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# DETERMINING THE MORALITY OF ACTIVE BUTHANASIA

UHON 499 Senior Honors Thesis

H. Dale Myers 01 December 1995 Graded and Advised by Dr. John Howie

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Death is the most brutal of all words in any language. It is the ultimate end, the finality of all. The cessation of both physical life and personhood. In a normal, healthy life, death is an issue that is left unspoken, but feared. Medicine has learned to extend life, but now it may extend physiological life long after the loss of individual personhood (the individual's uniqueness which makes one a distinct person).

Society now faces tremendous moral, ethical and personal challenges in dealing with the difficulties of persons who, while technically alive, have lost the ability to function as individuals. Some suffer debilitating pain, excruciating and permanent. Some live only due to medicine's machinery, the only sign of life a heartbeat, respiration and occupancy of physical space. These dilemmas have given an old word new meaning in today's society - Euthanasia.

# DEFINING EUTHANASIA

Euthanasia is the action of one individual killing another individual for reasons considered to be merciful. This is no new term. Some early supporters of euthanasia include Plato, Aristotle, and Luther (Thomasma & Graber, 1990, p.1). Euthanasia was also part of the Utopian society created by Thomas More in the Sixteenth Century (p.57). It takes on many other names too, depending on the action, individual consent and one's moral concept of life and death.

Euthanasia can be either be active or passive. Passive euthanasia is allowing one to die by not acting to stop death or taking an action to prolong life no longer. Active euthanasia however, requires a direct action to cause death. The differences between active and passive euthanasia can be black and white, or fall into a gray area that makes it seem to be of little or no difference in terms of consequences. The consequences in both cases are the same: Death. The circumstances of morally accepting active euthanasia are also the same: The loss of functional personhood, irreversible pain that medicine cannot ease, and intolerable pain that debilitates the individual's quality of life. Additionally, both passive and active euthanasia are morally acceptable under the principles of autonomy, right to privacy, and mercy.

PASSIVE EUTHANASIA - DO NOT RESUSCITATE, NO HEROIC MEASURES AND THE WITHHOLDING, OR FOREGOING OF LIFE SUSTAINING TREATMENT.

Passive euthanasia is the deliberate act of allowing one to die by withholding, or withdrawing, of medical interventions which artificially sustain life. This allows death to be the natural consequence of a terminal illness or accident. Passive euthanasia is now referred to as "foregoing life-sustaining treatment" by most medical ethicists (Scully & Scully, 1988, p. 112). This withholding, or foregoing, of medical treatment constitutes euthanasia because of an active decision to allow death to occur. This has become a daily event in American society, accepted morally (autonomy), legally (right to privacy), and medically (the right to refuse treatment). However we may wish to term passive euthanasia, it is

the action of taking no action. To take no action is in itself an action, hence, the foregoing of life-sustaining treatment is euthanasia. Do not resuscitate, take no heroic (or extraordinary) measures, and the foregoing of life-sustaining treatment are all distinctly passive euthanasia. They are also deaths of mercy and humaneness.

The acceptance of passive euthanasia has essentially led to the end of practical debate over its morality. Any further debate is "flogging a dead horse" (Fletcher, 1973, p. 150). The right to privacy, right to refuse treatment and respect for individual autonomy have been upheld as constitutional rights in both the Cruzan and Quinlan cases. These two cases provide bedrock standards in the moral justification and legal right of passive euthanasia: Expressed consent by a competent patient (or by surrogacy in the best interest of the patient) and the medical decision that life has ceased mentally (brain-death), or that there is nothing more that may be done.

# MORAL JUSTIFICATION OF PASSIVE EUTHANASIA

Moral justification of passive euthanasia lies in two distinct factors that are determinants of allowing one to die with dignity. First, the expressed consent of a competent (or formerly competent patient) to be euthanized and under what conditions. This consent can come as clear and convincing testimony from the family, the individual, or by a living will. For the euthanasia to be morally justified, it must be the expressed wish of a competent patient.

Living wills present the patient's expressed wishes to the family and doctor, establish the guidelines of care to be followed and state when medical intervention is to be discontinued. California became the first state to pass a natural death statute and acknowledge the legitimacy of living wills (Scully & Scully,1988,p.100). Thirty-eight states now recognize living wills and the "right to die". By creating guidelines in a living will, the expressed consent of the competent patient is legally expressed.

The second determining factor is that the patient's life as the person he or she was is over. It is now widely accepted, in the medical definition of death, that brain death constitutes death. If one is in a persistently vegetative state, has no signs of brain activity (cerebral), or cannot live without artificial means, then passive euthanasia is morally justified. In the case of the loss of personhood, such as in the end stage of terminal disease, passive euthanasia is acceptable, but only with expressed consent.

Most religions accept the principle of death with dignity and that life ends, in some cases, before physiological death (Larue,1985,pp.1-148). This allows for the moral acceptance of passive euthanasia and the right for an individual to choose death. Pope Pius XII stated that there was no moral obligation to maintain life when there was no hope for recovery (Colen,1976,p.58). Joseph Fletcher (1973) adds that, "ministers, priests and rabbis recognize the moralness of 'negative euthanasia' more than the medical

institution (p.150). (Appendix A shows the position of major religions in fuller detail).

To argue further the morality of passive euthanasia is unnecessary. Passive euthanasia is a daily fact of life in hospitals, nursing homes and hospices nationwide. The only difference is the phrasing of passive euthanasia in the more palatable terms of do not resuscitate, take no heroic measures and the foregoing of life-sustaining treatment. It is not immoral to recognize that one's personhood no longer exists even though there are physiological signs of life; it is merciful.

# ACTIVE EUTHANASIA

In active euthanasia the principles of autonomy and the right to privacy are not the only determining factors of morality. The principles of humanness and compassion also become determining factors in order to justify morally the act of relieving suffering by causing death. In active euthanasia it is not the disease or injury one dies as a result of, rather, it is as a result of a deliberate act to cause death. Though the death is not the direct result of the disease or trauma, it is a consequence of it; the death occurs from an action to relieve the suffering caused by the disease.

The requirement of aid to cause death is what most find morally apprehensible, especially if it is a physician. Leon Kass (1990) finds a "primary impediment within the very doctor-patient relationship" to actively euthanize, especially with the doctor's

role of a healer (Thomasma & Graber,p.148). This would have even further impact on the public's view of doctors and medicine (p.149). When it comes to the relief of endless suffering and medicine offers no relief, what is it one ought to do? The Hippocratic Oath requires a doctor to both preserve life and relieve suffering (Fletcher,1960,p.64). This creates a dilemma for the physician as well as the patient.

Every day we determine that there is a time when suffering and misery ought to be relieved. We morally accept this philosophy in passive euthanasia, abortion and in the active euthanasia of species other than humans. In those acts we use the terms humane, merciful, painless. In fact, we find it a moral obligation to put animals of another species "to sleep" because they suffer, are stray, or have bitten.

Ecclesiastes 3:19-20 says, "For the fate of the sons of men and the fate of beasts is the same; as one dies, so dies the other. They all have the same breath, and man has no advantage over the beasts, for all is vanity. All go to one place; all are from the dust, and all turn to dust again"(Cogden,1977,p.72). Is one morally correct to justify euthanasia for another animal species for the painless relief of suffering and in turn say it is immoral to do the same for man? Can there really exist a religious acceptance of the euthanization of one species which is said to be an equivalent in the Bible and intolerance for the relief of human suffering?

Truly a suffering animal ought to be put to sleep; it is the

morally just thing one ought to do. However afraid of death one might be, it is morally unjust to dictate that another must permanently suffer and live a life in misery. Eventually one loses personhood as a result, and consequently becomes dehumanized (Fletcher, 1960, p. 67). The sanctity of life and the right to life ought to be our most important right, but eventually we all lose that right and death comes to all. Circumstances do exist that morally justify, if not obligate, one to perform a deliberate act to relieve suffering when there is no reversibility, no relief for the pain, and there is no chance to live the life one formerly had.

#### MORAL JUSTIFICATION FOR ACTIVE EUTHANASIA

If one reads the volumes of articles about active euthanasia, he/she will find numerous arguments for and against active euthanasia. All of these arguments are valid and morally correct, but how can what one sees as a moral act be an immoral act to another and vice versa? It is in respect for the autonomy of another person and respect for another to make choices about his or her own life. Just as it is immoral to decide another's religious beliefs, or what their importance to society is, who is just to determine that another's pain is or isn't suffering? Who ought to determine that another should be euthanized to ease his or her suffering? To both of those questions the answer is, "No one"!

No one person is morally justified in determining that another's life is or isn't worth living. To one individual, the pain may be too much and there exists no quality of life. For

another, his or her value of the sanctity of life may be one in which pain is of no consequence. It is the individual who, according to their beliefs, must choose. Morally, no one else may do it for them.

If one objects to euthanasia on the grounds of their belief, either theistically or by their value of life, then, that objection for that person is valid, and morally acceptable. If one's center of life has become tortuous pain that cannot be relieved, then he or she has the right to choose an end to the suffering. If medicine's responsibility is to relieve suffering and cannot, then what is wrong with allowing one to seek medical relief of his or her suffering through euthanasia?

There is little substantive argument left when we have found both passive euthanasia and abortion morally accepted and constitutionally protected rights. Federal Judge Barbara Rothstein, in her decision against Washington voters who voted to turn down Initiative 119, a proposal to legalize physician assisted euthanasia, found no "constitutionally meaningful difference between the withdrawal of life-sustaining medical treatment and the provision of the medical means to end life in the case of terminally ill, competent patients" (Commonweal, 1994, p. A32). Since passive euthanasia is a deliberate act of not taking action to sustain life, and abortion a deliberate act of involuntary active euthanasia, there seems to be no distinct moral difference between active and passive euthanasia.

#### THE SLIPPERY SLOPE ARGUMENT AGAINST EUTHANASIA

Many refer to the "slippery slope" to argue against active euthanasia. This argument holds that if we accept this act of helping another to die, we will legitimize suicide (Kass, 1991,p.20), will allow the mentally ill to be euthanized, have mad doctors euthanizing at their will (not the will of the patient). In the extreme of this type of argument, our society will degrade to that of a "Nazi Germany". But while we hold the terminally ill, suffering, and consenting competent patient accountable for remaining alive, the moment they become artificially sustained or slip into coma they are passively euthanized!

The slippery slope argument holds validity only when argued in the terms of the principle of nonmaleficence, that one ought to do no further harm to a patient (Beauchamp and Childress, 1994, p. 230). The principle of nonmaleficence does not distinguish between no further harm and the relief of suffering, nor does it mention mercy. It is immoral to allow one to needlessly suffer when that suffering entirely replaces the individual's quality of life. It is humaneness that dictates the suffering. an end to Nonmaleficence is to do no further harm, and when the pain is intolerable, cannot be remedied and is in itself harmful, then nonmaleficence ought to dictate that a merciful end to the suffering be allowed.

Common sense would also seem to dictate that if the validity of the slippery slope holds true, then our already established rights of abortion and passive euthanasia have already placed us

somewhere on the slope. And while passive euthanasia would be above active euthanasia in this "slope", it would hold that abortion would place well below euthanasia because of the lack of voluntariness of the fetus and abortion for the reasons other than the fetus' or mother's life even farther down.

# EUTHANASIA: NOT A FORM OF HOMICIDE OR SUICIDE

Euthanasia is not a random act, nor is it unintentional. Its effect (death) is the result of a cause (illness, pain, brain death). There is morality in the relief of suffering, or no longer prolonging life. This is directly opposite to homicide and suicide, and to compare them with euthanasia is incoherent.

Homicide is constituted by the deliberate taking of another's life, and there is no justification for homicide. It is not based on any motive other than the self-interests of the murderer. This does not involve mercy or compassion, it is the outcome of a wanton disregard for the sanctity and value of human life. It violates another's right to live.

Suicide, the intentional taking of one's life, is perhaps the most often compared with euthanasia. Sociologist Emile Durkheim identified two basic types of suicide: egoistic and altruistic (Fletcher, 1976,p.173). The closest we may come to contrasting euthanasia and suicide is in altruistic suicide. Although the suicide is altruistic, who is to gain the benefit of the act? If a terminally ill patient takes their own life for the financial reasons of their family, it may be perceived as altruism. But in

this case, Leon Kass (1993) asks, "what principle of family am I enacting and endorsing with my 'altruistic suicide'" (p.380). This is not euthanasia in action or intent as it neglects mercy for the relief of endless pain. Altruistic suicide would also seem to bring about the connotation of one's duty to die to relieve the suffering of someone other than the true sufferer.

Suicide in any form lacks comparison with euthanasia. It lacks mercy. Suicide is most often the result of mental illness, egoistic reasons, or financial reasons. Mental illnesses can be controlled and a suicide due to mental illness is due to the illness itself, not the action of a competent person. Suicide for financial reasons is an opting out not due to the loss of personhood, but due to a monetary basis for the quality of life.

In all considerations, the term euthanasia cannot be applied to suicide or homicide due to the lack of regard for the sanctity of life (theistically or naturally) and the right to live. One who commits "suicide" to relieve pain is in all actuality committing voluntary euthanasia.

#### AN ACTIVE EUTHANASIA PARADOX; ABORTION

In discussing active euthanasia, we must discuss the already legal and morally accepted abortion. While abortion may be accepted, its acceptance is limited. So few people are in the middle ground of being both "Pro-Life" and "Pro-Choice". Divided among moral and religious lines, as is euthanasia, some morally accept abortion while others do not.

Ethicist Joseph Fletcher finds abortion as passive, involuntary and direct euthanasia (1973,p.154). However, abortion is a deliberate act taken for the merciful reasons of either the mother or the fetus without consent of the fetus, thereby constituting active euthanasia.

A fetus aborted after amniocentesis shows a fatal genetic defect, or a certainty that the fetus will be born only to live a short, painful life is aborted as a merciful act for the fetus. An abortion in the case of danger to the health of the mother is a merciful act to spare the mother. Abortion in the case of rape and incest falls into a gray area (in respect to the fetus), but this is somewhat an act of mercy (or compassion) for the mother. If forced to take the fetus to term, it violates all aspects of the mother's freedom of choice (autonomy). While it is morally justified, it is not in the merciful terms of euthanasia.

In all cases of abortion there is a lack of consent from the fetus. Consent, looked at later in this paper, ought to be the primary concern in active euthanasia. The fetus has no voice, therefore, cannot consent. The decision is made in either the best interests of the mother, or the fetus, by a surrogate (the parents or physician). While this constitutes involuntary active euthanasia it is morally justified by its compassion and mercy.

If we find abortion (for any reason) moral and a legal right, we ought to be able to find active euthanasia just as morally and legally acceptable. Both determine that there are certain physical and qualitative aspects that constitute a minimum basis for a good

life. And both recognize that personhood begins at a point beyond conception and ends, in some cases, at a point prior to actual physiological death. Personhood is the constitution of life, and without personhood one only exists physiologically (Fletcher, 1974, p. 163). A fetus, while physiologically alive, lacks personhood, therefore abortion for the reasons of mercy are morally acceptable.

#### CONSENT AND AUTONOMY

Who should consider active euthanasia, and can someone choose death for another? In all cases of euthanasia, active or passive, it must be the patient, and in the case of active euthanasia, always the patient through explicitly expressed consent. The principle of autonomy must be respected in the patient's right to choose an end to pain and suffering if there is no medicinal relief available.

Passive euthanasia and abortion are legally and morally just under the principle of autonomy. In the Karen Quinlan case, the Supreme Court of New Jersey ruled that Miss Quinlan had a constitutional right to refuse treatment, and this right could be exercised for her by her guardian or family (Grisez & Boyle, 1979,p.284). This ruling specifically allowed passive euthanasia and established that consent can come from either the individual or the guardian/family in the case of a formerly competent patient (as Quinlan was). This right to refuse medical treatment is expressed in the American Medical Association's (AMA) Fundamental Elements of

the Patient-Physician Relationship (Walters, 1994, 44).

For active euthanasia to become morally accepted, it must meet the same standards as passive euthanasia. Explicit consent of a competent patient, permanent and irreversible physical pain, the inability to ever return to the same quality of life, and the concurrence of more than one physician that this pain is permanent. Of utmost importance is that it ought to only be the patient, never the doctor who seeks euthanasia as a cure. Active euthanasia ought to be an option for the patient, not for the physician.

It ought to never be considered that there is ever any duty for one to be euthanized when one becomes ill. It is an option only for the sufferer and based only upon his or her own conditions. In Thomas More's <u>Utopia</u>, from the 16th Century, this same concept is explicitly stated in that only the sufferer shall choose to be euthanized and it shall not be determined by anyone else (p.57).

#### EUTHANASIA AND THE HIPPOCRATIC OATH

In the Hippocratic Oath there also exists a paradox concerning euthanasia. This oath states, "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect" (Walters, 1994, 43). This is an expressed banning of euthanasia to any physicians who have sworn to uphold it the Hippocratic Oath. The AMA's Fundamental Element forbids active euthanasia, but does recognize the right to refuse treatment (p.44). The acknowledgement of this right to refuse treatment

recognizes one's right to determine the course of his life, or the ending of it.

The argument that active euthanasia is a violation of the Hippocratic Oath is valid if one maintains the standards that Hippocrates has set forth. But this is hypocritical in the case of abortion. "Abortive remedies" are also expressly forbidden by the same oath and in the same paragraph as euthanasia. For one to disapprove of euthanasia and approve of abortion is incongruent if their basis is the oath. Some physicians do perform abortions, not all, but some do. Those that do perform abortions do so in violation of the Hippocratic Oath.

#### THE CONSEQUENCES OF ACTION AND INACTION

An ethical consideration of passive euthanasia, in finding it a moral act, is that death is a consequence of the terminal disease or injury. Some claim there is a moral difference of not acting to save a life, and deliberately doing something to end a life (Fletcher, 1960, p. 68), but if the consequence of one is the same as the other, and acted out in mercy and compassion, then it is only the means which differs. In "consequential" moral judgement, the end is a humane, dignified death, and a relief of suffering. The means are justified by relieving the suffering of the patient by allowing or causing physical death. The intentions of both passive and active euthanasia are the same, and both also require a decision, one to act deliberately, the other to not act. And when both consequence and intent are the same, there is no moral

distinguishment in turning off a respirator and injection of a lethal drug.

If the consequence of death were always bad, then death would never be acceptable in any case. Is killing in self-defense wrong? Is abortion always wrong? The consequence of death to the living is feared, but to one who is suffering or already dying it is not feared (Fletcher, 1960, p. 62). For some, the only relief for their suffering is in death.

#### THE DOUBLE EFFECT AND EUTHANASIA

Another form of active euthanasia, obfuscated as the justifiable consequence of a good intention, is the double effect (Glover,1977,p.87). If a physician gives medication to a patient, or increases the dosage of medication, and knows that this may shorten the life of the sufferer, then the physician is morally just as the death is unintended. The intention is the immediate effect of pain relief, not the shortening of life.

Death as a consequence in the double effect is unintended, but death as the consequence of euthanasia is intended. In the double effect, it is only the lack of intention that many use to justify the morality of the double effect. But in both, the consequences are the same, and if the consequence of death in active euthanasia is good (relief of suffering), it is as morally correct as the double effect. The only degree of separation is in the intent. The intention of euthanasia is a merciful death, the double effect's intention is to relieve pain, but the causing of death (if

not intended), is morally just.

In Kantian, or deontological, theory of ethics, it is the not the consequence of the action that is what makes the action moral. It is the intention which morally makes the act morally good or bad. In the double effect it is a duty to relieve the suffering, and the consequence, shortening of life, is acceptable as it is not intended.

In the consequentialism feature of utilitarian ethics there is little difference in the moral acceptance of active euthanasia when compared with passive euthanasia and the double effect. In consequentialism, it is the consequences of the action that determine the act to be morally right or wrong. If the consequences of passive euthanasia, abortion and the double effect bring about death, and death in certain circumstances is good, then we should be able to find active euthanasia morally justified in certain circumstances.

The double effect's moral acceptance is in the intention and not the consequence. However, if the consequence of death is known in both instances, what is the moral difference? Most ethical theories judge morality in terms of actions, duty or the consequence. In reality when are our intentions judged? Is a doctor who, while trying to save the life of a patient (good intentions) causes the death of the patient from a later infection judged on the intention or the consequence? It is the consequence that he inadvertently (or negligently through oversight) caused the death for which he will be held accountable. What is a physician

who overprescribes a medication for a patient which results in an overdose held accountable for? Again, his intention of relief for the patient is moot. It is the consequence he will be held accountable for.

What the double effect does allow for is for the unintended side effects of medical relief of suffering in certain situations. It is specific to when bad and good effects (consequences) occur and in euthanasia death (when justified and voluntary) is good (Beauchamp and Childress, 1994, p. 210). The principle of double effect is not a valid argument against euthanasia. It is simply active euthanasia except the consequence (death) is not immediate.

#### DR. KEVORKIAN, 26 AND RISING

There is no one doctor more infamous in present day society than Dr. Jack Kevorkian. In May of 1990, Dr. Kevorkian aided Janet Adkins in the relief of her suffering (Watts,1992,p.878). Mrs. Adkins suffered from Alzheimer's induced dementia. Using the device Kevorkian supplied, she administered a lethal dose of potassium after being sedated by barbiturates. Kevorkian was charged with first degree murder. In December of that same year, the charges were dropped after the judge ruled that Kevorkian had not broken any laws (Washington Post, 1990, p.A19). This was Kevorkian's first assisted euthanasia.

By late 1993, Kevorkian had assisted in at least 17 cases of active euthanasia (Worthington, 1993, p.2). In response to these cases, Michigan lawmakers passed a law making active euthanasia a

felony. In May of 1993 this law was declared unconstitutional, but was stayed by an appeals court for further appeal (p.2). To put the law to the test, Kevorkian assisted in the euthanasia of Thomas Hyde. Suffering from amyotrophic lateral sclerosis (ALS), Hyde inhaled carbon monoxide on August 4 from a device of Kevorkian's. Hyde released a clip that allowed the carbon monoxide to flow into a fitted mask. He did this with his only good hand (p.2).

In a strange twist to this case, the very man assigned to prosecute Kevorkian, Wayne County Prosecutor Wayne O'Hair, was sympathetic to legally allowing active euthanasia. While he did not approve of Kevorkian's disobeying the existing law, he stated that he would promote a measure for "physician-assisted suicides" (Worthington, 1993, p.2).

From that point to the present, Jack Kevorkian has not yet been convicted in the 26 "assisted suicides" in which he has "assisted". In most cases, the charges have been dropped. In January 1995, Kevorkian's remaining charges were dropped as well (<u>New York Times</u>, 1995, p. 12). Through either the lack of laws, or the acquittal by jurors (some of whom wept for Thomas Hyde), Dr. Kevorkian remains free.

While Kevorkian is able to skirt around the legal system, his assistance in these cases of euthanasia is not without some criticism. The largest criticism is Kevorkian's lack of a doctor/patient relationship (Beauchamp and Childress, 1994, p. 238). Dr. Kevorkian has been sought out by the sufferers that he has assisted due to both the lack of a legal euthanasia system and Dr.

Kevorkian's public notoriety. The media has been his largest advertiser. If there is anyone who can ever be termed as a champion of euthanasia rights in America, it is Jack Kevorkian: "Dr. Death".

# THE NETHERLANDS SYSTEM OF ACTIVE EUTHANASIA

The Netherlands is the only country which permits active euthanasia on request; however, the system is not one that would be permissible in the United States. The Dutch system did not start through law, but through a "de facto" arrangement twenty years ago in which prosecutors would not prosecute physicians for active euthanasia (Shapiro, 1994, 33).

It is estimated that more than 30,000 people in the Netherlands carry plastic living wills specifying active euthanasia. The media calls them "credit cards for easy death" (Fenigsen,1989,500). In 1990, there were 2,700 cases of physician assisted active euthanasia. In 1,040 of these, there was no consent from the patient, it was the doctors who decided for the patient (Shapiro,1994,33).

In 1994 a new Dutch law took effect for active euthanasia, it allows involuntary active euthanasia if the doctor can argue it is what the patient wanted (Shapiro, 1994, 34). While this legally validates the system, it makes it morally apprehensible. It is not the doctor who should determine that euthanasia is warranted, it is the patient who must decide. This form of involuntary euthanasia is now called "crypthanasia" (Fenigsen, 199, p. 502).

The moral problems with the euthanasia practiced in the Netherlands is the fact that it is not necessarily the patient who decides that the suffering must end by death. If physicians are allowed to decide, it then allows the slippery slope to develop. Kass notes that, "Physicians are always tired by patients slipping or not getting better. Once they think of death as a treatment option, then physicians simply give into their weaknesses" (Shapiro, 1994, 33). The determination by someone other than the sufferer and if physicians do see euthanasia as a "treatment", then the society would be well on its way down the slippery slope, if To be morally acceptable, it must be the not at the bottom. patient's determination, not the physician. It violates the autonomy of the individual for anyone else to determine the course of another's life (or death).

# LEGALIZATION OF ACTIVE EUTHANASIA

Legalizing or permitting active euthanasia through decriminalization (the act of not prosecuting, as in suicide) is morally correct. However hideous death may be to one, may not be to another. We must respect the autonomy of one who makes an informed, competent decision that this is to be their end, their relief. Conversely, we must respect another's opinion that euthanasia is not what they want. Clear, informed, and competent consent must be the grounds for active euthanasia. Anything less is not acceptable. If this consent is not present, then no one else can make that decision.

Is it humane to allow suffering? Is it humane to force one to die an undignified dehumanized death? Is it humane to force one who suffers intolerable pain to commit "suicide" (which carries larger social costs) instead of having the viable and moral alternative of medical euthanasia? Must we force family and loved ones to end the pain of their loved ones, such as the 21 mercy killings by family members in 1985 (Spencer, 1986, p. 2)?

Euthanasia allows one to die in a dignified way. It is the only moral, humane thing to do when medicine cannot relieve the pain, and the terminally suffering cannot go on any longer. When one has determined that they can no longer endure the suffering and pain, it ought to be acceptable for individual to choose euthanasia as the last measure. This choice must be made by the individual and no one else.

Fletcher (1977) foresees the legalization of active euthanasia in America and that it will one day be socially accepted (p.158). If it is indeed to become law, it must be for only those who choose it. This choice must be made by a competent patient who asks for it, and is advised of all other possible alternatives (hospices, experimental medications, double-effect dosages, etc.). Only after those conditions are met can one elect active euthanasia as the merciful relief of pain and suffering.

Leon Kass (1993), who is staunchly opposed to euthanasia, correctly argues, we do not have a "right to die", what we do have is a right to live a good life (Beauchamp,p.504). In passive euthanasia we recognize that, and the only difference between

active and passive euthanasia is action and non-action. And as Fletcher (1960) asks, "What, morally, is the difference between doing nothing to keep the patient alive, and giving a fatal dose?"(p.68). In both cases the intentions and the consequences are the same. As Kant said, "If we will the end we will the means"(Fletcher, 1960, p.68). Morally, action and non-action are the same if both the intentions (as seen in the double effect) and the consequences are the same: a merciful death. Death is both the intentions and consequences of passive and active euthanasia.

After unsuccessful attempts to legalize active euthanasia in California and Washington, Oregon voters passed an initiative to allow it. Immediately it went to the court system challenged by right to life movements and was struck down by the court. These laws are the correct way to allow euthanasia, not the Dutch system of "nolle prosequi" (no prosecution). Even those physicians in the Netherlands found guilty of violating the existing euthanasia laws are not given any punishment (Fenigsen, 1989, p. 501).

# THE AMERICAN MEDICAL ASSOCIATION'S MOVE TOWARD EUTHANASIA

The American Medical Association's (AMA) stance on euthanasia is mixed. It allows for the foregoing of life-sustaining treatments, but it does not allow the "intentional termination" of life for merciful reasons (Beauchamp and Childress, 1994, p. 227). Again we can find use of intention in separating the difference between passive and active euthanasia, but both are the intentional termination of life and the only difference is the action.

Now there may be a shift in the AMA's policy. The AMA ethics council has recently published a report that supports the removal of organs for donation from anencephalic babies prior to the infant's death to ensure the vitality of the organs for transplant (Krauthammer,1995,p.3B). The ethics council argument is based on the anencephalic infant's lack of personhood and that it cannot feel any pain (p.3B).

If the AMA adopts this view as acceptable, then it surely is a "foot in the door" for the AMA's acceptance of the right of active euthanasia for all patients. The intentional euthanasia of an anencephalic baby is active euthanasia, and with the exception of voluntariness, follows the same moral principles: lack of personhood and terminal suffering. Just as in abortion, voluntariness cannot be gained from the infant or fetus. If the AMA does accept the principle of euthanizing the anencephalic baby and not active euthanasia, then it will merely be allowing the euthanization for an altruistic cause (organ donations) and will ignore mercy and humaneness. It would also disregard voluntary euthanasia while incongruously accepting involuntary euthanasia.

#### CONCLUSION

Voluntary euthanasia is not the only answer to all of the problems for those who suffer. Hospices and improved analgesia minimize the need for euthanasia (Gillon, 1969, 67). While research and technology make great strides everyday, there exist diseases which wrack a body with tremendous and constant pain. Hideous

diseases that take away all dignity for the sufferer. Diseases which some fear more than death, as they make death unnatural, slow and painful.

No one truly wants to see the taking of life for any reason, but there are those people to whom death comes as a relief. To allow them to choose death over pain is more easily justified than watching a slow and unmerciful death (Fletcher, 1973, p. 149). How many more family members must be forced to end the pain; honest people who have never committed any crime before? How many more times does Dr. Kevorkian need to go to court to be found to have broken no law or be tried by a sympathetic prosecutor and acquitted by a sympathetic jury?

If euthanasia becomes legal it should only be between the patient who chooses and a physician who agrees that it is the last choice. Euthanasia must be voluntarily sought out by a competent patient, it should not be a "prescription" for doctors to utilize. There is no dignity in a death that is labeled a suicide or homicide when it was in fact justified euthanasia. The death is a consequence of the illness or injury, and while the means supposedly differ from passive euthanasia, the intent is the same: Death. Euthanasia allows one to die a merciful death, relieved of pain, and in the dignity and nobility of the person they are, not what they will cease to be.

Euthanasia is not of any benefit to society, it ought never be treated as a way of saving money or medical resources. Its only benefit is to the sufferer who is relieved mercifully of his/her

pain. There is a right to life for all, and no one has a "duty to die" (Shapiro,1994, p.34). Just as in the case of abortion, it can not be imposed as a duty to doctors who do not want to perform it. To treat it as a means of any thing other than bringing about a merciful death with dignity is to treat human life itself as based on a financial condition.

As we near the end of the century laws are being passed by voter initiatives to allow active euthanasia (only to be struck down by courts), courts cannot convict Jack Kevorkian and some progressive diseases which cause debilitating untreatable pain remain incurable. Court decisions have bounced back and forth on the legal right to euthanasia. In the moral determination of active euthanasia, the legal right and morally accepted passive euthanasia and abortion have no real consequential differences from active euthanasia. Death is death in all cases, and all are based on a quality of life, relief of suffering and the lack of personhood. Laws must be passed which explicitly set the standards active euthanasia so that there can a legitimate of be doctor/patient relationship and no one will have to seek out a Dr. Kevorkian. For some, there exist no other alternatives. To them death has become acceptable.

> "When all usefulness is over, when one is assured of an imminent and unavoidable death, it is the simplest of human rights to choose a quick and easy death in place of a slow and horrible one....Believing this choice to be of social service in promoting wider views on this subject, I have preferred chloroform to cancer."

> > Dr. Charlotte Gilman, 1939

# Major Religions' Beliefs on Euthanasia<sup>1</sup>

JudaismAgainstAllowedRoman CatholicAgainstAllowedGreek OrthodoxAgainstAllowedRussian OrthodxAgainstAllowedRussian OrthodxAgainstAllowedLutheranAgainstAllowedMethodistAgainstAllowedMennoniteAgainstNo positionChurch of Christ"Sub judice"AllowedMormonAgainstYesJehovah WitnessAgainstDo not opposeHinduismNo positionNo positionBuddhismAgainstAgainstKhrisnaNo positionNo position	<u>Religion</u>	<u>Active Euthanasia</u>	<u> Passive_Euthanasia</u>
Islam No position No position	Roman Catholic Greek Orthodox Russian Orthodx Lutheran Methodist Mennonite Church of Christ Mormon Baptist Jehovah Witness Hinduism Buddhism Khrisna	Against Against Against Against Against "Sub judice" Against Against Against No position Against No position	Allowed Allowed Allowed Allowed Allowed Allowed No position Allowed Against Yes Do not oppose No position Against No position Against No position

<sup>1</sup> All data extrapolated from Larue, G.A., 1985, <u>Euthanasia and</u> <u>Religion</u>.

<sup>2</sup> Christian teaching that suffering before death has a special place in God's saving plan (p.39).

- <sup>3</sup> The Synod affirms the positive benefits of suffering (p.64).
- <sup>4</sup> Recognize the "right to die in dignity"(p.87).

<sup>5</sup> Believe in the "dignity of life" (p.113).

- <sup>6</sup> Believe in strict caution of "no hope of recovery" (p.117).
- <sup>7</sup> Believe that a man may retire from life to "seek self-deliverance"(p.134).
- <sup>8</sup> Believe in a "natural dying trajectory", may assume against euthanasia (p.139)
- <sup>9</sup> Euthanasia would interfere with divine plan, "pain and suffering reduce sin"(p.141).

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