TAILPIECE

The Euthanasia Debate

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ABSTRACT

Debates about the moral dilemmas of euthanasia date back to ancient times. Many of the historical arguments used for and against the practice remain valid today. Indeed, any form of discussion on the subject often provokes emotive responses, both from members of the medical profession and the general public.

For this reason alone, the issue will continue to be debated at all levels of society. There are, however, other factors that ensure euthanasia will remain a subject of major controversy within medical, legal and governmental bodies.

Firstly, the act of euthanasia itself is illegal, yet in its passive form occurs on a daily basis in many of our hospitals (1). Secondly, medical advances have made it possible to artificially prolong the life of an increasing number of patients far beyond what was possible only a few years ago. Furthermore, we must all contend with the reality that financial constraints are an important consideration in modern health care provision. Finally, there is an ethical difficulty in interpreting the concept of a patient's right, or autonomy, versus the rights and duty of a doctor.

Before attempting to answer the questions posed by these issues, it is important to have some accurate definitions of both euthanasia and of the concept of morality. According to the House of Lords Select Committee on Medical Ethics, the precise definition of euthanasia is "a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering" (2). The term can be further divided into voluntary and involuntary euthanasia. The former is said to occur if a competent patient makes an informed request for a life terminating event and the latter can be used if a patient does not give informed and specific consent for such treatment. It is the occurrence of involuntary euthanasia which forms one of the main arguments against legalisation. This is discussed in greater detail below.

Euthanasia is frequently separated into active and passive forms. A number of authors consider these terms to be

misleading and unhelpful. They are, however, used in the literature and in discussion and consequently should be understood. Active euthanasia takes place if deliberate steps are taken to end a patient's life; this would include administration of potassium containing compounds to induce cardiac arrest, a practice that is illegal in this country. Passive euthanasia is the withholding of treatments necessary for the continuance of life. Whether the administration of increasingly necessary, albeit toxic doses of opioid analgesia is regarded as active or passive euthanasia is a matter of moral interpretation, but in order to pacify doctors' consciences, it is usually regarded as a passive measure. Many people, therefore, regard it as an acceptable facet of good professional practice.

Morality

The concept of morality is central to any discussion on euthanasia. Simplistically, morality can be defined as performing an act that one believes to be right and beneficial to others, as opposed to wrong and harmful to individuals and society. However, this simplistic concept of morality requires a more complex analysis if one is to have a meaningful understanding of these difficult and philosophical issues. As a consequence, medical ethics have evolved, which deal with the codes of conduct that govern the medical profession.

Morality requires that we strive to contribute to the maximum welfare of others. This is the principle of beneficence. In addition, morality presupposes a respect for a person's autonomy, which requires that they be allowed to act on the basis of their own desires.

One of the key difficulties in medical ethics is whether respecting a patient's autonomy should have priority over beneficence. For example, if a patient requests active euthanasia, should we respect their autonomy (i.e. their desire to have their life ended) or should we protect them against the harmful consequences of their own choice?

The way in which individuals develop an understanding as to what is morally acceptable is complicated and beyond the scope of this article. It involves a complex interaction of environmental, religious, educational, geographical, parental and genetic influences.

Practical Difficulties

Having defined both morality and euthanasia, we are now able to look at some of the reasons why euthanasia is considered a moral, or ethical, issue and then examine the concept of euthanasia as a medical dilemma.

Euthanasia can not be regarded as a purely moral issue. Although many of the arguments are moral ones, there are medical dilemmas which must be addressed.

Firstly, there is the evaluation of incurability. In order that a patient be labelled as having an incurable illness it is necessary for them to undergo appropriate medical assessment. If euthanasia were to be legalised, patients requesting euthanasia would have to undergo strict medical assessment before they could be regarded as suffering from an incurable illness. The caveat to this, of course, is that euthanasia would only be permitted in patients' with terminal illnesses. If, however, we believe that euthanasia should be legalised in all circumstances in which a patient requests that their life be terminated, then an assessment of incurability would be unnecessary. Indeed, a recent study conducted on behalf of the World Federation of Doctors who Respect Human Life revealed that 23% of the population were of the opinion that euthanasia should only be permitted if a patient is suffering from a serious illness, is in significant pain and requests that their life be ended.

The distinction between potentially curative and palliative treatment also requires clinical decisions to be taken, following appropriate assessment. Such decisions are made jointly between the patient, the relatives and the doctor. If euthanasia were to be decriminalised, it is conceivable that the delicate relationships which exist between these three parties in the decision making process would be weakened. For example, it may be that a patient who would previously have been offered a "curative" treatment regime would now only be offered palliation. This is itself a form of active euthanasia.

Evaluating whether a patient is mentally capable of making a decision about the proposed deliberate ending of their life would also cause difficulties. Koenig *et al* found that 11.5% of elderly medical in-patients suffered from a depressive illness (3). The implication of this is that a significant proportion of patients who might potentially request active euthanasia would not be of sound mind and would therefore be incapable of making informed decisions about their future treatment. Such patients may not be suffering from a physical illness, let alone a terminal condition, yet as a result of their mental state may request that their life be actively and prematurely terminated. We would, therefore, have to accept that patients suffering from dementing illnesses would never be capable of making informed

decisions about their future treatment and, therefore, euthanasia would never be permitted in such individuals, even though they might well fulfil the criteria of terminal illness, intractable pain etc. It would, therefore, be essential that all patients requesting active euthanasia were subjected to vigorous psychiatric assessment, in order to evaluate their mental state and their capacity to self-determination.

There is clear evidence from the Netherlands (where euthanasia is legal) that the strict guidelines requiring informed patient consent are frequently ignored and many such patients are subjected to what is effectively involuntary euthanasia (4,5). In fact, one recent study from the Netherlands showed that 10% of doctors had deliberately terminated the life of a patient without their explicit request (6). This forms the basis of the "slippery slope" argument and is discussed below.

Key Arguments

Discussions concerning the morality of active euthanasia require an understanding of the contemporary arguments used for and against the practice. Only when one is familiar with such arguments can a reasoned decision be made on the acceptability of euthanasia, which will be based upon one's individual understanding and interpretation of these ethical dilemmas.

Below is an outline of the arguments for and against the legalisation of active euthanasia.

- It is argued that legalisation of euthanasia will lead to a decrease in patient autonomy, for several reasons. Firstly, patients might feel an obligation to consent to active euthanasia because of a perception that they, or their illness, were a burden upon society, or their relatives. Secondly, they might feel that their dignity had been lost as a result of society's attitude towards ill people. Furthermore, there could be an implication that pain and suffering were to be feared and that premature death afforded by euthanasia was the only way to escape suffering.
- There is evidence from the Netherlands that the strict guidelines, requiring informed patient consent, are not consistently respected. This results in involuntary euthanasia and is regarded by some as the first step towards the Nazi-style slide into genocide. This is the so-called "slippery slope" argument - today the brain dead, tomorrow the mentally handicapped, the day after opponents of the government? (7,8)
- Proponents of the "slippery slope" argument also draw attention to the inconsistencies in the reporting of deaths due to active euthanasia in the Netherlands (4). This further exacerbates the idea that euthanasia is a sinister practice.

- Most people believe that doctors working with the terminally ill should promote the ethos of hope amongst their patients (9). They should not foster the intent to kill as part of their moral and clinical character. It is argued that permitting active euthanasia could encourage a feeling of hopelessness and thereby diminish the will of many patients to live.
- A patient's life should be considered valuable simply because he is a person, not because of what he does or who he is. Legalising euthanasia may remove this protection afforded to the weak, disabled and vulnerable members of society.
- It is known that requests for euthanasia are made much less frequently by patients afforded high quality palliative care e.g. Macmillan nurses, hospices etc (10). It is argued that high quality palliative care is needed to ensure that patients no longer feel the need to request an early death. In addition, the traditional psychiatric view is that a patient's wish to die will disappear when their depression is successfully treated.
- It is argued that unconstrained autonomy is not always in the patient's best interest. In upholding a duty to do no harm, a form of paternalism is justified in refusing a request for euthanasia.
- Finally, there is a social argument that it is society's opposition to deliberate killing that is the cornerstone to law and social relationships. And perhaps the practising doctor should be reminded of some words from the Hippocratic oath: "...I will give no deadly poison to anyone if asked, nor suggest such counsel ..."

Many of these arguments have direct counter-arguments, some of which merely require an interpretation of the ethical issues from a different moral perspective. Some of the arguments used to support the legalisation of active euthanasia are outlined below.

- One of the major arguments used in favour of active euthanasia is that the autonomy of individuals and of society as a whole would be increased. If a competent person, of sound mind, is supplied with the best available medical evidence, they should be allowed to make up their own mind as to how to deal with the future. This is the principle of beneficence. It also has the added benefit of minimizing patient suffering, another core principle of good medical practice.
- The existence of involuntary euthanasia is disputed or dismissed by some authors. There is also an opinion that in the UK we could improve on the situation in the Netherlands and that there would be no "slippery slope" towards involuntary mercy killing.
- Stipulating the requirement for an

advanced directive, a so-called 'living will', would decrease the chances of abuse of any guidelines for active euthanasia. This would state that deliberate steps should be taken to end the life of the patient if he or she were to fall victim to an incurable, incapacitating illness which would prevent the patient making such a decision. Patients could, for example, reaffirm and sign this 'living will' on an annual basis.

- Burgess argues against the idea of the potential "slippery slope" towards Nazi-style genocide. He suggests that the argument is deficient both in logical thought and historical awareness of the political and social situation in Germany, during the 1940s. (5)
- It is also argued that although the availability of high quality palliative care services may indeed reduce the number of patients requesting euthanasia, there will remain a group of people who will exercise their right to self-determination by choosing to have their life prematurely terminated by active and deliberate means. The wishes of such people must be respected and therefore legalisation of active euthanasia is necessary.
- Finally, a further argument cited by pro-euthanasia groups is simply that public opinion demands that active euthanasia be permitted in this country. In a recent poll commissioned by the World Federation of Doctors who respect Human Life and conducted by MORI, nearly two thousand people were approached. Seventy two percent felt that euthanasia should be made legal. In addition, almost 50% of doctors in Great Britain would be prepared to consider taking active steps to bring about the death of a patient if it was legal. (1)

I have outlined the major arguments used in the euthanasia debate. We all, by virtue of our religious beliefs, educational background, social awareness and perhaps personal experiences attach varying degrees of importance to each of the moral arguments. I have attempted to provide a framework on which individuals can formulate their own morally acceptable position.

The Role of Doctors in Euthanasia

The role of the doctor is often considered as a separate debate to that of legalisation of the practice itself. However, if euthanasia were to be legalised in the UK, there would inevitably be aspects of the terminal care of the patient, which would require substantial medical input.

It has already been stated that only doctors experienced in particular diseases are able to evaluate whether a patient's illness is incurable and terminal and that evaluation of a patient's mental state can only be carried out accurately by an experienced

psychiatrist. At the very least, physicians would be required to advise on the most humane and least distressing methods of terminating life and it is likely that the most appropriate means would vary between patients. Indeed, it was Samuel Williams who first proposed using morphine and anaesthetic agents to hasten the death of terminally ill patients, in 1870. (11)

Despite these practical arguments for the involvement of doctors in euthanasia, there are a number of compelling reasons why doctors may wish to play no part in the deliberate ending of a person's life. Gillett argues that doctors should not foster the intent to kill as part of their moral and clinical character (9). It is argued that any additional role could damage the doctor-patient relationship and thereby diminish the sensitivity that is so critical in these difficult and often depressing clinical situations. An extension of this argument is that the Hippocratic oath expressly prohibits doctors from participating in active euthanasia.

As a consequence of this dilemma, Randall has suggested that if active euthanasia were to be legalised, the act itself should be performed by a vocationally trained technician (12). He also proposed that assessment as to whether the patient is a suitable candidate for euthanasia should be made by two lawyers. This would not, however, remove the ethical dilemma from the medical profession because at some stage a doctor would be required to confirm that the patient was of sound mind and capable of reason, terminally ill and suffering from intractable pain. Doctors would, therefore, be an accessory to the act, even though they may not be directly involved in the hastening of death.

In the UK, a recent study by Ward and Tate has revealed that 12% of British doctors had actually taken part in active euthanasia (1). Whether or not we support the law at present, this is a practice which is currently illegal, yet seems to occur in our hospitals and throughout the community on a regular basis.

Doctors have another crucial role to play in the contemporary debate. They can ensure the subject remains a national issue and as such, a subject of continued public debate. Doctors alone can not expect to decide whether euthanasia should be legalised and if so, under what circumstances. However, as a profession, they are uniquely placed to offer accurate and objective information, which society can use to reason towards a morally defensible position.

Conclusions

Throughout this article I have endeavoured to be objective in my quest to present both sides of the debate. In parts, I may have inadvertently conveyed some of my own

opinions or prejudices and for this I apologise.

Medical ethics and morality do not demand that doctors prolong life at any cost. When a patient is informed and of sound mind he should be allowed to determine his future treatment. Whether this choice should include the option of electively terminating his own life and whether the medical profession should actively participate in this decision is the major ethical dilemma. Currently, it does not and doctors must therefore practise within the framework of the law as it stands.

Precise regulation of the medical profession, with over-zealous legislation, would be unpopular, unhelpful and impossible to formulate, because it would not be possible to legislate for every conceivable circumstance.

It may be, therefore, that formulating new legislation governing the deliberate ending of a person's life, is a decision that society as a whole must be made to take. However, setting out the precise codes of conduct governing individual cases should be left to the profession itself. This will ensure that any doctor whose standards differ markedly from his peers would no longer be able to pursue such standards. It would also protect the vast majority of doctors, who are dedicated to their patients' well being, from the nightmare scenario of being prosecuted for an offence which carries a maximum penalty of life imprisonment.

Finally, I leave you with a satirical rhyme from Margaret Brazier's book:

Thou shalt not kill; but needst not strive
Officiously to keep alive!

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