

Ethical issues in healthcare: euthanasia

[Health & Medicine](#), [Euthanasia](#)



Introduction

Frequently faced with decisions that impact on an individual's quality of life, and with power over life or death, the healthcare profession encounters many ethical issues where the distinction between right and wrong is not always absolute. To ensure that the welfare of the patient is always of paramount importance, and to protect those involved with the patient's care, healthcare organisations employ various ethical guidelines, committees, and procedures to handle these issues of morality.

The main motive of a healthcare professional, and therefore a primary ethical issue, is that of promoting patient welfare above all other concerns, or beneficence. Additionally, medical practitioners are compelled to consider three further important moral commitments. These are the patient's right to choose their treatment, known as autonomy, non-maleficence (to first do no harm), and justice, ensuring the provision of fair and equal treatment for all patients (Gillion, 1994). An issue that creates conflict for decision-making in nearly all of these domains is euthanasia.

Euthanasia may also be referred to as mercy killing, and is the act of a deliberate intervention with the intention of ending an individual's life with the purpose of relieving intractable pain and suffering (House of Lords Select Committee on Medical Ethics). Euthanasia has a variety of differing interpretations, being described as "Any action or omission intended to end the life of the patient on the grounds that his or her life is not worth living" by the Pro-life Society, and as a "Good death" by the Voluntary Euthanasia Society, who adopt the literal Greek translation "eu" and "thanatos" (British

Broadcasting Corporation, 1999). Euthanasia has become a topic of increasing debate amongst medical professionals, journalists, and politicians, however remains illegal in the UK. There are several categories of euthanasia, and the classification depends on the level of patient consent. Voluntary euthanasia infers a request from the patient for premature death, whereas involuntary euthanasia is conducted without the request of the patient. Non-voluntary euthanasia is conducted where patients are not in the capacity to request premature death themselves. The ethical dilemmas encountered with euthanasia are the reason that the act is shrouded in such controversy. These will be discussed below, through the case study of Ramon Sampedro, who became quadriplegic after a swimming accident at the age of 25, and application of ethical theory.

Ramon Sampedro described himself as “ a head attached to a corpse” (Euthanasia), and appealed to local and high courts for euthanasia as he was unable to commit suicide himself. Sampedro felt that his decision should be respected and he was being denied the right to suicide. There are several ethical and moral considerations as to whether Sampedro’s request should have been granted or not.

The sanctity of human life is expressed throughout religious scripture and moral rhetoric, and in the context of medical and healthcare ethics, manifests as a commitment to individuals’ right to health, to promote patient welfare and to do no harm (British Medical Association, 2007). The conflict between ending a life and non-maleficence is clear, however when considering the principle of beneficence, the definition of welfare comes

under debate. Sampedro obviously felt his quality of life was so impaired that he would be better dead. Consider the case of Diane Pretty, a sufferer of motor neurone disease, a neurodegenerative disease that causes weakness and wasting of the muscles, creating difficulty walking, talking, eating, drinking, and breathing (Motor Neurone Disease Association). At the time of requesting her death, Mrs Pretty was paralysed from the neck down, virtually unable to speak, and being fed through a tube (Singer, 2002). Living a life plagued with problems and pain, and knowing that she would die a distressing and enduring death, Mrs Pretty's welfare was evidently compromised. Wishing to die in a dignified and humane manner, Mrs Pretty took her case to the British courts, however requests for her husband to aid her death were rejected by the Convention for the Protection of Human Rights on the grounds of it being assisted suicide (Singer, 2002). The cases of Diane Pretty and Roman Sanpedro highlight a conflict between non-maleficence in which action would be taken to end human life, and promoting individual welfare and autonomy.

The outcomes of the above cases are in stark contrast to that of Mrs B. Mrs B was paralysed from the neck down, and kept alive by ventilator. Mrs B also professed a will to die, claiming her life was not worth living, and requested the ventilator be turned off (Singer, 2002). Due to her request for passive euthanasia, where treatment is withdrawn or not provided, the decision to turn off the ventilator and bring about her death was granted. In contrast, active euthanasia as with Pretty and Sampedro requires the implementation of a deliberate act to bring about death. Whilst all parties express the same will to die and implore an identical end result, only the autonomy of Mrs B

was respected. The distinction between the two types of euthanasia lies in that of letting die versus actively killing, known as the acts/omission doctrine. Many medical professionals, ethicists and philosophers support this doctrine, illustrated by Clough (1968) who quotes; “Thou shalt not kill but needst not strive, officiously, to keep alive”. However, others have differences of opinion. In his interpretation of the acts/omission doctrine, Blackwell (1996) illustrates how an act which is considered ethically right may infer the same immoral consequence as an act considered ethically wrong; “Thus suppose I wish you dead, if I act to bring about your death I am a murderer, but if I happily discover you in danger of death, and fail to save you, I am not acting and therefore, according to the doctrine, I am not a murderer”. In this ironic depiction of the doctrine, Blackwell (1996) acknowledges the power of intent, action, and consequence as a whole when approaching an ethical issue.

The acts/omission doctrine follows a school of thought frequently referred to in medical ethics, that of Deontology, where the focus is on choice and whether these decisions should be permitted, forbidden, or are morally required (Larry & Moore, 2008). The morality of a decision is judged on its adherence to certain precepts, which include duties towards anyone, for example ‘do not lie’, and duties relating to one’s individual circumstance and relationships, such as ‘provide for your children’ (Lacewing, 2006). Deontological thought insists that if certain ethical principles are followed, behaviour is moral and just, regardless of the consequences. Conversely, even if the end result is good, if the means are immoral the act is unjustified. This infers that an end can never justify its means, for example; lying is

always wrong even if it protects someone in the end. When considering the issue of euthanasia, a deontological approach proposes a thought process for decision-making, however does encounter moral conflict when considering whether euthanasia as a general principle is justified and ethically acceptable. A key percept of deontology when applied to clinical ethics is to heal (Pellegrino, 2005) therefore one can deduce that all forms of killing are wrong, and Sampedro should not be assisted in his death. However, if healing meant giving a patient medication with the intent of pain relief that would lead to their death, a deontological perspective would neglect the end consequence and permit the means. Deontology permits the duty of administering medication to relieve pain, however, if the same act were performed with the duty to kill, the act would be morally wrong and thus forbidden. This is an example of the rule of double effect, where outcomes that would be morally wrong if they were caused intentionally are admissible if they are foreseen but unintended (Quill, Dresser & Brock, 1997). By not intervening to relieve insufferable pain, the medical professional is inflicting harm on the patient, however to provide the dose of pain relief may hasten their death. The rule of double effect has been proposed to be ethically sound if several criteria are satisfied. These ensure that the physician did not intend maleficence either as a means or an end, that the nature of the choice is good, and that the good outweighs the bad (Marquis, 1991). The rule of double effect may enable physicians to overcome hesitations in providing pain relieving medications proportionally to their potential harmful effects (Quill, Dresser & Brock, 1997) and is a deontological principle that has potential for making some instances of

euthanasia permissible. Despite this, intent is difficult to interpret and prove, which can elicit abuse of the notion, or create difficulties for those acting under good intent with inability to prove such. In the case of Sanpedro, he does not need medication, and any intervention with such would have been an immoral act as the means would only be to bring about death.

When considering the distinction between passive and active euthanasia, deontology places emphasis on the intrinsic features of individual's actions and considers duties, principles, and the rights-claims of those involved (Candee & Puka, 1984). Therefore in accord with the principle of non-maleficence (ensuring patients' right to be done no harm), and the duty of care that compels a healthcare professional, an intervention to directly cause death, or active euthanasia, would be considered immoral and strongly opposed by deontological principles. Alternatively, passive euthanasia is more in line with a deontological approach, which involves a decision based out of respect for the patient's wish, and with the aim of doing good. Passive euthanasia respects the patient's right to refuse treatment regardless of the consequence.

A contrasting ethical approach is the utilitarian perspective, which postulates that morality judgement is dependent on a decision's consequence, and that this consequence must be weighted for its utility. Classically, utility and well-being are determined by the presence of pleasure and the absence of pain (Bentham, 1823) however, this has expanded to consider knowledge, autonomy, friendship and economic value (Hooker, 1997). Consider the prospect of euthanasia in the instance of a patient experiencing severe and

chronic pain, in a state of incapacity that prevents them from functioning without aid. A utilitarian philosophy would weigh the intense physiological and psychological suffering experienced by the patient against the patient's autonomy and the relief that would come with death. The thought of death to this individual is pleasurable, and would provide happiness, whereas an individual living a fulfilling life is made unhappy by the thought of their death. With a utilitarian perspective, if Sampedro could provide adequate justification for his death, his request may be deemed permissible.

Utilitarianism does not distinguish between active and passive euthanasia, as its focus is on the morality of the end consequence rather than the act by which it is brought about. A particular difficulty faced when approaching euthanasia with a utilitarian perspective is that of when the balance becomes tipped, deciding when it is that a person becomes better off dead than alive (Mitchell, 1995). It is important to acknowledge that happiness or unhappiness is not permanent and may be changed (Sheldon & Lyubomirsky, 2006). For some, pain, suffering and despair may be enduring, however for another, whilst unhappiness may be prominent in the initial throws of a terminal illness, as they adapt they may again begin to find fulfilment and enjoyment in life. The case of Joni Eareckson Tada poignantly illustrates this proposal. After suffering a diving accident at the age of 18, Joni became paralysed from the neck down, and during her rehabilitation experienced anger, depression and suicidal thoughts, and “ begged my friends to aid me in suicide”. 38 years on, Jodi now professes “ It concerns me deeply that now we live in a culture which capitalises on that depression and reinforces to people like myself that ‘ you’re better off dead than

disabled'. That is unfortunate, that's sad, that is evil." (Swanson).

Autonomy, the respect for an individual's self-determination and responsibility for their own healthcare decision, is acknowledged in relation to both the means and consequence of euthanasia. This is something emphasised by the British Medical Association (2006). In the request for active euthanasia, patient autonomy conflicts with non-maleficence, where a doctor is required to cause harm to the patient, and in request for passive euthanasia, patient autonomy conflicts with beneficence, where a doctor cannot act to prevent harm. Again the definition of beneficence and non-maleficence depends greatly on the connotation of 'harm'. For euthanasia to be justified, the harm of letting someone die must be less than the harm in keeping them alive. Patient autonomy also depends on the capacity to consent, where a patient must have the information necessary to understand the severity of any medical decision and the benefits and risks that will accompany the outcome (UCSF). In cases where patients are unable to make or comprehend decisions due to incapacity, difficulties arise where decisions must be made on their behalf. Sampedro evidently had a full informed understanding of his decision; however the maleficence caused by someone having to kill him would outweigh his wish. The issue of capacity to consent highlights the importance of personhood with respect to euthanasia. Singer (1979) proposes that only humans with rationality are 'persons' and therefore deserving of rights and respect. Following the theories of Singer and other western bioethicists, it may be inferred that those who are not classified as persons, do not have the same rights and do not command the same dignity. Fletcher (1972) proposed that,

amongst others, alcoholics, the mentally ill, those in a persistent vegetative state and the senile are not considered 'persons'. If the lives of these individuals are not to be held with the same moral considerations, the impetus for euthanasia is greater, as justification comes from relieving societal expense and resources. The ecological validity of these theories is demonstrated as the definition of personhood is frequently raised with regard to decisions to terminate treatment at the end of life, and for those in vegetative states (Cranford & Randolph Smith, 1987). Whilst individuals lacking the consciousness do not command the same moral respect for autonomy, a rational and sentient person, such as Sampedro, demands moral obligation, and therefore the right to autonomy. This again highlights the conflict between the various moral duties resonant to euthanasia; if someone is deemed rational, should their wish to die not be respected?

The dilemma of euthanasia is likely to be a topic of contention for many years to come. Whilst both deontological and utilitarian philosophies provide moral grounds with which to approach the issue, each individual case and request owes its own appraisal and sweeping generalisations cannot be made. The British Medical Association (BMA) (2006) alludes to the dangers of these generalisations, stating that resulting pressures from scarcity of NHS resources, marginalisation of the inarticulate, and emotional, psychological and financial tensions can lead to poor decision making by the ill or disabled. These pressures may impinge on an individual's rationality, affecting both the means behind their decision for euthanasia, and their perception of the consequences. Whilst someone may be happy living with disability, possibility of euthanasia opens up avenue for manipulation, where

individuals are coerced into premature death to benefit or relieve family members. The BMA (2006) acknowledge the principles of autonomy (where a person's wish for euthanasia should be valued) and beneficence (with respect to ending suffering) are compelling theories, however concern arises from how interpretation of these in society may lead to a change in perception of the chronically ill, disabled, or mentally impaired. The notion that these people have the right to premature death may mean that they are not considered as societal equals and creates implications for protection of the vulnerable.

Sampedro eventually died 29 years later as a result of poisoning. Despite the decision against active euthanasia, Sampedro still maintained his wish. This may highlight the validity of such wishes. However, in my opinion, and that of religious scripture, Sampedro's death was the loss of a dignified and valuable human life equal to all others despite his disability. Life is given by God, and therefore only he should have the right to take it away. Enabling the poisoning of Sampedro meant that someone had interfered with this natural, spiritual process, and brought about the death of an innocent man which can only be deemed as murder, and morally unacceptable.

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