

# Euthanasia

by Tim Maughan

Highly publicised cases of terminally ill patients asking doctors to help them die have kept euthanasia in the news. It is easy to feel sympathy for people with serious illnesses, and we may wonder how we would cope in their position and think that we would want euthanasia ourselves. However we need to think carefully about the wider implications of legalising euthanasia.

The word 'euthanasia' comes from the Greek roots *eu* (well) and *thanatos* (death), but currently means much more than 'good-death'. Euthanasia has been usefully defined as 'the intentional killing, by act or omission, of a person whose life is felt not to be worth living'.<sup>1</sup> This is the definition that will be used here.

Euthanasia can be achieved either by acting deliberately, or by not taking an action deliberately. In either case a doctor's particular choice of action has ended a patient's life. This is justified on the basis that the person's life was 'not worth living', either in their own, or in someone else's assessment.

Before we look at the subject in more detail, it is important to establish three situations that should not be considered as euthanasia. First, stopping, or deciding not to initiate, a medically useless treatment is not

euthanasia. A medically useless treatment is one where the suffering it causes would outweigh any benefits.

Secondly, giving treatments aimed at relieving pain and other symptoms when the treatment may also carry some risk of shortening life is not euthanasia; it is called 'double effect'.

Thirdly, competent people always have permission to refuse treatment and doctors cannot force them to have treatment against their will. If the person dies as a consequence the doctor is not performing euthanasia.

## The value of intent

The term *passive euthanasia* is used by some people to describe situations where a doctor deliberately allows a person to die. Some bioethicists say that in these situations 'killing' is the same as 'letting die'.<sup>2</sup> But the term 'passive euthanasia' is confusing.

The key issue is intention. Allowing terminally ill patients to die when there is nothing more that can be done to relieve their symptoms or treat their illness has long been part of good medical practice. Letting patients die when useful symptom-relief or treatment can be given is negligent.

Some argue that pain relief can shorten the lives of people with terminal cancer and therefore the doctor is actually aiding the patient's death. Under the doctrine of 'double effect' this is deemed ethically acceptable, since the doctor's intended outcome is pain relief and the unfavourable result of shortening life is not the intent.<sup>3</sup> In reality, successful pain relief can extend life as appetite and wellbeing improve.

The issue is that we normally place great value on intent. You can see it when we accept distinctions between manslaughter, negligence, crimes of passion and murder. In addition, intention is an important consideration when we make allowances for people with diminished responsibility. We don't just look at the outcome and simply apply a blanket punishment. We may even consider what alternatives were available.

If we ignore intent we are at risk of dehumanising ourselves. We effectively say that our motivations and intentions are not important and that all that matters are the outcomes, the products of our lives. If we do not consider intent when we discuss end of life decisions we dehumanise the doctor, turning him or her into little more than a technician who answers only to the wills of others.

### Euthanasia terms

*voluntary*; death is specifically requested by a patient

*non-voluntary*; euthanasia occurs when the patient is incapable of giving meaningful consent

*involuntary*; a competent patient's life is ended without their request

# Pro-euthanasia voices

Arguments for euthanasia fall into three main categories: compassion, autonomy and economics.

## Compassion

Many people fear that during a final illness they will have symptoms that cannot be treated, or that they will be 'kept alive' longer than they wish. The compassion argument is that letting people 'die with dignity' is kinder than forcing them to go on suffering.

This assumes that there are no treatments for the symptoms which prompt each request for euthanasia. In fact most physical symptoms such as pain and nausea can be reduced and in many cases effectively treated. This treatment may need to be managed by specialists in pain control or palliative care, and can be given in the community, in hospices or in dedicated hospital units.

Similarly, patients with motor neurone disease (a serious progressive neurological disorder) are often afraid of choking to death. But studies from the largest and most experienced hospice units have demonstrated that, with appropriate palliative care, this virtually never happens.<sup>4</sup> Some unpleasant effects of disease, like immobility and paralysis, may not be reversible, but people can still have meaningful lives.

Some symptoms are not physical and medicine alone cannot relieve the fears felt by people who have no hope beyond death. This is a very real issue, but it points to the need for spiritual as well as medical support for dying people. Real compassion will offer support in a way that can enable hope, bring meaning to life and give a new sense of empowerment in spite of

suffering. Few patients request euthanasia when their physical, emotional and spiritual needs are properly catered for.

## Autonomy

Autonomy is closely connected to the concept of human rights. The 1998 Human Rights Act established a list of fundamental 'rights' for every human being. These should not be impeded by anyone else.

Consequently some people argue for euthanasia on the basis that patients have a 'right to die'. For example in 2002 Diane Pretty, who had motor neurone disease, went to the European Court arguing that her right to die was an application of the right to life laid out in Article 2 of the Human Rights Act. The Court did not agree, ruling that Article 2's right to life did not include a right to choose when to end that life, and certainly not the right to demand help from someone else to end it. What is really being talked about by 'a right to die' is a right to have one's life ended - or more specifically the right to be killed by a doctor.

This has repercussions for doctors' rights and freedoms. A patient's right to die would impose on doctors a duty to kill.

Another intriguing consequence of giving doctors the power to kill could be the loss of a patient's autonomy. Vulnerable people could end up avoiding asking for medical help, for fear that their doctors would recommend euthanasia.

Autonomy is a powerful concept in western society, but the promise of being able to do 'whatever we want' is unrealistic. It is not possible to have complete autonomy, because our decisions impact other people. Inevitably others will be affected by an individual choosing to die.

## Economics

One argument is that we simply can't afford to keep people alive. It has been expressed by leading economists such as Jacques Attali, the former president of the European Bank for Reconstruction and Development, who said, 'As soon as he gets beyond 60-65 years of age, man lives beyond his capacity to produce, and he costs society a lot of money... euthanasia will be one of the essential instruments of our future societies.'<sup>9</sup>

In fact, the costs of terminal care are often exaggerated. Dying patients frequently just need good nursing care, and although this is labour intensive, the additional costs are not high even for those who require medication. It is curative, rather than palliative, care that is expensive.

## Arguments against euthanasia

There are three key arguments against euthanasia; that it is unnecessary, dangerous and morally wrong.

### Unnecessary

Many believe that terminally ill people only have two options: either they die slowly in unrelieved suffering, or they receive euthanasia. In fact, there is a middle way, that of creative and compassionate caring.

Dying patients can be managed effectively at home or in the context of a caring in-patient facility.

A comparison between the UK and the Netherlands is informative. In the Netherlands euthanasia is accepted, and there is only a very rudimentary hospice movement. By contrast, a UK House of Lords committee in 1994 recommended that euthanasia should not be allowed and advised further spending on the UK's already well developed facilities to care specifically for people who are terminally ill.<sup>10</sup>

This is not to deny that there are patients presently dying in homes and

#### Related issues covered by other CMF files

Issues related to euthanasia include decisions about withholding or withdrawing life-sustaining treatment,<sup>5</sup> advance directives,<sup>6</sup> resuscitation of a patient,<sup>7</sup> refusal of treatment by a competent patient and physician assisted suicide.<sup>8</sup>

hospitals who do not benefit from the latest advances in palliative care. But the solution to this is to make appropriate and effective care and training more widely available, rather than to provide for euthanasia. There is genuine concern that legalisation of euthanasia will reduce the quality and availability of palliative care.

## Dangerous

People with a terminal illness are vulnerable and lack the knowledge and skills to alleviate their own symptoms. They are often afraid about the future and anxious about the effect their illness is having on others. They can be depressed or have a false sense of worthlessness. They may be confused, or have dementia. It is very difficult for them to be entirely objective about their own situation.

Having the option of euthanasia is dangerous, because it would encourage vulnerable and potentially confused people to ask to die, rather than asking family, friends and society to take care of them.

Many elderly people feel a burden to family, carers and society. They may feel great pressure to request euthanasia 'freely and voluntarily'. Vulnerable people will be particularly sensitive to the suggestion that they are a burden on friends and relatives.

Additionally, an elderly person will be aware that they are using up financial and emotional resources and may be sad that their children's inheritance is dwindling; money that could help put their grandchild through university.

There is evidence that where euthanasia is legalised this pressure does occur. In the five years since the USA state of Oregon legalised physician assisted suicide, 35 per cent of patients receiving help to die said that feeling a burden on family, friends/caregivers was one of the reasons for their choice.<sup>11</sup> The question is, do we want a society where elderly and infirm people feel required to ask to die?

Vulnerable people need to hear that they are valued and loved. They need

to know that we are committed first and foremost to their wellbeing, even if this does involve expenditure of time and money. The way we treat the weakest and most vulnerable people speaks volumes about the kind of society we are.

Chairman of the 1994 House of Lords Select Committee on Medical Ethics, Lord Walton of Detchant, explained their recommendation not to allow euthanasia as follows: 'We concluded that it would be virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law in the United Kingdom could not be abused. We were also concerned that vulnerable people - the elderly, lonely, sick, or distressed - would feel pressure, whether real or imagined, to request early death.'<sup>12</sup>

Where voluntary euthanasia has been legalised and accepted, it has led to involuntary euthanasia. This has been demonstrated in the Netherlands<sup>13</sup> where, as early as 1990, over 1,000 patients were killed without their consent in a single year.

A report commissioned by the Dutch government showed that for 2001, in around 900 of the estimated 3,500 cases of euthanasia the doctor had ended a person's life without there being any evidence that the person had made an explicit request.<sup>14</sup>

In addition, when it came to reporting euthanasia there was a huge gulf between the expectation of Dutch law and actual practice. For example, only 54 per cent of doctors fulfilled their legal responsibility to report their actions concerning euthanasia. The researchers estimated that euthanasia accounted for 2.5 per cent of all deaths in the country. On average, five cases a year involve children.

Responding to the statistics, The Royal Dutch Medical Association was pleased that reporting had increased, but 'regretted' the number of doctors still not following the guidelines.

## Morally wrong

Traditional medical ethics codes have never sanctioned euthanasia. The

Hippocratic Oath states 'I will give no deadly medicine to anyone if asked, nor suggest such counsel...'. The 1949 International Code of Medical Ethics declares 'a doctor must always bear in mind the obligation of preserving human life from the time of conception until death'. In its 1992 Statement of Marbella, the World Medical Association confirmed that assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession.

Medical practice is based on the ethic of preserving life and relieving suffering. The introduction of 'legalised death' into the doctor patient relationship is likely to damage this relationship. Doctors may become hardened to death and to causing death and start to see their patients as disposable, particularly when they are old, terminally ill, or disabled. Reciprocally these vulnerable groups of people may start to doubt the intentions of their doctors. In the Netherlands disabled people already describe a growing mistrust of their doctors and fear of being admitted to hospitals<sup>15</sup> - which should be places of care and safety for the vulnerable members of society.

## The root problem

Diagnosing the root problem of a society that wants to kill its most frail and vulnerable members rather than care for them is a difficult and lengthy process, but euthanasia will not solve the problem. It will only add another symptom. Addressing over-interventionism, suffering and fear of death, by giving people ultimate control over the timing and mode of their death will not help the individuals, or society as a whole, to come to terms with the issues.

We should be addressing the all too often ineffective drives to maintain life at all costs. We need to analyse our attitudes to illness, suffering and death. We should look at what it is to care for and respect our elderly

members, and address the difficulties that they experience under current social structures. Ultimately we need to rediscover the virtues of responsibility and trust.

From the perspective of our health and beauty promoting society, the vision or anticipation of serious illness is an awful prospect. People think that they would rather be dead than survive with severe disability. However, people in that condition have a different view of the situation. They have arrived there through a series of steps, gradually getting used to worsening health and coming to terms with their problems. At the same time they have a growing realisation that life, even in its restricted current form, is still a valuable thing. So, to the healthy onlooker, euthanasia seems to be a compassionate solution, whereas to the well cared for dying patient, life is still a wonder and something to be fought for.

## A Christian approach

Most religious faiths regard intentionally ending life as morally wrong. A fundamental Christian principle is that human beings are made in the image of God and therefore worthy of the utmost respect, protection, wonder and empathy. As a result Christians have always been deeply committed to relieving human suffering and are

often involved in palliative care and the hospice movement.

'Bearing one another's burdens'<sup>16</sup> is at the very heart of Christian morality, and Christians are called to love others in the same way that Jesus Christ loved, which for him meant making sacrifices and willingly laying down his life for others. So Christians should be at the forefront of providing the best quality care for patients who are terminally ill. In addition the Bible is very clear that 'Life is a gift from God and is held in trust'.<sup>17</sup> It is not our right to take life.

In the Bible, death is the penalty for murder,<sup>18</sup> and the prohibition is formalised in the sixth commandment, 'You shall not murder'.<sup>19</sup> The word murder used here derives from the Hebrew *ratsach*, which is equivalent to the Greek *pheneuo*.

The meaning of the word is further defined in four main passages in the first five books of the Old Testament - the Pentateuch.<sup>20</sup> These passages show that 'intentional killing of an innocent human being' is prohibited. This distinguishes it from unintentional killing (manslaughter), capital punishment and self-defence. This is the definition that forms the foundation of our Statute books.

But Christians also believe that death is not the end. It leads to judgement and either a wonderful existence with God in heaven, where there is 'no more death, mourning, crying or pain',<sup>21</sup> or eternal separation from God. For those who have not 'made their peace with God',

euthanasia is not a 'merciful release', but it may propel them towards a judgement for which they are unprepared.<sup>22</sup> This may be the worst thing we could ever do for them.

So Christians should promote compassionate care for all people with terminal illness, not euthanasia, ensuring that their physical, emotional and spiritual needs are met in ways that are appropriate to each individual.

## References

- <sup>1</sup> HOPE Leaflet. *Euthanasia is OK sometimes, isn't it?*
- <sup>2</sup> Steinbock B & Norcross A (eds). *Killing and Letting Die*. New York:Fordham University Press. 1994
- <sup>3</sup> Simon KM & Miller SA. *Pain management at the end of life*. *J Am Osteopath Assoc*. 2001;19(10):599-608
- <sup>4</sup> O'Brien et al. *Motor neurone disease: a hospice perspective*. *BMJ*. 1993;304:471-3
- <sup>5</sup> Vere D. *When to withdraw or withhold treatment*. CMF File 7. London:CMF. 1999
- <sup>6</sup> Paul J. *Advance directives*. CMF File 19. London:CMF. 2002
- <sup>7</sup> Webb-Peploe M. *Do not resuscitate dilemmas*. CMF File 13. London:CMF. 2001
- <sup>8</sup> Myers K. *Physician-assisted suicide*. CMF File 9. London:CMF. 2000
- <sup>9</sup> Quoted in: Salomon M. *L'avenir de la vie*. Paris:Seghers. 1981. p273-275
- <sup>10</sup> *Select Committee on Medical Ethics. Report*. London:HMSO 1994
- <sup>11</sup> *Fifth Annual Report on Oregon's Death with Dignity Act*. 6 March 2003
- <sup>12</sup> Walton. *Hansard*. 1994; May 9:1345
- <sup>13</sup> *Rommelink Report*. 1991. A translation is published in *Lancet*. 1991;338:669-74
- <sup>14</sup> Sheldon T. *Only half of Dutch doctors report euthanasia, study says*. *BMJ*. 2003;326:1164
- <sup>15</sup> *The Telegraph*. 15 Oct 1998
- <sup>16</sup> *Galatians* 6:2
- <sup>17</sup> *Best EE. Suicide: ethical and moral issues from a theological perspective*. *Can J Psychiatry*. 1986;31:97-100
- <sup>18</sup> *Genesis* 9:6,7
- <sup>19</sup> *Exodus* 20:13; *Deuteronomy* 5:17
- <sup>20</sup> *Exodus* 21:12-14; *Leviticus* 24:17-21; *Numbers* 35:16-31; *Deuteronomy* 19:4-13
- <sup>21</sup> *Revelation* 21:4
- <sup>22</sup> *Hebrews* 9:27; *Revelation* 20:15

### Previous titles in the CMF FILES series:

- No.1 *Introduction to ethics*
- No.2 *Animal experimentation*
- No.3 *Christian views on ethics*
- No.4 *Adolescent sexuality*
- No.5 *The ethics of caring*
- No.6 *Artificial reproduction*
- No.7 *When to withdraw or withhold treatment*
- No.8 *Dependence and addiction*
- No.9 *Physician-Assisted Suicide*
- No.10 *What is a person?*
- No.11 *The human genome*
- No.12 *Therapeutic cloning and stem cells*

- No.13 *Do not resuscitate dilemmas*
  - No.14 *Genes and behaviour*
  - No.15 *Human experiments*
  - No.16 *Reproductive cloning*
  - No.17 *Resource allocation*
  - No.18 *The mind body problem*
  - No.19 *Advance directives*
  - No.20 *Homosexuality*
  - No.21 *Sex selection*
- These can be found at:  
[www.cmf.org.uk/pubs/pubs.htm](http://www.cmf.org.uk/pubs/pubs.htm)  
 or ordered free from CMF.

Tim Maughan is Professor of Cancer Studies at the University of Wales College of Medicine and Consultant Clinical Oncologist at Velindre Hospital.