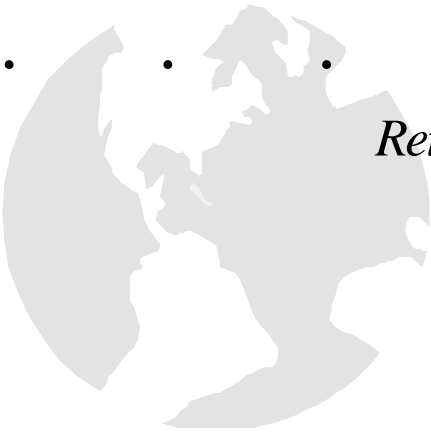




To Die or Not to Die:



Rethinking the Morality of Voluntary Euthanasia

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The thought of taking one's own life is considered abominable in many societies. Over a century ago, asking a physician to help one take their own life was considered unthinkable and unethical but so was the thought of human organ transplant. Today, our society has become more liberal and has learned to live with human organ transplant as standard medical practice. Notwithstanding, euthanasia remains ever more divisive legally, morally and ethically speaking. For doctors especially, euthanasia poses serious conflict with the very pillar of medical practice – the Hippocratic Oath. The Hippocratic Oath is believed to have been written by Hippocrates, the father of medicine, in the 4th century BC, or by one of his students. It requires a new physician to swear upon a number of Greek healing gods - Apollo the physician, and Asclepius, and Hygieia and Panacea - that (s)he will uphold a number of professional ethical standards. One of the best known prohibitions is, “to do no harm” (Martí-Ibáñez, Félix p88:1961).

In this paper, I will attempt to make a case for the moral permissibility of voluntary euthanasia. First, I shall define euthanasia as well as make a distinction between active, passive, voluntary and non-voluntary euthanasia. I will attempt to make a case for the ethical permissibility of voluntary euthanasia, and then finally, I will conclude with a contemporary brief discourse on the legal stance of euthanasia from a European and American perspective to buttress my case. In the interest of brevity, I shall consider voluntary euthanasia only for individuals who are terminally ill and suffering from excruciating pain. My arguments will be evaluated from a Kantian and Utilitarian perspective.

Euthanasia falls under a unique category of ethics called death and dying. Euthanasia is derived from the Greek words “eu” meaning good and “thanatos” meaning

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death which when combined means beautiful death. According to F.M. Kamm, “Euthanasia involves killing or bringing about someone’s death due to a final act by some other person (such as a doctor) with the intention that the person’s death is in the best interest of the person who will die.” (F.M. Kamm, p122:2007)

Consider the case of Chantal Sébire, a retired 53-year-old French teacher who suffered from esthesioneuroblastoma, a rare and incurable form of cancer, and fought for the right to die through euthanasia. Over time, the cancer burrowed through her sinuses, nasal cavities, and eye socket, leaving her face severely disfigured. She also lost her senses of sight, taste, and smell. The doctor’s prognosis was that this rare disease was also going to damage her brain over time and eventually kill her. She made a public appeal to the French president, Nicolas Sarkozy, to allow her to die through euthanasia, stating that “One would not allow an animal to go through what I have endured.” (Time.com, March 15, 2008). On March 17, 2008, she lost her case in a French court, with the magistrate noting that while French law does allow for the removal of life-support equipment for terminally ill patients, it does not allow a doctor to take action to end a patient’s life. Having failed to secure State approval to end her suffering, Sébire resorted to unorthodox means to end her life of misery.

Euthanasia can be active or passive. Active euthanasia is when somebody does something to actually kill the terminally ill person (for example giving a lethal injection to somebody who’s dying from cancer). This is usually done by a doctor or anyone else but the important thing is that they would not die on their own. Passive euthanasia is when you kill someone by taking away something that they needed to live (for example turning off a life support machine that is keeping someone alive or not feeding them).

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The point here is that you are not killing them but rather you are taking away what they need to survive (Walter Sinnott-Armstrong, *Moral Dilemmas*, p216:1988).

Euthanasia as we know it can be classified into voluntary, non-voluntary and involuntary. Voluntary euthanasia is when the person who is to die decides that she wants to die. It is his/her decision. Non-voluntary euthanasia is when the person involved does not choose to die because they are not able to understand the choice or are unable to choose (for example people who have lost the ability to understand the ideas or severely handicapped children). This often applies to severely injured accident victims. In involuntary active euthanasia, one person decides that another person's life is no longer worth living or no longer of value, and has him/her killed even though the patient wants to go on living (you might be right to call this murder).

Euthanasia and individual autonomy are inextricably linked, thus, it's important that I address the issue of autonomy. In cases involving euthanasia, the question people tend to ask is whose autonomy is being extended – is it the patient's, doctor's, State's or the next-of-kin's? As John Lachs writes, “that in the end, our lives belongs to no one but our selves (Lachs John, p 13:1994). Similarly, philosophers such as Dworkin, Scanlon and Nagel suggest that each individual has a right to make the most intimate and personal choices central to persona, dignity and autonomy, a right that encompasses the right to exercise some control over the time and manner of one's death. At the heart of modern bioethics is the respect for autonomy. It is rooted in the liberal, moral and political tradition of individual freedom and choice. A fully conscious patient has the ultimate autonomy over all other stakeholders. Similarly, if such a patient has expressed a desire

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to live in spite of their horrendous condition then involuntary euthanasia becomes a crime and should not be permissible.

For Emmanuel Kant, the 18th century German philosopher, the fundamental moral law was expressed in the “Categorical Imperative”: “Act only according to that maxim whereby you can at the same time will that it should become a universal law,” or, in another formulation, “Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means.” (Mary J. Gregor p25:1999). Broken down, it is wrong for others to treat me as mere means for their ends, but equally wrong for me to treat myself as a mere means for my own ends: As others should respect my dignity as a person by not using me merely as a means for their purposes, I should have proper regard for my own dignity as a person, and not simply use myself as a means for my own purposes. But that is precisely what I do when I aim at my own death as a way to eliminate pain. So I ought not to pursue that aim, and therefore ought not to consent to a morphine injection aiming at death, or give one to a patient who has consented

According to Utilitarianism, “Actions,” according to John Stuart Mill, “are right as they tend to promote happiness, wrong as they tend to produce pain or the reverse of happiness.” (Harry J. Gensler, Earl W. Spurgin, James Swindal, p198:2004). Act Utilitarians support the view that it is the value of the consequences of the particular act that count, so if breaking the law would lead to the greatest good for the majority then it would be the correct act to follow. However, Rule Utilitarianism states that you must follow the rules even if it doesn’t lead to the greatest pleasure for the individual at the

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time. It focuses solely on the idea that you should follow the rule that will bring about the greatest good within the community.

So, in the case of Chantal Sébire, even though the greater happiness for the individual would have been derived by allowing euthanasia, it would lead to further conflict and debate about under what circumstances you are allowed to use Euthanasia. This leaves me to conclude that Utilitarianism leaves no potential leeway or flexibility. Current theories of Utilitarianism provide no practical way to measure what is “good” Utilitarians ask for the greatest good, but when different people find different things to be good, the task of figuring out the greatest good is simply impossible. However, the main concern and argument of critics is encapsulated in slippery slope theory; that is, the lack of proper safeguards as encapsulated in the slippery slope theory. Opponents also argue that legalizing euthanasia could lead to forceful killing of those who do not want to die but who are considered to be socially undesirable and are outcasts from mainstream society. Historically, this has already happened, with the Nazis being prominent among those who have practiced this type of euthanasia. My argument in this scenario is that euthanasia must not be seen as a medical template, ready to be applied to anyone that is terminally ill. Euthanasia should be the last resort which must be adopted under strict and unique conditions such as Sébire’s.

From a deontological perspective, it is the intent of an action such as respect for rights, duties or principles rather than rightness or wrongness of consequences that determines morality. Thus, Kant’s theory will become applicable if we modify its inherent flaws - which include its blanket application and its lack of flexibility to accommodate unique individual circumstances. This is where relativism or situation

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ethics plays a role. This means that in any situation, when faced with a difficult decision about whether to help someone to die, we need to act out of love, which means ignoring any hard and fast rule and doing what the situation requires. Universalizing the maxim, “I should help Chantal Sébire to die” would give a universal law that everyone should be helped to die. Obviously, this is self contradictory. What we need is a way to frame the importance of “end” in a less a priori and more factual manner. Conversely, if you took the maxim “I should help Chantal Sébire, who is terminally ill, suffering unbearably and desperate to die, to die” you might create a more acceptable universal rule such as “Anyone who is terminally and incurably ill, suffering greatly and has freely chosen to die, should be helped to die”. Shortly before Sébire decided to take matters into her own hand and end her suffering, an opinion poll showed that 87% of French public supported euthanasia as the way to end Sébire’s suffering (Time.com, March 15, 2008).

There are a critical number of characters involved in euthanasia each vying for supremacy, wanting their opinions to be heard; the patient, their loved ones, society, and the government as the supreme custodian of the law of the land. Yet each brings a divergent perspective which serves to stoke the controversy thus widening the ethical divide. The question then becomes “Who has the authority to decide?”. One approach to ending the conflict may be to create a hierarchy of authority. As stated in a prior paragraph, if we agree that ultimately, each individual has a right to make the most intimate and personal choices central to personal dignity and autonomy, then the patient would rank atop. Going by previous court precedence, the patient’s next-of-kin such as husband or wife, then parents rank next in that hierarchy. Naturally, society should come next. However, despite its third place in that hierarchy, it tends to command enormous

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influence in determining what is right or wrong which supports Kant's Categorical Imperative. One of the reasons behind society's reluctance, and by extension governments', is the absence of a system of safeguards or stop-gap measures aimed at preventing people from abusing any such laws.

The collective will of society plays a prominent role in the development and application of laws. The rigidity expressed by the French government in turning down Sébire's plea is based on the government's fear of setting a legal precedent that would open a "Pandora's Box" which will certainly lead to an uncontrollable wave of deaths should euthanasia be legalized.

Ultimately, this end-of-life dilemma becomes a two-way decision between a medical personnel and the patient. A doctor's duty to save life in most instances tends to outweigh other duties. For example, patients hospitalized for a heart attack have long been treated with morphine to relieve chest pain. However, an analysis by researchers from the Duke Clinical Research Institute has shown that these patients have almost a 50 percent higher risk of dying. This is because Morphine directly affects the respiratory system by depressing it, and, when a sufficient amount of the drug is taken, the person will stop breathing and die (Science Daily online, May 5th, 2005). Despite its risks, morphine is still prescribed by doctors. Isn't it an oxymoron to attempt to save lives with a drug such as morphine when we know that it actually heightens the risk of death? Why then is it legally impermissible for doctors to intend death when it is the lesser evil, in order to produce the greater good of no pain; why is it morally and ethically wrong to benefit the patient by giving him or her a shorter, less painful life rather than having him or her endure a longer, painful and more agonizing one? A doctor has a duty to relieve

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suffering, thus it is permissible to end that suffering by death if it is in the person's best interest.

In a 2003 British survey, 55% of UK doctors believed that someone with a terminal illness and uncontrollable physical suffering should be allowed to opt for voluntary euthanasia. The findings were based on a survey of over 1,000 doctors registered on the medical website Medix-UK on behalf of the Voluntary Euthanasia Society. Similarly, in a 2006 Gallup Poll, United States responders were asked the following question, "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?" 69% answered "Yes", 27% answered "No" and 4% were unsure (BBCNews.com January 24th, 2003).

From a legal standpoint, Belgium legalized voluntary euthanasia in 2002, thus ending the long isolation of the Netherlands as the only country in which doctors could openly give lethal injections to patients who have requested help in dying (CNN.com, May 17th, 2002). Currently, passive euthanasia is allowed in all 50 US states. Just like the French, it is legal to withdraw any life-supporting treatments (including nutrition and hydration) so long as the patient or the patient's proxy or decision-maker consents. On the other hand, active euthanasia is only allowed in the state of Oregon and it is illegal in the other 49 states. Under the provisions of Death with Dignity Act, physicians are legally allowed to prescribe death-inducing drugs for terminally ill patients (so declared by two doctors) when they wish to escape unbearable suffering. These patients must request a physician's prescription for lethal drugs three times (Time.com, October 17th,

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2007). If euthanasia is intended to benefit the patient, how can we produce a benefit if we eliminate the potential beneficiary?

Under what circumstances should terminally injured and ill people have the right to choose to die? The Supreme Court made a definitive statement in the landmark 1990 case *Cruzan v. Director, Missouri Dept. of Health* that severely injured patients have a constitutional right to refuse medical treatment and die. But the court also ruled that states can require “clear and convincing” evidence of a patient's intent to forgo medical treatment, a rather high evidentiary standard to meet.

What’s more, in 1975, 21-year-old Karen Ann Quinlan was admitted to the hospital in a coma and was later declared by doctors to be in a “persistent vegetative state.” After five months on a ventilator, her parents requested that the ventilator be removed and that Ms. Quinlan be allowed to die. Following doctors’ refusal, her parents brought the matter to court; the US Supreme Court reversed the New Jersey Superior Court’s denial. The US Supreme Court affirmed that, “Although the Constitution does not explicitly mention a right of privacy, Supreme Court decisions have recognized that a right of personal privacy exists and that certain areas of privacy are guaranteed under the Constitution.” (Menikoff, p247:2001). Even more, the court asserted that the patient’s right and autonomous judgment are to prevail over the physician’s judgment in decisions at the end of life (Menikoff, p247:2001). In order to attain that legal inflection point, the movement for the legalization of voluntary euthanasia needs to gather critical mass.

Finally, euthanasia in Sébire’s case would have provided intrinsic worth, that is, empathy, benevolence, and respectfulness. Empathy would encourage the State to have compassion for her; benevolence would encourage helpful actions resulting from the

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fuller understanding of the person's predicament and respectfulness would encourage our respect for the person as an individual, and for us to respect their rights and wishes. It is worthy to note that no one objects to ending the life of animals in critical conditions suffering from excruciating pain; we deem it best to end the suffering and let such animals enjoy a peaceful death. If that be the case, shouldn't we extend similar favor to human beings in similar conditions? On a personal note, could we all imagine standing by our spouse or someone we love so dearly watching them suffer from an irreversible medical condition which has greatly impaired their quality of life? Wouldn't we be respecting that person's autonomy by granting their last wish? Which is more barbaric and unethical: Ending the torment and suffering or standing by and watching the agony play out? It takes extraordinary courage and compassion to assist someone you love with ending that suffering.

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