Euthanasia: Issues Implied Within

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Abstract

Euthanasia is defined as “a deliberate act undertaken by one person with the intention of ending life of another person to relieve that person's suffering and where the act is the cause of death”. Assisted suicide is defined as “the act of intentionally killing oneself with the assistance of another who deliberately provides the knowledge, means, or both”. In ‘physician-assisted suicide' (PAS) a physician provides the assistance. The present literature –based review article is prepared with the aims (1) to understand the genesis of the idea of euthanasia (2) to peek into the historical chronology related to this idea (3) to learn the arguments and counter arguments given for this idea (4) to look into the patient's perspective related to his request for death (5) to know the global scenario regarding euthanasia, and (6) to generate an awareness about the concept behind euthanasia – more than ‘legal medical death'. In ancient Greece and Rome, euthanasia was an everyday reality. The proposals for euthanasia revived in the 19th century with the revolution in the use of anesthesia. It has been claimed that advances in life-sustaining medical technology have renewed interest in euthanasia again. Fear of being kept alive by technology along with the extrapolation of anesthetics to make death easier have been the facilitators for this renewal of debates on euthanasia. The arguments and justifications advanced both for and against euthanasia have hardly changed in over a century, that is, human right born of self-determination versus fear of ‘slippery slope'. Looking from patient's perspective, the patient asks for death when his psychological purview changes from ‘why me' to ‘what next'. Physical symptoms rarely serve as primary or sole motivation for death request. Instead individual values appear to have primary role to play. An avoidance or immediate refusal runs the risk of adversely affecting the patient's care. The motivation behind patient's request should be explored and a deeper understanding should be reached. Globally, Netherlands in 2001 and Belgium in 2002 have legalized euthanasia. Oregon, USA has legalized only PAS in 1997. Northern territory of Australia was the first to legalize euthanasia in 1995 and first to repeal the act in 1997. According to Swiss penal code, suicide is not a crime and assisting suicide is a crime if and only if the motive is selfish. It condones assisting suicide for altruistic reasons. In conclusion, the people practicing medicine should have an analytical viewpoint while having a debate on euthanasia. There is a need to understand the arguments and counter arguments given for euthanasia so that formal guidelines can be worked out regarding this vital issue, for the primary goal of all the medical practitioners is to infuse control in all patients to live gracefully and to die peacefully.

INTRODUCTION

Debates about the ethics of euthanasia and physician-assisted suicide date from ancient Greece and Rome ([1]). Euthanasia is defined as “a deliberate act undertaken by one person with the intention of ending life of another person to relieve that person's suffering and where the act is the cause of death”. Euthanasia may be ‘voluntary', ‘non-voluntary' or ‘involuntary'. Euthanasia is voluntary when the suffering person has requested and consented for ending life. It is non-voluntary when the suffering person has neither requested nor consented for ending life. And it is involuntary when the suffering person has requested contrary to ending life. Assisted suicide is defined as “the act of intentionally killing oneself with the assistance of another who deliberately provides the knowledge, means, or both”. In ‘physician-assisted suicide' (PAS) a physician provides the assistance ([2]).

AIMS

The present literature-based review article is being worked out:

- To understand the genesis of the idea of euthanasia.
- To peek into the historical chronology related to this idea.
- To learn the arguments and counter arguments given for this idea.
- To look into the patient's perspective related to his

request for death.

- To know the global scenario regarding euthanasia.
- To generate an awareness about the concept behind euthanasia – more than ‘legal medical death'.

HISTORY

In ancient Greece and Rome, euthanasia was an everyday reality where many people preferred voluntary death to endless agony ([3]). This widespread acceptance was challenged by the minority of physicians who were part of the Hippocratic School. The ascent of Christianity reinforced the Hippocratic position on euthanasia and culminated in the consistent opposition to euthanasia among physicians ([4]). The proposals for euthanasia revived in the 19th century with the revolution in the use of anesthesia. In 1870, Samuel Williams first proposed using anesthetics and morphine to intentionally end a patient's life. Publication of Williams's euthanasia proposal prompted much discussion within the medical profession ([5]). By the 1890s, the euthanasia debate has expanded beyond the medical profession to include lawyers and social scientists ([6]). Probably the most notable event occurred in 1906 with introduction of Ohio bill to legalize euthanasia, a bill that was ultimately defeated ([7]). Two more Parliamentary bills were introduced; this time in Britain in 1936 ([8]) and 1969. They never sparked widespread public discussion or concern in the medical profession. The euthanasia issue was like a recurring decimal with periodic reappearances ([9]). With the increasing acceptance of patient autonomy and the right-to-die in the United States ([10]), the euthanasia debate has once again become a matter of public concern.

DEBATE ON EUTHANASIA

The arguments and justifications advanced both for and against euthanasia have hardly changed in over a century.

THE ARGUMENTS FOR EUTHANASIA

- It is human right born of self-determination.
- It would produce more good than harm, by putting an end to the inescapable suffering.
- There is no substantive distinction between active euthanasia and the withdrawal of life-sustaining medical interventions (passive euthanasia); in fact, active euthanasia is more controlled and timely.
- Its legalization would not produce deleterious consequences.

THE ARGUMENTS AGAINST EUTHANASIA

- The assumption that most deaths are painful is wrong.
- The practitioners are increasingly willing to stop the futile treatments and use pain medications more aggressively and frequently; consequently there is no need for euthanasia.
- The distinction between active and passive euthanasia has to be maintained because of ‘the intent' to deliberately end someone's life.
- The adverse consequences of legalizing euthanasia enumerated as follows:
- Euthanasia has abuse potential – a certain and easy method of being rid of an objectionable relative.
- Predictions made by even highly skilled and competent physicians regarding disease prognosis may not be fulfilled and judging ‘medical futility' may actually be futile.
- Patients will be under undue pressure to request euthanasia in order to relieve their families of distress – patients will be in dilemma.
- There will be a ‘slippery slope' – initially the terminally ill could voluntarily request euthanasia, then the aged could, and then involuntary euthanasia for incurably demented persons, absolute idiots and convicted murderers would be justified.
- It has been claimed that advances in life-sustaining medical technology have renewed interest in euthanasia again. Fear of being kept alive by technology along with the extrapolation of anesthetics to make death easier have been the facilitators for this renewal of debates on euthanasia.

THE PATIENT'S PERSPECTIVE

WHEN DOES PATIENT CONSIDER DEATH?

The patient asks for death when his psychological purview changes from ‘why me' to ‘what next'. An initial request for death should be interpreted as a call for information about

the future and an appeal for a commitment to respond to anticipated suffering ([11]).

WHY DOES PATIENT REQUEST DEATH?

- Being a burden
- Being dependent on others for personal care
- Loss of autonomy
- Loss of control
- Loss of control of bodily functions
- Loss of dignity
- Loss of independence
- Loss of meaning in their lives
- Pain or physical suffering
- Poor quality of life
- Ready to die
- Sees continued existence as pointless
- Tired of life
- Unable to pursue pleasurable activities
- Unworthy dying
- Wants to control circumstances of death
- Physical symptoms rarely serve as primary or sole motivation for death request. Instead individual values appear to have primary role to play.

HOW OFTEN DO PATIENTS CONSIDER DEATH?

Among 988 patients interviewed ([12]), 60% supported PAS in abstract and 10.6% seriously consider for themselves at the time of initial interview. 10.3% patients were considering PAS at the time of second interview, done after two months. However, half of those were newly contemplating PAS and half of those previously considering PAS were no longer considering the option.

MORAL AND LEGAL FRAMEWORK OF THE PHYSICIAN

Physicians vary in their moral beliefs and actions regarding PAS. A non-judgmental stance should be taken despite complex legal and moral issues. In a questionnaire-based study conducted on 2761 physicians ([13]), 60% agreed that PAS should be legal in some cases. However, only 46% were willing, if PAS were legal, to prescribe lethal medication. 31% were unwilling to prescribe for moral reasons even if PAS would have been legal. 7% reported having written a prescription knowing that the patient intended to use it to take his/her own life. Some physicians provide lethal prescriptions to terminally ill patients even if jurisdictions where the practice is illegal.

RESPONDING TO A REQUEST FOR DEATH

An avoidance or immediate refusal runs the risk of adversely affecting the patient's care. The motivation behind patient's request should be explored and a deeper understanding is reached. Should the request for death persist, patients should be informed that physicians will not honor their request but their needs for comfort will continue to be met.

EXPLORING THE REQUEST FOR DEATH

When physicians commit themselves to remain present with patients and to respond to their suffering, the patients' requests for death are abolished in almost all cases.

Figure 1

EXPLORING THE MOTIVATION	
Expectations and fears	Fear of uncontrollable symptoms
	Expectation of lingering death
Lack of awareness about options for end-of-life care	Aggressive pain and other symptoms management
	Terminal sedation
	Withdrawal and withholding of life-sustaining treatment
	Voluntary stopping eating and drinking
Family and caregivers	Feeling of burden on the family
Sense of quality of life	Understanding patient's values
Ruling out depression	Diagnosing and treating treatable depression

GLOBAL SCENARIO

A look at laws governing euthanasia throughout the world ([14]):

Australia: Northern territory of Australia was the first to legalize euthanasia in 1995 but the Apex Court of Australia repealed this state legislation in 1997.

Oregon: Oregon is the only state in US to have legalized PAS and not euthanasia, and that too under certain circumstances in 1997. There is no moral or legal obligation for physicians to comply with a patient's request for PAS even in Oregon. The Oregon Death with Dignity Act (ODDA) applies only to people who have reached the age of majority (legal age) and have been diagnosed as being

terminally ill. It offers the successful applicant assisted suicide; a doctor gives the patient a prescription for a fatal dose of barbiturates that the patient can take. This state legislation has recently received nod of the Supreme Court of United States opening the door to many more such laws across the United States for ending the lives of the terminally ill. In a 6-3 vote, justices ruled that a federal drug law could not be used to prosecute Oregon doctors who prescribed overdoses intended to facilitate the deaths of terminally ill patients ([15]).

Netherlands: PAS and euthanasia have been practiced openly for approximately 20 years. These practices have been codified into law and formal guidelines have been established in 2001. The law is not limited to adults, nor does an applicant for euthanasia have to be terminally ill. The main basis for a request is hopeless and unbearable suffering, regardless of life expectancy. All cases are reviewed by medical committees, and instances of suspected wrongdoing are referred to judicial investigators. The Dutch government is reviewing a protocol to allow euthanasia, with parental consent, for infants born with terminal and painful illnesses.

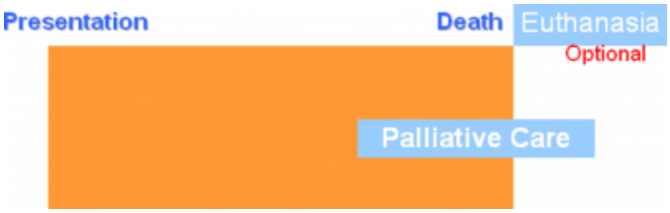
Belgium: The Belgian Act on Euthanasia, passed in 2002, defines euthanasia as “intentionally terminating life by someone other than the person concerned at the latter's request.” Assisted suicide remains illegal. Requirements include that the patient should have attained the age of majority that the request be “voluntary, well-considered and repeated” and the patient be “in a futile medical condition of constant and unbearable physical or mental suffering that cannot be alleviated.” All acts of euthanasia must be reported to the authorities.

Switzerland: An interesting situation exists in Switzerland ([16]). According to Swiss penal code Article 115, suicide is not a crime and assisting suicide is a crime if and only if the motive is selfish. It condones assisting suicide for altruistic reasons. It does not require the involvement of a physician nor that the patient be terminally ill. It only requires that the motive be unselfish. Switzerland also allows voluntary organizations to help people, including foreigners, end their lives. Where lethal medication is required, a doctor's prescription is obtained. All acts of assisted suicide are reported to the police and investigated. Murder upon request by the victim (euthanasia) is considered less severely than murder without the victim's request (homicide) but it remains illegal. Decriminalizing euthanasia was tried in 1997 but it was recommended to remain illegal because it would have created dangerous legal circumstances where a non-physician helper would have to be prosecuted where as the physician would not.

Britain: A bill was introduced in October 2005 in the House of Lords that would allow a competent and terminally ill person who has reached the age of majority and is suffering unbearably to request either assisted suicide or voluntary euthanasia. It sets requirements including an assessment by an attending physician that the patient is likely to die of natural causes within a few months, that the patient is competent to make the request and that he or she is suffering unbearably. The patient must sign a written declaration of intent. If this has not been revoked within 14 days of the date on which the request was first made, the patients can receive the means to take his or her own life or, if the patient is physically unable to do that, have his or her life ended through voluntary euthanasia. A medical committee would review all cases.

Figure 2

Figure 1: Holistic Care



HOLISTIC CARE

The authors suggest that palliative care physicians should accept euthanasia as strive for perfection while taking care of terminally ill patients, especially in those cases where in spite of aggressive pain and symptom management patients and physicians both alike feel helpless. The authors are of point of view that terminal sedation was borne to counter such helpless clinical scenarios but it does not impart ‘total' control to patients as euthanasia would do. Empowering patients with option of euthanasia would quash their fears of being stuck up in inescapable suffering and they would plan their life before death with greater sense of control.

The authors emphasize on the instillation of ‘control' in patients. The authors see euthanasia as an extension of ‘birth control', i.e., ‘death control'. The fetuses' fates are decided by the physicians predicting the viability of good quality of life outside uterus and would-be mothers deciding whether to carry on the pregnancy or not. Similar is the condition of terminally ill patients and the authors suggest that patients should be allowed to decide for themselves at this point of

life.

CONCLUSION

It is important to recognize that euthanasia is not a new concept to medical profession. There is a need to understand and analyze the arguments and counter arguments given for euthanasia so that formal guidelines can be worked out regarding this vital issue, for the primary goal of all the medical practitioners is to infuse control in all patients to live gracefully and to die peacefully.

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