more direct cases, life-saving treatment is deliberately withheld in the face of an immediate, lethal threat-for instance, antibiotics are withheld from cancer patient when an overwhelming infection develops, since through either the cancer or the infection will kill the patient, the infection will kill them sooner and in a much gentler way. In all of the passive euthanasia cases, the patient's life could be extended;it is mercy that demands that he or she be allowed to die.

The second component of the mercy principle may also demand the easing of pain by means more direct than mere allowing to die; it may require killing. This usually is called "active euthanasia. In passive euthanasia, treatment is withheld that could support failing bodily functions, either in warding off external threats or in performing its own processes; active euthanasia, in contrast, involves the direct interruption of ongoing bodily processes that otherwise would have been able to sustain life. However, although it may be possible to draw a conceptual distinction between passive and active euthanasia, this provides no warrant for the ubiquitous view that killing is morally worse than letting die. Nor does it support the view that withdrawing treatment is worse than withholding it. If the patient's condition is so tragic that continuing life brings only pain, and there is no other way to relieve the pain than by death, then the more merciful act is not one that merely removes support for bodily processes and waits for eventual death to ensue; rather. it is one that brings the pain- and the patient's life- to an end now. If there are also grounds on which it is merciful not to prolong life, then there are grounds on which it is merciful to terminate it at once. The easy overdose, the lethal injection, are what mercy demands when no other means will bring relief.

Pain is a thing of the medical past, and euthanasia is no longer necessary, though it may have been, to relieve pain. Given modern medical technology and recent remarkable advances in pain management, the sufferings of the morally wounded and dying can be relieved by less dramatic means. For instance, many once-feared, painful diseases-tetanus, rabies, leprosy, tuberculosis-are now preventable or treatable. Improvements in battlefield first aid and transport of the wounded have been so great that the military coup de grace is now officially obsolete. We no longer speak of "moral agony" and "death throes" as the probable last scenes of life. Particularly impressive are the huge advances under the hospice program in the amelioration of both the physical and emotional pain of terminal illness, and our culturewide fears of pain in terminal cancer are no longer justified: cancer pain, when it occurs, can now be controlled in virtually all cases. We can now end the pain without also ending the life.

It is flatly incorrect to say that all pain, including pain in terminal illness, is or can be controlled. Some people still die in unspeakable agony. With superlative care, many kinds of pain can indeed be reduced in many patients, and adequate control of pain in terminal illness is often quite easy to achieve. Nevertheless, complete, universal, fully reliable pain control is a myth. Pain is not yet a "thing of the past", nor are many associated kinds of physical distress. Some kinds of conditions, such as difficulty in swallowing, are still difficult to relieve without introducing other discomforting limitations. Some kinds of pain are resistant to medication, as in elevated intracranial pressure or bone metatases and fractures. For some patients, narcotic drugs are dysphoric. Pain and distress may be increased by nausea, vomiting, itching, constipation, dry mouth, abscesses and decubitus ulcers that do not heal, weakness, breathing difficulties, and offensive smells. Severe respiratory insufficiency may mean an agonizing final few hours. Even a patient receiving the most advanced and sympathetic medical attention may still experience episodes of pain, perhaps altering with consciousness, as his or her condition deteriorates and the physician attempts to adjust schedules and dosages of pain medication. Many dying patients, including

half of all terminal cancer patients, have little to no pain, but there are still cases in which pain management is difficult. Finally, there are cases in which pain control is theoretically possible but for various reasons does not occur. Some deaths take place in remote locations where there are no pain-relieving resources. Some patients are unable to communicate the nature or extent of their pain. And some institutions and institutional personnel who have the capacity to control pain do not do so, whether from inattention, malevence, fears of addiction, or divergent priorities in resources.

In all of these cases, of course, the patient can be sedated into unconsciousness; this does indeed end the pain. But in respect of the patient's experience, this is tantamount to causing death: the patient has no further conscious experience and thus can achieve no goods, experience no significant communication, satisfy no goals. Furthermore, adequate sedation, by depressing respiratory function, may hasten death. Though it is always technically possible to achieve relief from pain, at least when the appropriate resources are available, the price may be functionally and practically equivalent, at least from the patient's point of view, to death. And this, of course, is just what the issue of euthanasia is about.