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by

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## Introduction

Over the years, there has been a significant debate over the ethics of making active voluntary euthanasia and physician-assisted suicide available for terminally ill patients, coming with increasing arguments on their moral adequacy. There is an increasing tendency to write in favor of accepting the morality of euthanasia in an effort to form public consensus. By physician-assisted suicide it is meant that the physician provides the means for a patient to end his or her life. By active euthanasia it is meant that the physician personally administers a lethal drug. Death will be caused in order to end a life of suffering, because the patient does not want to continue living, or because life has deteriorated into a minimal condition that cannot be considered dignified.

The considerable advancement of medicine in the last several years has led to the question of whether it is obligatory to use all possible means to keep a person alive, in other words, if we are to use all available therapy even when there is little chance of success.

In this context there has appeared the question of a right to die with dignity. For some, dying with dignity means dying without pain. Any death that is accompanied by suffering is considered undignified. Death can be induced by the administration of a drug with the intention of ending the life as well as the suffering. Active life-ending interventions are selected with the aim of quickly ending the patient's life when there is no

possibility of a cure and the patient has manifested his desire not to continue living. For many others the right to die with dignity implies the removal of life support systems or the withdrawal of treatment from terminally ill patients in order to allow them to succumb to the underlying disease, thus freeing the patient from the slavery of overtreatment.

There has been a debate over the reach of the term "euthanasia." In the past, the concept of euthanasia has been divided into active and passive. By passive euthanasia it is meant to hasten the death of a patient by removing life support equipment or by stopping medical procedures or treatment. By active euthanasia it is meant to induce death by the application of a lethal agent.

However, from the point of view of professional ethics it is irrelevant whether the life of a patient is taken by act or by omission of a necessary treatment. In both cases, death is induced intentionally. Rather, the definition of euthanasia must be understood as deliberately ending the life of a patient who is suffering or has an incurable disease, when requested by either the patient or the family.[1] Here, omission is taken to mean the deprivation of a medical treatment that is considered valid and necessary for the patient to live.

On the other hand, it is not euthanasia to refrain from medically futile treatment, or to remove unnecessary life support systems, allowing the patient to succumb to the underlying disease, or in death induced by "double-effect" drugs that are given to relieve suffering, but may also shorten life. There is no obligation to undergo or to prolong a treatment that is considered futile by the medical profession. The practice of hastening death with palliative care interventions to relieve the terminally ill patient's pain, suffering, and other symptoms is accepted as ethical and legal, provided the intention of the physician is to relieve pain and other symptoms and not to hasten death.[2]

Physicians are considered the logical candidates to seek for help in dying since, for many terminally ill patients, assistance in dying is seen as an extension of relief from suffering and as a form of caring, consistent with the profession.[3] Furthermore, it is already being done. According to anonymous polls, 13 to 19 percent of physicians in the United States have participated in physician-assisted suicide.[4] Oregon has become the first state to legalize physician-assisted suicide.

In this paper, I am going to analyze and critique the arguments in favor of euthanasia and physician-assisted suicide in order to make an ethical judgment in the question of whether there exists a right to commit suicide or to request euthanasia for terminally ill patients.

## Reasons Given in Favor of Euthanasia and Physician-Assisted Suicide

**1) The argument of poor quality of life.** Those who advocate euthanasia and physician-assisted suicide argue that in some circumstances living is worse than dying, that the pain and suffering caused by a terminal disease may make life so agonizing and unbearable that death may seem "an act of humanity" and physician-assisted suicide a way to die with dignity.[5] The physician will act under the principle of beneficence to relieve the pain and suffering of terminally ill patients. For the dying patient, suffering may go far beyond pain. This includes: progressive loss of activity, mobility and freedom, increasing helplessness and dependence on others, physical discomforts such as nausea, dyspnea, inability to swallow or talk, fear of dying, incontinence, weakness, loss of dignity, and dementia.[6] Life loses all quality and meaning to the point that death is preferable.

**2) Respect for autonomous persons demands recognition of their right to decide how they will live their lives.** This includes the dying process, the ability to choose one's own destiny. We have the right to avoid intolerable suffering and exert control over the way we die. Some authors believe there is a right to commit suicide and, therefore, to be free of unreasonable restrictions on the means by which one can exercise this right.[7] Battin has argued that there is an unequally distributed, but fundamental, right to suicide which we have because it can be constitutive of human dignity, at least in a negative sense, when life becomes unbearable.[8] The patient's right to self-determination has been a most central argument in favor of physician-assisted suicide.[9] Often it is assumed, without argument, that this implies a patient's right to request another agent to intervene so as to bring about his or her death.[10] Even with adequate palliative care there are cases in which it is not possible to avoid the suffering.[11]

**3) The principle of beneficence, compassion with the suffering.** This has been used as an argument in favor of euthanasia.[12] In this way, euthanasia is considered a virtuous act. The nonabandonment of the patient has been part of the traditional care provided by physicians. Physician-assisted suicide must be judged in light of this ethical principle of nonabandonment.

**4) The experiment with euthanasia in Holland.** This is regarded as successful by the general public and the medical profession in that country.

**5) The public stigma attached to suicide is decreasing.** In most jurisdictions, suicide is a legal act, and has been so for decades. Most suicides are seen as resulting from temporary mental illness, usually depression,[14] but the reason that terminally ill patients desire to shorten the process of dying is to terminate their suffering. This raises the concept of rational suicide. A person who is terminally ill may not be able to exercise the option of suicide because of mental or physical limitations. In a way, they are being discriminated against because of their disability, given that able-bodied people have the option.

**6) The distinction between "passive" and "active" euthanasia has been criticized for dependence on problematic conceptions of causation and on the belief that the sheer difference between killing and letting die is morally relevant.** From the patient's point of view, discontinuing life support measures and active voluntary euthanasia are similar in that the fundamental desire is for an earlier and more comfortable death. The intention is morally irrelevant in the evaluation of the morality of the action. They are also similar morally in that both are done with the intent of ending life.[15] In the case in which discontinuing supportive measures and allowing the patient to die produces days or weeks of extreme discomfort, active euthanasia seems to be morally preferable.[16] For some, discontinuing a ventilator cannot be considered a refusal of treatment, but a request to be killed.[17] For Patrick Hopkins[18] there is no metaphysical, essential, and intrinsic moral difference between machines and natural bodily organs, so that omitting treatment is a form of killing since we deprive the person of an organ that can only function with the aid of a machine or medical technology and that we need to set aside our prejudices against the artificial, and extend the option of good killing (active euthanasia) to those trapped by nature. If our society recognizes that life can be sufficiently burdensome on life-sustaining treatments, such as a respirator or dialysis machine, and that this medical intervention can be withdrawn or withheld (what some call passive euthanasia), then it can be sufficiently burdensome to justify active euthanasia.

**7) The principle of double effect is a form of active euthanasia.** Physicians are allowed to give increasing doses of narcotics when there is a severe pain or, it is presumed, with the knowledge that these drugs depress respiration and could hasten death.[19]

**8) John Hardwig has argued that when modern medicine allows us to survive far longer than we can take care of ourselves, there is a duty or responsibility to die in consideration of our loved ones, so as not to**

**impose crushing burdens on them.**[20] In a time when total medical funding is restricted and being continually reduced, it may not be ethical to engage in extremely expensive treatment of terminally ill people.

## Responses to the Arguments

**1) Quality of life issues are confused with the value that the quality of life has.** Quality of life issues have a strong subjective component. Very easily the health care professional will substitute his/her quality of life standard for that of the patient. Human life has an intrinsic value. Good health cannot give dignity to human life because health does not possess life in itself, rather it participates in life. The dignity of the person cannot be erased by illness. Rather, loss of dignity is imputed to the patient by reactions of caregivers and family to the patient's plight or appearance.

**2) The terminally ill patient is in an extremely vulnerable position, so that his/her autonomy is diminished, suffering from depression, anxiety, fear, dejection, rejection, and/or guilt.** Under these conditions, it is very difficult to have a clear conscience and some will almost blindly follow the suggestions of a physician. To bring about death by euthanasia is not within the competence of the medical profession. Physician-assisted suicide is not consistent with the doctor's pledge to heal and treat. Physician-assisted suicide is against the traditional ethical codes (Hippocratic, World Health Association, AMA). It will lead to a distrust in physicians. Furthermore, we do not have a right to commit suicide, for the simple reason that life does not belong completely to us. No one can say that he/she has given life to himself/herself. Recently in two unanimous decisions, the Supreme Court of the United States declined to constitutionalize the "right to death with dignity" (26 June 1997, *Washington v. Glucksberg* and *Vacco v. Quill*). In these, the plaintiffs contended that the statutes violated their patients' Fourteenth Amendment "liberty interest," so that there is a constitutionally recognized "right to die" that outweighs the state's interest in preventing suicide by "terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians." Not all intimate choices about one's life qualify as protected rights.

**3) The compassion that is talked about by the proponents of euthanasia reflects a distorted view.** True compassion does not eliminate the sufferer, but seeks to relieve the cause of the suffering. Otherwise, the life of the patient is devalued. Besides, compassion is a spiritual quality,

which means "suffering with," to be presented to the sufferer. It is not a principle or a self-justifying reason.

**4) The experience of the Netherlands has shown the reality of the slippery slope.** There have been successive steps in relaxation of criteria: extension to non-terminal patients, minors, Down syndrome, patients with mental suffering, severe depression, dementia, involuntary euthanasia "under certain conditions," and non-terminal AIDS patients.[21]

**5) It is not the same to commit suicide as it is to aid in a suicide.** The latter is a form of homicide, even if the underlying reason is compassion. Though attempting suicide has lately been decriminalized, the state's interest in preventing it has not wavered, including penalizing those who aid in the attempt. No matter how ill a person is, he is still among the living and therefore has a right to live. Data suggest that the interest of patients in euthanasia stems, in the majority of cases, to depression or psychological distress, rather than pain. This suggests that much of the debate about euthanasia is misplaced, since it focuses on pain and the use of euthanasia for pain relief, when in fact pain does not seem to be the primary motive.[22] Suffering of psychological origin can also be relieved with adequate counseling and psychiatric intervention. With proper support, including pain relief, psychological and spiritual therapy, and friendship, the patient can die in a dignified way as a member of the human family. No present-day legislation allows for help in committing suicide for a person who is going through a period of depression. Rather, their depression would be treated. To legalize physician-assisted suicide would contribute to desensitization to killing throughout all of society.

**6) There is a special relationship between the doctor and patient.** An omission of an act, if it brings about harm, may bring legal liability. If a competent patient refuses consent to treatment or continued treatment, the legal effect is that the physician is absolved from his or her duty by the patient. The physician terminates the treatment, but the subsequent death is caused by the underlying disease which the physician no longer has authority to treat. The physician is not killing the patient but letting him die. Ordinarily no one is under a duty to help a neighbor, such omissions to act bring no liability.[23]

We cannot forbid the voluntary acceptance of a death which medical intervention can only postpone. What is forbidden is unlawful killing. Often in the dialogue there is a confusion between passive euthanasia and euthanasia by omission. The latter brings legal liability but the former does not since natural deaths are not killing and thus are neither illegal nor

immoral and do not confer responsibility. In this sense, it will be helpful if the term "passive euthanasia" is avoided while we retain the qualification of euthanasia by omission, which implies a negligent act. An example that intention has its place in moral life is that when the person does not die after removal of the treatment, the person is left alive. This is not satisfied by assisted suicide. It is one thing to desire death and bring this about actively, and another to desire death and allow it to occur. It is one thing to respect the will of the patient to reject treatment and another to take his life. It is not merely a psychological difference, but also a moral one. To allow someone to die of a disease for which we are not responsible and cannot cure is to allow the disease to be the cause of death. The intention of allowing one to die is compassion and not death, while the intention of active euthanasia is death as a means for compassion.[24]

Conclusions about causation simply reflect judgments about the right place to assign responsibility. When a person turns off a life-supporting respirator without authority it is clear that he is causing the patient's death. But when a physician follows the patient's directions to disconnect a respirator he has not acted wrongfully, since he has no duty to continue treatment against the patient's wishes, even though this is causally related to the patient's death.

It is not dignified to continue aggressive treatment of the patient when there are no possibilities of cure (futile treatment).[25] A futile treatment does not produce a benefit any longer to the patient, but damage.[26] It is not the same thing to help to live someone who is living as it is to prevent to die someone who is dying. A treatment is considered futile if it only preserves unconsciousness or does not allow an end to dependency on the intensive care unit. Quantitatively, a physician can consider a treatment futile when the empirical data demonstrate that it has less than 1% probability of being beneficial to the patient.[27] Life and death issues cannot be decided with absolute certainty, simply because there is no strict and specific relation between the etiology and the disease. Our knowledge of an empirical reality is always approximate, probable. We cannot ask a physician for an absolute degree of certainty in his or her decisions. Nevertheless, it is the decision of the patient to continue with a futile treatment, since there is no absolute certainty. For an act of omission to be euthanasic the treatment omitted or withdrawn must be a useful one, not a futile one.

**7) Optimal palliative care could provide adequate pain relief for most terminally ill patients.**[28] Inpatient hospice units provide an example of supportive measures at the end of life with comfort care rendering superfluous any consideration of physician-assisted suicide. To legalize

physician-assisted suicide would divert attention away from pain relief and palliative care. The easy road for the health care professional is to be free from frustration, hostility and anguish that come from "hopeless" cases. The issue of hastening death with palliative care interventions for terminally ill patients is accepted as ethical and legal, provided the intention of the physician is to relieve pain and other symptoms and not to hasten death.[29] A disproportionate sedation can cause interruption of feeding and hydration of the patient, who will die of hunger or thirst in a state of unconsciousness, or will die of overdose. In this case, euthanasia can be hidden and is effected by an omission that leads to the patient's death by hunger. Ethically, the physician must look for pain relief that will carry less risk and still free the patient from unnecessary suffering.

**8) To allow physician-assisted suicide would leave an impact on other sufferers who are ill, aged, or weak.** This would devalue their lives and they may undergo assisted suicide under pressure. Further pressure is exercised if there are economical constraints. This undermines the call to generosity to those who surround the patient, who must free the patient from extra pressures.

## Ethical Reflections

Practically all religious traditions, including groups such as Christians, Muslims, and Jews, consider life as a gift from God, to be given and taken at the time of His choosing. Suicide can never be an option. Aristotle affirmed[30] that suicide is an unjust act and cannot be allowed, not because it goes against the individual, but because it goes against the community. Human life has value and dignity in and of itself because it is the life of a person. Physical life is constitutive of the person and a condition for his existence, is the fundamental value of the person, and therefore cannot be valued, taking as criteria minor and relative values, nor can it be relegated to the disposition of others.[31] Besides, Christians believe that God supports people in suffering and, therefore, to actively seek an end to one's life would represent a lack of trust in God's promise. Also, as Christians we have an obligation to support and be with those who are suffering and we believe that suffering brings us closer to Christ, identifying us with His cross and participating in redemption. Part of the problem with the present debate over euthanasia is that no value is given to suffering. Even considering that life can become unbearable, the final word is that life cannot be taken. Suicide is not ethical.

The question that has been raised is whether believers have the right to take their own personal beliefs and extend them to the entire population,

including secularists, atheists, and agnostics. I will argue that they do in this case, since believers are not saying anything that a non-believer could not accept as rational. Both believers and non-believers agree with the common conception that life and death are given to us. Not everything is autonomous in the human being. We do not give life to ourselves, we have received it from our parents. Therefore we do not have absolute dominion over our own lives and we cannot take them. We must distinguish between possessing something, such as our lives, and assuming it. We have received our lives, life is not an object that we possess, rather, we are responsible for what we do with our lives and we are able to choose options. These possibilities make us able to assume our lives. We are personal living beings, but we do not possess our lives as we would an object.

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31. The Magisterium has evaluated euthanasia as "a grave violation of the Law of God, since a deliberate killing is morally unacceptable for the human person" *Evangelium Vitae*, n. 65.