

ETHICAL JUSTIFICATIONS FOR VOLUNTARY ACTIVE EUTHANASIA

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The topic of euthanasia gives rise to a host of ethical questions including those regarding the quality of life, beneficence, and the responsibilities of physicians toward their patients. While there are many kinds of cases in which euthanasia may be considered, such as those involving severely handicapped newborns and patients with debilitating but not fatal conditions, this paper focuses on the situation of late-state terminally ill patients who are suffering and want active euthanasia as an option for ending their pain. This paper explains why, under such circumstances, voluntary active euthanasia may be ethically justified.

Active and passive euthanasia are generally thought of as two separate phenomena, with the first involving the commission of an act that brings about death, and the second involving the omission of treatment that would prolong life.⁴⁷¹ In addition to active and passive euthanasia, there is a third approach to euthanasia some view as a separate and distinct category. This approach is referred to as physician-assisted suicide. Physician-assisted suicide is similar to active euthanasia in that it involves a direct act intended to cause a patient's death. In active euthanasia, a doctor performs the act intended to cause death, while in physician-assisted suicide, the patient performs the final act.

ACTIVE EUTHANASIA: SUICIDE OR HOMICIDE?

One of the primary concerns about active euthanasia is that it involves a direct act by a person other than the patient. This being true, opponents to active euthanasia view voluntary euthanasia as murder rather than as suicide. Particular controversy exists over the issue of euthanasia in health care settings where doctors help consenting patients to die. Rather than being viewed as murder, however, proponents of euthanasia describe it as "suicide through the agency of another."⁴⁷²

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⁴⁷¹ BRENDAN MINOGUE, *BIOETHICS: A COMMITTEE APPROACH* 6 (1996).

⁴⁷² ROBERT N. WENNBERG, *TERMINAL CHOICE: EUTHANASIA, SUICIDE, AND THE RIGHT TO DIE* 19 (1989).

"[J]ust as one can commit a *homicide* or murder through the agency of another, so one can commit *suicide* through the agency of another."⁴⁷³ It can be argued that suicide occurs whenever a person intends to die, regardless of whether he performs the suicidal act himself or has another perform it for him.⁴⁷⁴ Three conditions must be met for an act to be defined as a suicide.⁴⁷⁵ First, "[t]he action must, with reasonable certainty, lead to the death of the person engaging in it."⁴⁷⁶ Second, "it must be known to the actor that his death would be a virtual certainty were he to engage in that act."⁴⁷⁷ Third, "[t]he actor must engage in that action for the express purpose of bringing about his own death."⁴⁷⁸ According to this definition then, voluntary active euthanasia, which satisfies all three of these conditions, qualifies as suicide, and should not be considered a form of murder.

NONMALEFICENCE

Another, more complex, issue raised by the question of euthanasia in a health care setting is the question as to exactly what a physician's responsibility is toward a patient who wants to die. In effect, the question becomes that of what creates the doctor's duty to help such a patient end his life. An important ethical principle that, applied to biomedical ethics, can be used to justify a doctor's role in euthanasia is nonmaleficence.

The principle of nonmaleficence asserts that "a doctor ought not to inflict evil or harm or bring his patients into the risk of evil or harm."⁴⁷⁹ Because of the way technology has advanced the practice of medicine, doctors today are able to provide a host of life-prolonging treatments that were previously unimaginable. Using these treatments, however, is not always the best way to serve the patient's interests. For example, using respirators and feeding tubes, physicians have the ability to keep patients in persistent vegetative state (PVS) alive for an indefinite amount of time. Many treatments available through modern medical technology successfully sustain life, but in fact reduce the quality of life led by the patient without ultimately providing a cure. Modern medical technology, turns "prolongation of life into prolongation of dying."⁴⁸⁰ Patients who receive treatments that take a tremendous physical toll upon them,

⁴⁷³ *Id.*

⁴⁷⁴ *Id.* at 22.

⁴⁷⁵ EIKE-HENNER W. LUGE, *THE PRACTICE OF DEATH* 103 (1975).

⁴⁷⁶ *Id.*

⁴⁷⁷ *Id.*

⁴⁷⁸ *Id.*

⁴⁷⁹ Dieter Giesen, *Dilemmas at Life's End: A Comparative Legal Perspective*, in *EUTHANASIA EXAMINED* 202 (John Keown, ed., 1995).

⁴⁸⁰ JERRY B. WILSON, *DEATH BY DECISION: THE MEDICAL, MORAL, AND LEGAL DILEMMAS OF EUTHANASIA* 58 (1975).

treatments which neither adequately combat the pain of their conditions nor provide a cure, simply endure a prolonged period of pain and suffering. Similarly, patients who decide to withdraw such treatment but who do not have the option of euthanasia are left to die in perhaps even more excruciating pain because of the extra toll that the combined effects of their illnesses and past treatments take upon them. Thus, medical interventions that prolong life, either right up to the time of death or to a point where the patient is left to suffer in a horribly decrepit state, clearly do the patient more harm than good. In both cases, the doctor is in a position to end the patient's suffering, but instead prolongs it, thereby causing more harm to the patient. While one view of the principle of nonmaleficence calls for doctors to preserve their patients' lives regardless of the quality of those lives, another view holds that the medical interventions cause the true harm to the patient through prolonged or more intense suffering.⁴⁸¹

BENEFICENCE

Another principle justifying voluntary active euthanasia is beneficence, the complement of nonmaleficence. Beneficence requires a doctor to act in ways that best promote the welfare of his patients.⁴⁸² However, there is controversy over what courses of action a doctor should take to properly fulfill this duty. While some assert that beneficence requires a doctor to preserve life no matter what the cost, others argue that a patient's interests are best served by a doctor who respects the patient's autonomy, is sensitive to the pain he is suffering, and is willing to take action to end that pain. In the case of a terminally ill patient, suffering uncontrollable pain and asking for an end to his life, it seems that the most helpful act would be to end his life in a merciful way. In such a case, death is imminent, and the doctor has two choices remaining: let the disease take its course or end the patient's life. While the first option achieves nothing except for prolonging the patient's suffering and allowing him a painful death, the second clearly fulfills the doctor's obligation of beneficence by acting to end the patient's pain and making his inevitable death a little easier.

THE HIPPOCRATIC OATH

The principles of beneficence and nonmaleficence provide important perspectives from which to view the physician's role in euthanasia. They

⁴⁸¹ See DAVID C. THOMASMA & GLENN C. GRABER, EUTHANASIA: TOWARD AN ETHICAL AND SOCIAL POLICY 3 (1990).

⁴⁸² See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 259 (1994).

show how, in certain situations, ending a patient's life is the best thing that a doctor can do to help that patient. Still, "[s]ome people find it especially difficult to accept the idea of *physicians* engaging in active euthanasia. Doctors, they remind us, are dedicated to protecting and preserving life. . . . Thus we should not expect *them* to kill, regardless of whatever might be right for the rest of us."⁴⁸³ That is to say that some people see mercy killing as actually being "incompatible" with a doctor's role.⁴⁸⁴ One reason for this feeling may be that people see doctors as having pledged to only preserve life when they took the Hippocratic Oath.⁴⁸⁵

The Hippocratic Oath does not contain any specific statement obliging doctors to preserve life at all costs.⁴⁸⁶ The Oath does, however, provide expressions of both beneficence and nonmaleficence: "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them."⁴⁸⁷ A statement like this is in no way a commitment to prolong life when, in some circumstances, helping to bring a terminally ill patient's life to a faster and less painful end is the best thing that a doctor can do to "help the sick" and not "injure or wrong them."⁴⁸⁸ The Oath is subject to much interpretation, especially when one considers the time and context in which it was written. The opening statement, "I swear by Apollo Physician and Asclepius and Hygieia and Panacea. . . .," demonstrates that the Oath cannot be taken in a literal sense.⁴⁸⁹ In addition, it would hardly be appropriate for a doctor today to be bound by any set of rules written without a conception of the problems faced in the practice of modern medicine.⁴⁹⁰

QUALITY OF LIFE

Physicians who practice active euthanasia may offend opponents of the practice who believe that human life is sacred and killing is morally wrong.⁴⁹¹ These absolutes are simplistic and ignore the complex issues that arise when a patient is irredeemably ill and would rather die than continue suffering. When a patient reaches a point where his physical condition keeps him from deriving pleasure from anything around him (or in the case of persistent vegetative state, from *experiencing* anything

⁴⁸³ JAMES RACHELS, *THE END OF LIFE: THE MORALITY OF EUTHANASIA* 118 (1986).

⁴⁸⁴ *Id.* at 121.

⁴⁸⁵ O. RUTH RUSSELL, *FREEDOM TO DIE: MORAL AND LEGAL ASPECTS OF EUTHANASIA* 220 (1975).

⁴⁸⁶ *Id.* at 221.

⁴⁸⁷ See BEAUCHAMP & CHILDRESS, *supra* note 12, at 189.

⁴⁸⁸ RUSSELL, *supra* note 15.

⁴⁸⁹ Hippocrates, *The Hippocratic Oath*, in *ANCIENT MEDICINE: SELECTED PAPERS OF LUDWIG EDELSTEIN* 6 (O. Tempkins & C.L. Tempkins, eds., 1967).

⁴⁹⁰ RUSSELL, *supra* note 15, at 221–22.

⁴⁹¹ *Id.* at 117–19.

around him), it becomes appropriate to evaluate the patient's life, and to decide if he has anything to gain by continuing to live and suffer. Proponents of this view accept that "death is not an absolute evil to be avoided at all costs and in all circumstances, and life is not an absolute good to be maintained and preserved at all costs."⁴⁹² Accepting this idea is a necessary first step toward understanding the feelings of a suffering, terminally ill patient who sees no value in living out the rest of his illness. "Because human life is sacred, a person should not be degraded by being required to endure prolonged, useless suffering . . . while waiting for physiological death."⁴⁹³ In addition, it is important to note that we live in a society where, in situations such as war, capital punishment, and self-defense, we are willing to overlook both the sacred value of human life and our supposed moral aversion to killing.⁴⁹⁴

MORALITY AND THE PRINCIPLE OF DOUBLE EFFECT

One attempt to "try to preserve the categorical injunction against killing" while at the same time recognizing that a patient's interests may best be served otherwise is through the principle of "double effect."⁴⁹⁵ This principle holds that "one may perform an action with a bad effect--for instance, the death of a person--provided one foresees but does not intend that bad effect; one must be doing the act to achieve a different, good effect. . . ."⁴⁹⁶ Therefore, according to this principle, it is acceptable for a doctor to give a patient drugs if the intention is to relieve pain, even though he knows that the drugs will shorten the patient's life.⁴⁹⁷ Thus, such an action is considered morally acceptable because the intention is not specifically to bring about the patient's death. One can seriously question, however, whether there is a moral difference between giving a patient drugs specifically to cause his death and giving a patient drugs to relieve his pain knowing that to do so will cause his death. "What is true of morals is true of law. There is no legal difference between desiring or intending a consequence as following from your conduct, and persisting in your conduct with a knowledge that the consequence will inevitably follow from it, though not desiring that consequence."⁴⁹⁸ Taking responsibility for one's actions means taking responsibility for any foreseeable consequences of those actions. A doctor cannot shirk moral or legal responsibility for such consequences by saying that bringing them

⁴⁹² *Id.*

⁴⁹³ WENBERG, *supra* note 2, at 77.

⁴⁹⁴ *See, e.g.*, RUSSELL, *supra* note 15, at 217.

⁴⁹⁵ MARGARET P. BATTIN, *THE LEAST WORST DEATH: ESSAYS IN BIOETHICS ON THE END OF LIFE* 17 (1994).

⁴⁹⁶ *Id.*

⁴⁹⁷ *See, e.g.*, RUSSELL, *supra* note 16, at 18.

⁴⁹⁸ *Id.* at 126 (citing Dr. Glanville Williams in *THE SANCTITY OF LIFE AND THE CRIMINAL LIFE*).

about was not the primary intention of his actions. It is inconsistent, therefore, for a doctor practicing active euthanasia to be seen as morally inferior to a colleague who is doing exactly the same thing while merely claiming he has different intentions.

PLAYING GOD

Opponents to active euthanasia claim that it is "playing God." Presumably this means that by interfering with the natural progression of a patient's condition, a doctor practicing euthanasia is exercising a certain power over life and death that only God should have. This accusation is countered, however, by the simple fact that a doctor interferes with the natural progression of a patient's disease every time he provides him with treatment.⁴⁹⁹ When a doctor saves a patient's life, it is not thought of as "playing God," although presumably that doctor is exercising the same power over life that a doctor practicing euthanasia is exercising over death.

JUSTICE

In addition to moral concerns involving the power over life and death, there is another principle that some have asserted as a justification for euthanasia. This principle, the principle of justice, can be thought of as expressing "fair, equitable, and appropriate treatment in light of what is due or owed to persons."⁵⁰⁰ In regard to existing laws against euthanasia, many people see it as unjust that a patient who is in pain is denied the chance for an easy death, and made to suffer longer because of legal constraints.⁵⁰¹ Laws prohibiting euthanasia can be viewed as unjust to family members, who must endure a longer period of emotional and financial strain, and to doctors, who may see relieving the patient's pain as a primary duty that they are being kept from performing.⁵⁰²

Some opponents might argue that a patient who truly wanted to die would find a way to end his life, with or without the help of a doctor. This assumption, however, is problematic in ways that hearken back to the issue of justice. Many patients in advanced stages of a terminal illness are physically incapable of performing the actions necessary to end their lives. It is unjust to deny such patients the right to end their suffering simply because they cannot perform the necessary actions. Even patients who are

⁴⁹⁹ WENNBERG, *supra* note 2, at 93.

⁵⁰⁰ BEAUCHAMP & CHILDRESS, *supra* note 12, at 327.

⁵⁰¹ JERRY B. WILSON, *DEATH BY DECISION: THE MEDICAL, MORAL, AND LEGAL DILEMMAS OF EUTHANASIA* 55–56 (1975).

⁵⁰² *Id.*

physically capable of performing the actions may require a doctor's instructions to perform them correctly. Without those instructions, the patient's suicide attempt may not only fail, but may in fact result in additional harm and suffering. Patients may also fear the legal consequences for family members and friends who might be present when they kill themselves. That fear leaves them with no choice but to carry out their suicide alone and die without anyone nearby for comfort. Therefore, maintaining the illegal status of euthanasia breeds injustice.

DANGERS OF LEGALIZATION

Opponents of euthanasia often discuss the possible dangers that can result from legalization. One such danger is found among patients whose illnesses put them into a state of depression. It is thought they might make rash decisions to end their lives, and that emotional doctors and family members might comply without proper caution.⁵⁰³ Proponents of euthanasia, however, can point to just such a situation to advocate legalization of euthanasia. A euthanasia law could limit the practice to hospital settings and provide safeguards such as requiring at least two physicians to certify a patient's lack of prospects for recovery.⁵⁰⁴ While the decision to end one's life still ultimately rests with the individual, legalizing euthanasia would not obligate physicians to assist in suicide unless the patient is competent, death is imminent, and more conventional means of alleviating pain have failed. "[Physician]-assisted suicide makes sense for a limited number of Americans, those who are terminally ill and who are competent enough to request their own death."⁵⁰⁵ This type of cautious exercise of euthanasia is the kind that should be provided for in an appropriate euthanasia law. Having such a law would provide patients with more protection and additional options than they get from current practices of euthanasia performed in secret. Unregulated secret suicides pose a real danger to patients in terms of the possibility that their own emotional states, as well as those of their assistants, will lead to irrational acts.

Another potential danger perceived by euthanasia opponents is the possibility of incorrect diagnosis.⁵⁰⁶ Of course this possibility cannot be completely discounted. It would be irresponsible to say that diagnoses are perfectly accurate all of the time. However, as mentioned above, many argue that active euthanasia should be considered as a last resort when the patient has reached a point where death is imminent, and pain has become

⁵⁰³ *Id.* at 58.

⁵⁰⁴ RUSSELL, *supra* note 15, at 225.

⁵⁰⁵ Arthur Caplan, *Can High Court Rule Over Death?*, PHILADELPHIA INQUIRER, Oct. 12, 1996, at A7.

⁵⁰⁶ RACHELS, *supra* note 13, at 165–66.

uncontrollable by conventional means. At that point, it should be more than clear that the patient has no hope of recovery. Again, by having a law that allows euthanasia, physicians could be involved in the patient's decision, offer him alternatives, and possibly avoid the chance that a misdiagnosed patient would choose to end his life prematurely. In addition, the possibility that mistakes will be made exists in every form of killing that is currently sanctioned by our society. Innocent people have been executed, civilians have been killed during war, and people have been killed in self-defense when in reality they posed no threat. The possibility of making mistakes does not make these practices illegal and should not make the practice of euthanasia illegal.

THE SLIPPERY SLOPE

Another argument against legalization is one that is referred to as the "slippery slope" argument. This argument asserts "that although some acts of euthanasia may be morally permissible . . . , to allow them to occur will set a logical precedent for, or will causally result in, consequences that are morally repugnant."⁵⁰⁷ The idea behind the slippery slope is that "if euthanasia were legally permitted, it would lead to a general decline in respect for human life."⁵⁰⁸ For example, opponents of euthanasia often cite the involuntary euthanasia program that was implemented in Nazi Germany as having led directly to the emergence of concentration camps.⁵⁰⁹ This application of the slippery slope argument can be countered, however, with the assertion that the Nazi euthanasia program did not, in fact, cause the Holocaust, but was an initial product of the same "political, social, and psychological factors of the Nazi period "that also led to concentration camps."⁵¹⁰ Also, the Nazi euthanasia program was involuntary. Involuntary euthanasia occurs against a patient's will or without his consent, and can only be classified as murder. Any law allowing euthanasia would only be applicable to competent patients who voluntarily choose to die.

Still, opponents voice the concern that if euthanasia were to be legalized, it could be abused and forced on people against their will. Three main sources of potential abuse are suggested.⁵¹¹ The first source is families who shoulder the financial and emotional burden of a relative's prolonged illness and may try to "manipulate or pressure patients into choosing death."⁵¹² A second source is physicians who may use euthanasia

⁵⁰⁷ BATTIN, *supra* note 25, at 115–16.

⁵⁰⁸ RACHELS, *supra* note 36, at 170–71.

⁵⁰⁹ BATTIN, *supra* note 25, at 116.

⁵¹⁰ *Id.*

⁵¹¹ *Id.* at 167.

⁵¹² *Id.* at 168.

"as the solution for every treatment problem they cannot solve" or to "cover their medical mistakes."⁵¹³ Physicians might also pressure patients into euthanasia by convincing them that they have no viable options in terms of treatment or pain control.⁵¹⁴ A third source is health care institutions that may, to contain costs, limit a patient's treatment choices.⁵¹⁵ While the possibility of such abuse is a serious concern, advocates do not feel that keeping euthanasia illegal is the appropriate solution.⁵¹⁶ By keeping euthanasia illegal, we may avoid the abuses that could possibly result, but we also deny the benefits of euthanasia to patients who currently suffer from terminal illnesses.⁵¹⁷ The slippery slope argument "usually takes the form of an appeal to the welfare or rights of those who would become victims of later, unjustified practices however, . . . no account is taken of the welfare or rights of those who are to be denied the benefits of this practice."⁵¹⁸ Therefore, the best way to resolve this issue is to allow euthanasia but to control the practice so as to prevent abuse.

REGULATING EUTHANASIA

There are several ways to regulate the practice of euthanasia. First, psychological evaluation, counseling, and a waiting period must be required for the patient to ensure that he is competent, has based his decision on sufficient information, was given enough time to decide, and was not improperly influenced by anyone during this time.⁵¹⁹ Second, the opinions of several professionals must be obtained in the physical and psychological evaluation of the patient. Third, every instance of euthanasia must be documented as far as the patient's medical condition, alternatives to euthanasia presented to the patient, and various aspects of the patient's decision process including "a clear expression of the patient's choice."⁵²⁰ Another possible means of regulation is through a federal agency, either one already in existence or one designed specifically to address issues of euthanasia, where reports on practices of euthanasia could be sent for review.⁵²¹ Such an agency could conduct "retroactive inspection on a broad scale of patterns of performance of euthanasia" to take place in order to help show any "patterns of euthanasia abuse" that may already exist.⁵²²

⁵¹³ *Id.*

⁵¹⁴ *Id.*

⁵¹⁵ *Id.* at 171.

⁵¹⁶ *Id.* at 118.

⁵¹⁷ *Id.* at 119.

⁵¹⁸ *Id.*

⁵¹⁹ *See id.* at 173–76.

⁵²⁰ *Id.* at 177.

⁵²¹ *Id.*

⁵²² *Id.* at 178.

While it is true that no regulation can guarantee that legalized euthanasia will always be morally employed, it is also true that any law runs the risk of being abused.⁵²³ Legalizing and regulating euthanasia will provide greater protection for patients than the current practice of euthanasia performed in secret. A law that permits but regulates euthanasia will provide the benefits of the practice to patients who seek it while at the same time imposing restrictions to prevent a slide down the slippery slope.

CONCLUSION

Advances in medical technology provide many options for prolonging a terminally ill patient's life, often beyond the point at which he is able to derive value from that life or even live free from pain. For such a patient, voluntary active euthanasia is ethically justifiable. If a patient is competent, autonomy dictates that he should have the right to choose when and how he will die. In addition, the principle of justice asserts that it is unjust to deny such patients the opportunity to end their pain. Doctors have responsibilities of beneficence and nonmaleficence toward their patients and both are served in the practice of voluntary active euthanasia. Legalizing this form of euthanasia and controlling its practice with regulations provides the best compromise between opponents interested in protecting against abuses and terminally ill patients who could benefit from the practice by ending their suffering. For such patients, death is not a tragedy, but a blessing.

⁵²³ *Id.* at 173.