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Euthanasia – is there a case?

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Traditional Abrahamic religious teaching states that it is wrong to kill the innocent. However, advances in medical care have created new situations. The principle of double effect and the distinction between ordinary and extraordinary therapies have allowed religious ethicists a degree of latitude when it comes to thinking about euthanasia. Secular ethicists have also been challenged by these developments, and there are various opinions ranging from conservative to radical among these writers. In essence the principle of autonomy tends to trump all other issues, and this would mean that an autonomous decision to die by refusing treatment is to be respected. An autonomous request to be actively killed is more controversial, but there seems to be growing legal and ethical support for this under tightly controlled circumstances. Apart from theological objections, opponents of euthanasia raise practical concerns such as the slippery slope argument and the effect of active euthanasia on the doctor-patient relationship. When it comes to decision making in those patients who cannot function autonomously, such as neonates, patients in intensive care and patients in a persistent vegetative state, the issue is clouded. Health professionals must act in the patient's best interests, but what these are may be difficult to define. In many cases there is no pre-existing decision of the patient that can be used as a basis for end-of-life decision making. Health care providers have to make use of surrogates to help reach a decision, and this is controversial. This paper attempts to place the current discussions around euthanasia in context and to highlight both areas of agreement and of contention.

The traditional role of the physician has been to preserve human life. However, we have now reached a stage where physicians are often accused of preserving human life long after life itself has become a burden to the person living it. Throughout the developed world the demand for the legalisation of the right to end life is increasingly heard. This is referred to as euthanasia or mercy killing. Euthanasia means 'A good death' in Greek and covers a number of separate but interrelated issues. This paper attempts to place the euthanasia debate in context and to highlight both areas of consensus and of contention.

The following proposed definitions are intended to assist in the discussion.¹⁻⁹

Voluntary euthanasia is a conscious decision made by an individual that his/her life is actually no longer good for him/her and that death is more desirable.

Involuntary euthanasia is a decision made by a third party on behalf of a person who is no longer in a position to make one that his/her life is burdensome and that death is more desirable.

Physician-assisted suicide (PAS) recognises the fact that individuals who wish to end their life may be physically incapable of performing the act and may need assistance in the process.

Active euthanasia and passive euthanasia may be regarded as direct killing, as opposed to allowing someone to die.

What does religion say about euthanasia?

There is broad consensus across religious beliefs that it is wrong to kill an innocent human being. It is usually stated there is an inherent sanctity about all human life as each life belongs to God.¹⁻⁸

Killing of the innocent, suicide and euthanasia have been considered deserving of moral opprobrium. This position has been well documented by the scholastic philosopher Thomas Aquinas. He condemned suicide for the following reasons.

- It violates one's natural desire to live.
- It harms other people.
- Life is the gift of God and is therefore only to be taken by God.

However, there are grey areas in the religious objection to suicide. Religious moralists distinguish between ordinary and extraordinary methods of supporting a life. To withdraw an ordinary therapy is considered wrong, but a physician is under no moral obligation to continue with an extraordinary means of supporting a life. The other theory that is often used in religious-based medical ethics is the principle of double effect. This states that while it is wrong to commit a bad act, a good act is good in itself. If a good act has unintended bad consequences, then the person performing the act is not morally blameworthy for those consequences. This was used to justify the administration of high doses of opioids in patients suffering from advanced cancer, who were in extreme pain. The religious prohibition on mercy killing is nuanced and not absolute.

Modern secular medical ethics

The traditional Hippocratic Oath was explicit that the role of a physician was to preserve human life and not to be instrumental in its destruction.¹⁻³ The oath stated 'To please no one will I prescribe a deadly drug nor give advice which may cause his death.' 'Primum non nocere' is another famous adage that warns doctors at all costs not to harm their patients. These traditional concepts are opposed to the killing of a human being. Modern secular medical

ethics rests on four principles: autonomy, beneficence, non-maleficence and justice.¹⁻³ However, these principles may come into conflict.

Why would someone want to die?

People want to kill themselves for many reasons. The commonest cause of suicide remains clinical depression. Suicide in these patients must be seen as a tragedy. There are other reasons that may prompt a person to feel that life is intolerable. An individual may be in a state of chronic and excessive pain. A terminal and chronic illness may result in excessive medical expenses which will deplete financial resources available for the surviving relatives without significantly improving the quality of life for the patient. In some patients a serious disease may adversely affect the quality of life of an individual to the point where he/she no longer wishes to continue living. Neurological diseases are especially feared as they lead to a loss of autonomy. The philosopher Charles Taylor in his monograph *The Ethics of Authenticity* points out that in the modern era the issue of personal choice has come to be seen as central to our authenticity as human beings.¹⁰ We value our ability to choose and control all aspects of our life including the end of our life. It is regarded as a truism that we live in a multi-cultural world where different cultural viewpoints compete in an open market of ideas. Is it possible to establish a moral consensus for supporting or rejecting the different forms of euthanasia?

Voluntary euthanasia

It is generally considered morally praiseworthy to prevent a suicide if one is not certain of the motive or state of mind of the suicide victim. However, in the case of a person who has come to this decision with a clear mind the situation is different. The current emphasis on autonomy and self-determination would suggest that a person's autonomous decision to end his/her life should be respected. Refusing potentially life-saving surgery is a form of voluntary euthanasia and is easy to comply with. There is a movement for people to make their autonomous wishes regarding the end of their life known while they are competent. This so-called advanced directive is of uncertain legal standing. It is also common for many people not to think ahead about unpleasant issues such as death and disability. *The British Medical Journal* has published guidelines on assessing competence of a decision in the elderly to refuse therapy.¹¹ A patient must understand the condition, prognosis, and proposed therapy, and be able to reason consistently and to act on the basis of such reasoning. A patient must be able to communicate their choice and the reasons for that choice and understand the practical consequences of their choice. There is very little guidance about patients who seek active euthanasia. If a patient wishes to actively end his/her life, the physician is under no obligation to assist with this and in fact runs the risk of legal sanction if he/she does assist. This is a somewhat anomalous situation as it appears that we are discriminating between methods of choosing death.

Involuntary euthanasia

Often the question of euthanasia arises when an individual is not capable of making a decision and the decision is referred to surrogates. Usually a surrogate is a close relative or life partner of the individual concerned. The question asked is what would that individual have wanted if he/she were competent to make a decision? This is always difficult, as being related does not imply intimacy,

and often the topic of death and disability might never have come up in conversation. There are examples of surrogates getting it wrong or forcefully imposing their wishes on the patient. Jennifer Allwood thought it would be merciful to smother her 67-year-old father who had cancer. He was able to fight back and survived.¹² It is important that the relationship of trust between a doctor and patient be maintained. A feeling on the patient's part that a doctor may also become an executioner may undermine this trust. There is undoubted pressure on medical professionals to conserve resources. Who is the physician responsible to, the patient with whom he already has a fiduciary relationship or a theoretical future patient who he does not yet have a relationship with? The principles of medical ethics may come into conflict with each other.

Passive euthanasia

Passive euthanasia is accepted and in reality is widely practised. It is often called withdrawal of therapy. If further care is unlikely to be of any therapeutic benefit, a physician is not obliged to continue therapy. The current approach is for a physician to declare that future therapy is futile and then to withdraw therapy on the basis of futility.^{11,13} Experienced physicians can read the writing on the wall when it comes to outcome in many situations. However, this approach has been accused of bringing back old-fashioned paternalism. Pro-life pressure groups have begun to show interest in how these decisions are made and communicated to the patients and relatives. Issues of distributive justice in the form of resource constraints may influence the definition of futility. In a country with a well-developed social health care system a patient with renal failure would receive life-sustaining renal dialysis therapy. However, in a developing country a patient with a similar disease and demographic profile may not have access to dialysis. So definitions of futility may change depending on circumstance. Medical decisions about futility can expect more intense scrutiny in the future. In the case of children with significant deformities that require specialised care it is important for the physician to understand that his/her patient is the child, not the parents. The physician should be motivated by the child's best interests, not those of the parents.¹⁴⁻¹⁶ The following British legal precedents are relevant to the discussion. In 1981 Baby B was born with Down syndrome and intestinal atresia. The parents refused to consent to the surgery and stated that they wished the baby to die as its quality of life would be poor. A lower court judge ruled in favour of the parents.¹⁷ The hospital appealed and the decision was reversed, as it is generally accepted that a child with Down syndrome can experience a good quality of life. A landmark ruling was the 1993 Bland case.^{5,17} Anthony Bland was left in a persistent vegetative state (PVS) after being crushed during the Hillsborough Football Stadium disaster in 1989. Four years later his parents and the hospital trust successfully sought permission from the High Court and the House of Lords to withdraw artificial nutrition and hydration. Both courts agreed. Peter Singer has described this judgment as courageous and marking a 'seismic shift against the concept of sanctity of life'. The Law Lords stated that the continuing maintenance of Bland's physiology was of no benefit to him.⁶

Higher functions are controlled by the cerebral cortex. Lower functions are maintained in the brainstem. Almost all countries have accepted evidence of brainstem death as evidence of death of the person. However in the case of cortical dysfunction the patient is considered to be in a PVS and cannot be declared dead. They may well remain in this condition for many years. There are some moralists who would argue that without higher cortical func-

tion a person in a PVS is dead and that all that remains is a physical organism. Authors such as Singer and McMahan would have no moral objection to withdrawing the feeding tube and would have no objection to actively killing a patient in a PVS.^{5,6}

Terry Schiavo's husband wished to have her feeding tube removed and for her to be allowed to die. Her parents felt that this was morally wrong and not in keeping with Terry's own wishes.^{18,19} The prolonged legal struggle eventually resulted in the tube being removed and in Terry's death. The debates revolved around a number of issues. The argument in favour of removing a feeding tube would state that we did not intend to kill the patient by removing a tube which was causing her discomfort and a loss of dignity. The fact that she was unable to maintain nutrition and died from dehydration was a foreseen but unintended consequence of removing the tube. The other issue was that of ordinary versus extraordinary therapies. Some treatments such as mechanical ventilation, home-based intravenous nutrition and renal haemodialysis are expensive but no longer experimental. Are they still to be considered extraordinary therapies? Christopher Reeves survived for several years following a high spinal cord injury.²⁰ The therapy required to do this was extremely expensive and complex. It is doubtful whether a quadriplegic patient in the developing world would have access to this care. The definition of ordinary and extraordinary depends on social class and geographical location. A 'one size fits all' approach to morality may not be possible in the modern world.

Active euthanasia

Although there is much acceptance of passive euthanasia there are areas of contention within it. There are three arguments in favour of active euthanasia. They are the relief of intractable pain, the respect for autonomy and the closely related fear of a loss of dignity that accompanies the loss of autonomy. The widespread acceptance of autonomy and respect for individual choice when it comes to passive euthanasia has caused many to question the basis for the moral and legal objection to active euthanasia. Internationally there has been a movement towards legalising active euthanasia. Several bioethicists distinguish between justified and unjustified PAS. Beauchamp and Childress can see no moral objection to prevent an autonomous individual from requesting help with ending his/her life and they can see nothing morally wrong with a physician assisting the aforesaid individual.² They feel that frustrating an individual to achieve his/her objective is morally wrong. It will result in a loss of dignity and in despair. In this case causing death is not an evil act. However they are quick to qualify this by pointing out that unjustified PAS is a problem. The case of Dr Kevorkian is described.² The general consensus is that he had no doctor-patient relationship with his victims, had not established their diagnoses adequately and acted with indecent haste. However, they point to cases such as that of McAfee, a quadriplegic man who wanted to end his life by disconnecting himself from his ventilator. This was in keeping with his right to refuse treatment; however he required the administration of a sedative to control the pain while he disconnected himself from the ventilator. The court used the principle of double effect to get around this by stating that the administration of sedation was part of the medical therapy designed to control his pain. Beauchamp and Childress believe that assisted suicide is justified under strict conditions.

Although this would seem to indicate consensus among secular bioethicists, there are several objections. Is anyone ever re-

ally totally autonomous, or do the social relations influence our decisions? Are we ever able to properly assess autonomy? The argument about intractable pain is controversial as modern pain therapy is increasingly effective. The loss of dignity argument is a strong one and appeals to secular society as autonomy is so highly valued. Many religious and secular moralists have serious objections to active voluntary euthanasia. These have been highlighted, but it is perhaps unjustified for these views to be imposed on secular society as a whole. Especially in the case where there is an autonomous decision made for suicide, we should not frustrate the wishes of a competent human being. The situation of involuntary euthanasia is much more of a concern as there is no autonomy and we need to err on the side of protecting those who cannot speak for themselves. There are concerns that may well become more central as objections to the widespread adoption of active euthanasia. These are the so-called slippery slope argument and the centrality of the doctor-patient relationship.

The slippery slope argument

This is a well-used argument by opponents of abortion and euthanasia. Opponents refer to the history of the mid-20th century. The argument is that a move to unsanctify human life resulted in the rise of utilitarianism. This may result in the minority and the weak being left behind. The examples of this approach were the Nazis and the eugenicists. The American eugenicists were interested in eliminating mental retardation.¹⁻³ There was a strong element of racism in this as they were often concerned that decreased fertility in Americans of Protestant stock would result in demographics changing as immigration of poor Catholics continued unchecked. The Nazi programme of active involuntary euthanasia targeted mentally incapacitated children. They were referred to as life unworthy of life. Now, is it a simple case of scaremongering by the pro-life lobby? There may well be an element of this. There is no evidence in places like Holland that there has been an upsurge in euthanasia for racist reasons. However there are valid concerns. Will elderly disabled people be encouraged to ask for active euthanasia by a society that is weary of paying the cost to support them? The impending demographic crisis in Europe is real.²¹ Increased longevity and falling birth rates have resulted in an inverted demographic triangle. Will it not be cheaper to euthanise the elderly? Non-treatment on the basis of old age has been used unacceptably as a mechanism for rationing scarce resources.^{22,23} There have been well-publicised murder trials involving health care professionals who have been guilty of murdering a number of elderly patients by lethal injection.²⁴ These are the actions of psychopathic personalities, but do they reflect an underlying social perspective? So the slippery slope argument cannot be dismissed out of hand as scaremongering. The pro-life lobby quotes as an example of the slippery slope the extension of active euthanasia to neonates with severe congenital deformities in the Netherlands. In 2005, the Groningen Protocol was published setting out the circumstances under which doctors could kill a neonate with severe and untreatable pathology.²⁵⁻²⁷ The protocol established three categories: those neonates with no chance of survival; those who after intensive treatment face a very grim future with severe problems; and a third group who are not dependent on intensive medical treatment and who may survive for many years, even into adulthood. Pro-life groups claim that this would amount to pre-emptive killing.

The doctor-patient relationship and euthanasia

Despite the ongoing commercialisation of society, medicine retains a proud standing as a traditional profession. Most health care workers would describe medicine as a vocation or calling rather than a mere career. Doctors want to preserve life and alleviate suffering. Alleviating suffering by ending life has never been part of the medical professional code. Legalising euthanasia will change this. It is unclear how this will change the profession, but it is a real concern. The widespread adoption of professionalism in sport has improved performance in the sporting codes. However, there is evidence that professionalism has resulted in fewer people playing amateur sport. Amateur sport was supposed to teach sportsmanship and encourage a healthy lifestyle. Now it would seem that it is only there for the children of talent. It is very difficult to predict the long-term ramifications of legalising euthanasia on the doctor-patient relationship, but we are deluding ourselves if we think that it will not have long-term unexpected consequences. Physicians are expressly concerned with the most vulnerable groups in society. Physicians have traditionally been regarded as advocates for these groups. If we introduce active euthanasia we would lose our status as defenders of the weak.

The role of conscience

Aquinas believed that a formed and informed conscience could not be lightly overridden. We are all capable of moral reasoning and once we have reached a moral belief we should try to fulfil our belief. Throughout history following one's conscience has cost individuals dearly. It would be wrong for law makers to attempt to prescribe behaviour of individual doctors. It will be important for the right to conscience to be respected if legislation to legalise euthanasia is propagated in South Africa.

What is so sacred about human life?

Religion has always maintained that human beings are created in the image of God and that human life is sacred. This belief is no longer accepted absolutely by secular society. One of the most eloquent critics of this belief is Peter Singer.⁶ He believes that life is only of value if it is possessed by a sentient creature that can feel pain and has expectations of a future. Singer would regard a person such as Terri Schiavo, who suffered extensive destruction of her cerebral cortex, as a non-person as she could no longer experience the world or look forward to a future. Jeff McMahan in *The Ethics of Killing* states that the best way to think of human beings is as 'embodied minds'.⁵ For Singer and McMahan, once your higher cerebral functions have been lost you are a non-person.^{5,6} The conclusions of these speculations are radical. Singer and McMahan would probably have gone further with Terri Schiavo. They would have supported actively killing her by removing her organs and transplanting them. They would argue that Terri Schiavo was long dead; all that remained was her body. Removing her organs would not have harmed her and may have benefited several other patients who needed her organs.

Conclusion

Euthanasia is controversial. The right to refuse treatment is well accepted. When it comes to withdrawing treatment there is consensus that provided therapy is futile then there is no moral censure. However, there are issues around the exact definition of futile

care. The definition may unfortunately be dependent on resource constraints. Passive euthanasia when it is involuntary is also controversial as the autonomy of the individual is not respected. This may be impossible in cases where the individual is unlikely to ever regain autonomy. The principle of double effect and the distinction between ordinary and extraordinary means are also areas for discussion. Once again definitions are difficult as resource constraints as well as the spread of technology mean that what was once extraordinary may become routine in relatively short periods of time. Active euthanasia has become an issue in a society that values personal choice and control. While there are religious reasons to reject active euthanasia, the secular reasoning appears to be compelling. There are however a number of practical concerns. Although the slippery slope argument is prone to hyperbole, there are valid concerns about how changing our position leads to real but often intangible changes in the relationship between physicians and patients. Active involuntary euthanasia seems to be opposed by the vast majority. Despite a few radical voices it seems unlikely that it will garner mass acceptance.

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Article

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