

# Active euthanasia — time for a decision

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**SUMMARY.** *There has been renewed interest in the moral arguments surrounding euthanasia. Some patients are now apprehensive of advanced medical technology which they fear may result in a prolonged and undignified death. In the current situation of scarce resources for health care, both patients and doctors could be coerced into considering active euthanasia if it was legally available. In this paper it is argued that doctors now need to make a clear statement rejecting active euthanasia but affirming that in certain cases passive euthanasia, or letting die, may be morally justifiable.*

**Keywords:** *euthanasia; medical ethics; doctor-patient relationship; patient autonomy; terminal care.*

## Introduction

WHEN a patient asks for help to die, the doctor faces a moral challenge. Medical training instils a sense of responsibility to preserve life, yet there is a duty to relieve suffering. The patient may claim a right to choose to die. To determine how doctors should respond to a request for euthanasia, it is necessary to explore the limits of their respect for a patient's autonomy.

There has been renewed interest in the moral arguments surrounding euthanasia.<sup>1-3</sup> A British Medical Association report concluded that euthanasia was 'intuitively wrong'.<sup>4</sup> Conversely, a working party of the Institute of Medical Ethics suggested that 'assisted death' should be acceptable in certain clinical situations: 'A patient's sustained wish to die is a sufficient reason for a doctor to allow him to do so.'<sup>5</sup>

The debate is fuelled by a medical technology which allows death to be postponed. Some patients have become wary of this technology and fear a prolonged, undignified process of dying.

Euthanasia literally means 'a good death' but the word has acquired a different interpretation, implying a positive attempt to end the life of a patient. A doctor who attempts to kill a suffering patient intends active euthanasia. Doctors refraining from treating a potentially remediable condition which results in the death of the terminally ill patient are employing passive euthanasia. Passive euthanasia may involve physically neglecting the basic needs of the patient such as food and water, or taking a decision not to prescribe futile treatment as the patient approaches death.<sup>6</sup>

## Suffering and euthanasia

It may be argued that if pain and other distressing symptoms were well controlled, requests for euthanasia might cease, or be dismissed as irrational.<sup>7</sup> However, there remains the possibility that even if pain were relieved, the patient might still rationally request euthanasia. Arguments about the adequacy of palliative care do not seem to reveal anything about the morality of euthanasia.

Improvements in palliative care have meant that it is only in a small minority of patients that pain remains uncontrolled. It is this small group which cause anguish to relatives, doctors and

nursing staff. Doctors, however, are not qualified to judge that this suffering is always a negative value. Patients who have suffered in their terminal illness have often enriched the lives of their families and their carers by their experience.

The process of dying, like that of living, is different for each individual and may be a time of personal growth. For some a dignified death is a quiet, painless process, others 'rage against the dying of the light'.<sup>8</sup> Past experience in Nazi Germany provides a dramatic example of the harm which can follow judgements about the value of 'lives not worth living'.

On the other hand, the working party of the Institute of Medical Ethics concluded that 'a doctor acting in good conscience is ethically justified in assisting death if the need to relieve intense and unceasing pain or distress caused by an incurable illness greatly outweighs the benefit to the patient of further prolonging his life'.<sup>5</sup>

Patients' suffering may be exacerbated by a feeling that they are a burden to others. A request for euthanasia may be a test to see if their life is still valued by others. Death with dignity is hard to define as the perception of indignity may be clouded by the observer's fears and prejudices. Judaeo-Christian ethics emphasize the sanctity of human life, establishing its intrinsic value. But even from a secular viewpoint, I believe that doctors face the moral challenge of seeing that the life of an old, wasted, jaundiced and dying patient is still of infinite value. I suggest that devaluing such a life on the basis of age, non-productivity, cost or degree of physical handicap is not morally acceptable.

For doctors, the sanctity of life doctrine is enshrined in the Hippocratic oath. Part of the essential qualification of being a doctor is an absolute rejection of killing a patient. A patient's trust and expectation of doctors as healers is based on this fundamental ethic. Doctors have special duties of beneficence and non-maleficence and to kill a patient is to neglect these duties. If the role of the physician becomes eroded to include killing patients on their request, then some patients might be deterred from seeking advice. Their loss of trust in the doctor might lead patients to conceal symptoms lest the doctor decide that their lives were no longer worthwhile.

## Euthanasia and slippery slopes

Many of the arguments against active voluntary euthanasia take the form of a slippery slope. This infers that if doctors allow active voluntary euthanasia in certain specific circumstances then imperceptible steps lead down a slope to involuntary euthanasia. On this slope doctors may slide towards a reduced sensitivity to killing and then to a slackening in professional resolve to save and prolong life.<sup>9</sup> These arguments defend maintaining a psychological barrier against killing and allowing no erosion of this rule. However, this view precludes any moral change, even in possible cases of assisted death for those patients who could not physically commit suicide. Morally, it would seem to be preferable to analyse each individual case rather than accept such a broad prohibition.

## Politics of euthanasia

The terminally ill patient may be vulnerable to subtle pressure to request active euthanasia. In situations of economic shortage, it might be tempting for some doctors and health service managers to decide that euthanasia could be a practical solution to the expensive problem of caring for terminally ill patients. If life-extending care for these patients were then seen as a selfish

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choice, society might be unwilling to fund such care. Indeed, the existence of a policy of accepted active voluntary euthanasia would be powerful sign to elderly or terminally ill people that the remainder of society did not have a strong interest in their survival and would thus tend to further isolate this vulnerable group. In any moral argument it is vital that issues of rationing and euthanasia be considered separately.

### A right to die

Patients may believe that the doctor's duty to respect their autonomy gives them a right to choose to die sooner rather than later. Respect for autonomy however, carries the limitation that such respect does not infringe the autonomy of others. A patient's request for euthanasia interferes with the autonomy of the doctor. Exercising autonomy implies taking responsibility for one's decisions. If patients decide to take their own lives, this carefully considered decision could be argued to be acting within the bounds of their autonomy. However, by requesting their doctor's assistance to kill them, they are attempting to shift the moral responsibility and are thus not acting in an autonomous way.

When a patient makes an autonomous choice of suicide, there is no criminal offence (suicide act 1961). However, assisting suicide remains a crime. It may seem illogical that to assist a person to perform a non-criminal act is itself a criminal offence. The attitude of the law is that killing in this sense of assisted death should be considered as murder. However, in practice the law recognizes the necessity of allowing mitigating circumstances and this is reflected in the form of lenient sentencing.

The law has a clear prohibition on all actions causing intentional death. The suicide act, in legalizing suicide, is a pragmatic response to the practical problem of administering sanctions to suicide victims. It is not an acknowledgement of a right to die. In prohibiting killing, the law acknowledges the sanctity of life and ensures that any patient's right to die can never be a doctor's right to kill. Killing is not permitted except in cases of self defence, just war, or capital punishment. In none of these situations is the killing for the benefit of the person killed, but is only allowable to protect the lives or welfare of others.<sup>10</sup> There is no legal right for a person to authorize another to kill him or her.

### Living wills

Some patients make a written directive, known as a living will, which states their wish not to be resuscitated in certain clinical situations, for example advanced cancer or dementia. Living wills have no legal force in the United Kingdom but are legal in some parts of the United States of America. There is a risk that these wills, or advance directives, could become a substitute for sensitive communication between patient and doctor.<sup>11</sup> Steps need to be taken to elicit the patient's choice with compassion, to record this information and to inform other professionals involved in his or her care. Such effective communication might calm the anxieties of patients about unnecessary treatments and thus lead to a reduced demand for living wills. Living wills take no account of the fact that patients may change their minds during the course of their illness. The presence of a living will may be of some help in influencing a doctor's decision, but it is a sad reflection on the quality of the doctor-patient relationship that a resort to such a formal device is considered necessary in palliative care.

### Unfinished business

Respecting patients' autonomy means recognizing that dying patients can still make choices. They need time to cope with their symptoms, to assess their past life and to find meaning: time to

resolve family relationships and to reflect on their destiny. Active euthanasia denies these possibilities and thus limits a final opportunity to exercise autonomy. The patient, the family, and the doctor cannot know for certain what the future holds for any individual. Clinical experience reveals that the final few hours of a patient's life may be of great value for both the patient and the family.

### Medical mistakes

Dying patients may become clinically depressed. In such a situation feelings of low self esteem and suicidal inclinations are common. Doctors often miss a diagnosis of depressive illness, particularly in elderly people.<sup>12</sup> If doctors are unable to recognize treatable depression then their responses to a depressed patient's request for assisted suicide may not be reliable. Their reaction may be influenced by their own fears about ageing, cancer and dependency. The concept of rational suicide remains a central philosophical controversy. Doctors have to consider the problem of just how severe depression must be before it precludes rational decision making. It is possible that general practitioners and other doctors who might be involved in implementing active voluntary euthanasia may lack the specialized psychiatric skills needed to assess the rationality of a patient who wishes to end his or her life. Without these skills the doctor may agree to assisted death when appropriate psychiatric treatment might alter the patient's choices.

The act of active voluntary euthanasia is final and makes no allowance for mistaken diagnosis. The fact that there is a strong prohibition on active euthanasia has, to some extent, stimulated the hospice movement to improve the care of dying patients in the last 20 years. Perhaps if active euthanasia were permitted, there would be less incentive to research better methods of controlling pain and other distressing symptoms in the dying patient.

### Killing and letting die

The traditional medical view that it is worse to kill than to let die finds support in the acts and omission doctrine, in Roman Catholic theology. This doctrine argues that actions that result in some undesirable consequence are morally worse than a failure to act which has the same consequence.

If a doctor kills a terminally ill patient to save the ward budget, that action is morally wrong; yet allowing the same patient to die from a chest infection at the patient's request may be morally right. Doctors owe patients a duty not to kill them but feel less strongly that they have to 'strive officiously to keep alive'.<sup>13</sup> Initially it may appear that respect for autonomy has little influence on the moral difference between killing and letting die, but this impression is false. If doctors continue to actively treat a patient who has expressed a wish not to receive heroic treatment, they would be failing to respect the patient's autonomy. Refusing to kill such patients does not infringe their autonomy, as they retain their right to kill themselves. Withholding futile life prolonging treatments in such patients is not only morally permissible but morally required.

Doctors share an intuitive feeling that if they kill someone they are responsible for the death, but by letting a patient die, the patient dies from the underlying disease. However, doctors have a special duty to their patients, and it could be argued that in passive euthanasia, they have 'acted' as their intention is not to treat. The danger of this argument is that we fail to recognize there is a world outside the self. The arguments about killing and letting die assume that doctors can control everything, both within and beyond the patient. Doctors require a sense of humility to acknowledge the lethal power of many diseases. To debate, on

moral grounds, withholding antibiotics is one matter, but the practical reality is that widespread cancer will cause death.

Not only is the outcome of a person's actions important in a moral analysis, but also the person's intentions and obligations.<sup>14</sup> Some theologians argue that we can clearly distinguish intended from unintended consequences of an action — the principle of double effect.<sup>15</sup> Thus, the doctor giving a slow injection of morphine with the intention of relieving the patient's pain would not be morally culpable, if as a side effect of the morphine treatment, the patient developed a fatal bronchopneumonia. However, in practice, it may be difficult to distinguish what is foreseen as a side effect from an intention.

Another issue relevant to the debate is that of ordinary and extraordinary means. Ordinary means are morally obligatory, such as food and water, extraordinary treatments may be morally optional.<sup>15</sup> However, the problem for the clinician is that there are no clear boundaries between ordinary and extraordinary means. A judgement about the desirability of treatment must be made before a decision about what is excessive treatment. So the assessment of ordinariness or extraordinariness does not help in deciding whether treatment should or should not be given.

### Compassion

An appeal to compassion does not alter the legality of the doctor's decision, but it does modify the moral position.<sup>16</sup> Doctors face a dilemma if they oppose euthanasia. They are distressed by the patient's suffering which they feel a duty to relieve, but on the other hand, they have a duty not to kill the patient. Doctors' autonomy may be overridden by their perception of their duty to relieve suffering. Cases in which active euthanasia has been carried out demonstrate just how distressing it is for compassionate staff to watch a patient suffer. In appropriate palliative care, the needs of the professional carers should receive attention as well as those of the patient and the family. One way forward in resolving this dilemma would be to give doctors the opportunity to discuss ethical issues with colleagues and with ethicists.<sup>17</sup>

Doctors have to make judgements which involve an intuitive element. This is more difficult to analyse in a conventional philosophical manner. A tension exists between existential philosophical arguments which see no necessary moral difference between active and passive euthanasia, and the doctor's conviction of a significant moral difference. At the core of this debate lies the doctor's belief in the sanctity and value of life. Once judgements begin to be made about quality of life, active euthanasia becomes a possibility. The philosophical arguments which throw doubt on the moral significance of the distinctions need to take account of the bond of trust developed between the general practitioner and the patient in the years when treatment was given with curative intent.<sup>18</sup> It seems that the emotions, values and intuitions of the doctor must play a part in the relationship with the patient and give rise to rational argument which needs to be considered in any moral analysis.

### A time for decision

Improved communication between doctors, nurses and patients and their families will lead to a better mutual understanding of the patient's wishes. I believe that active euthanasia should be firmly rejected by all those involved with the care of the dying patient. Treatment of the cancer may have ceased, but treatment of the patient carries on until the moment of death. Killing is not morally acceptable but letting die is different and acknowledges that death is a natural end to life.

The focus of care is the patient, but the professionals also need support and help; decisions are often difficult. Most doctors have

been involved in the care of patients where they have considered active euthanasia, but have realized the harm that would result from even a small erosion of their duty not to kill.

The medical professional has duties and obligations to aid the dying as autonomous and dignified individuals. There is a moral difference between being an executioner and being a doctor who is prepared to stay with a patient in the difficult process of dying. Our society needs to agree appropriate ways of caring for the dying. Those professionals, doctors and nurses involved in such care need to give a clear message to the rest of society that active euthanasia is unacceptable.

At present, most patients with advanced cancer are admitted to acute hospital wards to die. This inappropriate use of high technology resources could be avoided if patients were allowed to remain at home with their families. If dying patients were fully informed of their options for care, and community resources were used appropriately, then many of these patients might be enabled to die at home.<sup>19</sup>

Informing patients and their families involves listening to their views. These may not be framed in ethical jargon, but nonetheless professionals need to listen to the voice of the lay person. Medical decisions need to be informed by sound ethical principles but should take account of medical intuitions and the emotional component of the doctor-patient relationship.<sup>20</sup> Doctors will then be in a better position to deliver compassionate, effective ethical care at the bedside.

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