The morality and legality of voluntary euthanasia

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The Morality and Legality of Voluntary Euthanasia For most people involved in euthanasia they believe that some conditions are so bad that death is a benefit over living. The motive of the person who commits an act of euthanasia is to benefit the one whose death is brought about. Debate about the morality and legality of voluntary euthanasia has only become an issue in the last half of the twentieth century. The ancient Greeks and Romans did not consider life needed to be preserved at any cost and were tolerant of suicide in cases where no relief could be offered to the dying In the sixteenth century, wrters described communities as one that would facilitate the death of those whose lives had become burdensome as a result of ‘ torturing and lingering pain'. But it has only been in the last hundred years that there have been concerted efforts to make legal provision for voluntary euthanasia. Until quite recently there had been no success in obtaining such legal provision. However, in the nineteen seventies and eighties a series of court cases in The Netherlands culminated in agreement being reached between the legal and medical authorities to ensure that no physician would be prosecuted for assisting a patient to die as long as certain guidelines were strictly adhered. In brief, the guidelines were established to permit physicians to practise voluntary euthanasia in instances where a competent patient had made a voluntary and informed decision to die, the patient's suffering was unbearable, there was no way of making that suffering bearable which was acceptable to the patient, and the physician's judgements as to diagnosis and prognosis were confirmed after consultation with another physician. In the nineteen nineties the first legislative approval for voluntary euthanasia was achieved with the passage of a bill in the

parliament of Australia's Northern Territory to enable physicians to practise voluntary euthanasia. Subsequent to the Act's proclamation in 1996 it faced a series of legal challenges from opponents of voluntary euthanasia. In 1997 the challenges culminated in the Australian National Parliament overturning the legislation when it prohibited Australian Territories from enacting legislation to permit euthanasia. In Oregon in the United States legislation was introduced in 1997 to permit physician-assisted suicide when a second referendum clearly endorsed the proposed legislation. Later in 1997 the Supreme Court of the United States ruled that there is no constitutional right to physician-assisted suicide. However, the Court did not preclude individual States from legislating in favour of physician-assisted suicide. The Oregon legislation has, in consequence, remained operative and has been successfully utilised by a number of people. In November 2000 The Netherlands passed legislation to legalise the practice of voluntary euthanasia. The legislation passed through all the parliamentary stages early in 2001 and so became law. The Belgian parliament passed similar legislation in May 2002. Advocates of voluntary euthanasia contend that at least five guidelines should be met before considering the act: 1. suffering from a terminal illness; 2. unlikely to benefit from the discovery of a cure for that illness during what remains of her life expectancy; 3. as a direct result of the illness, either suffering intolerable pain, or only has available a life that is unacceptably burdensome 4. has an enduring, voluntary and competent wish to die 5. unable without assistance to commit suicide, It should be acknowledged that these conditions are quite restrictive, indeed more restrictive than some would think appropriate. In particular, the conditions

concern access only to voluntary euthanasia for those who are terminally ill. While that expression is not free of all ambiguity, for present purposes it can be agreed that it does not include the bringing about of the death of, say, victims of accidents who are rendered quadriplegic or victims of early Alzheimer's Disease. Those who consider that such cases show the first condition to be too restrictive may nonetheless accept that including them would, at least for the time being, make it far harder to obtain legal protection for helping those terminally ill persons who wish to die. The fifth condition further restricts access to voluntary euthanasia by excluding those capable of ending their own lives, and so will not only be thought unduly restrictive by those who think physician-assisted suicide a better course to follow, but will be considered morally much harder to justify by those who think health care practitioners may never justifiably kill their patients. More on this anon. The second condition is intended simply to reflect the fact that we normally are able to say that someone's health status is incurable. So-called ‘ miracle' cures may be spoken of by sensationalist journalists, but progress toward medical breakthroughs is typically painstaking. If there are miracles wrought by God that will be quite another matter entirely, but it is at least clear that not everyone's death is thus to be staved off. The third condition recognises what many who oppose the legalisation of voluntary euthanasia do not, namely that it is not only release from pain that leads people to want to be helped to die. In The Netherlands, for example, it has been found to be a less significant reason for requesting assistance with dying than other forms of suffering and frustration with loss of independence. Sufferers from some terminal conditions may have their pain

relieved but have to endure side effects that for them make life unbearable. Others may not have to cope with pain but instead be incapable, as with motor neurone disease, of living without life supports which at the same time rob their lives of quality. A final preliminary point is that the fourth condition requires that the choice to die not only be voluntary but that it be made in an enduring way and be competent. The choice is one that will require discussion and time for reflection and so should not be settled in a moment. As in other decisions affecting matters of importance, normal adults are presumed to choose voluntarily unless the presence of defeating considerations can be established. The onus of establishing lack of voluntariness or lack of competence is on those who refuse to accept the person's choice. There is no need to deny that it can sometimes be met. The claim is only that the onus falls on those who deny that a normal adult's choice is not competent. The are also many that believe that voluntary euthanasia is wrong in every case and make a very good argument against the practice. It is often said that it is not necessary nowadays for anyone to die while suffering from intolerable or overwhelming pain. We are getting better at providing effective care and hospice care is available. Given these considerations it is urged that voluntary euthanasia is unnecessary. A second, related objection to permitting the legalisation of voluntary euthanasia is to the effect that we never have sufficient evidence to be justified in believing that a dying person's request to be helped to die is competent, enduring and genuinely voluntary. The request to die may not reflect an enduring desire to die. Even advocates of voluntary euthanasia have argued that normally a cooling off period should be allowed. We can

never be justified in believing someone's request to die reflects a settled preference for death. This goes too far. If someone discusses the issue with others on different occasions, or reflects on the issue over an extended period, and does not waver in her conviction, her wish to die is surely an enduring one. There is a widespread belief that passive voluntary euthanasia, where life-sustaining or life-prolonging measures are withdrawn or withheld, is morally acceptable because steps are simply not taken which could preserve or prolong life and so a patient is allowed to die, whereas active voluntary euthanasia is not, because it requires an act of killing. The distinction, despite its widespread popularity, is very unclear. Whether behaviour is described in terms of acts or omissions which underpins the alleged distinction between active and passive voluntary euthanasia, is generally a matter of opinion and not of anything of deeper importance. Consider, for instance, the practice of deliberately proceeding slowly to a ward in response to a request to provide assistance for a patient who is subject to a ‘ not for resuscitation' code. Or consider ‘ pulling the plug' on an oxygen machine keeping an otherwise dying patient alive as against not replacing the tank when it runs out. Are these acts or omissions; cases of passive euthanasia or active euthanasia? More fundamentally, though, those who think some reliance can be placed on the distinction think that, at least in a medical context, killing is morally worse than letting die. Consider the case of a patient suffering from motor neurone disease who is completely respirator dependent, finds her condition intolerable, and competently and persistently requests to be removed from the respirator so that she may die. Even the Catholic Church in recent times has been prepared to agree in

cases like this one to the turning off of the respirator. Is this merely a case of letting the patient die? It is often said that even if motives and consequences are agreed to be in common, if someone's life is intentionally terminated she has been killed, whereas if she is no longer being aggressively treated her life is not ended by the withdrawal of such aggressive treatment but by the underlying disease. For the average person it really amounts to a personnal decision that can only be evaluate on a case by case concideration where the individual circumstances usually dicate the outcome. Bibliography • M. Burleigh, 1994, Death and Deliverance: Euthanasia in Germany c. 1900-1945 (Cambridge: Cambridge University Press). • J. Griffiths, A. Bood, and H. Weyers, 1998, Euthanasia and Law in The Netherlands (Amsterdam: Amsterdam University Press). • H. Kuhse, P. Singer, P. Baume, A. Clark, and M. Rickard, 1997, " End-of-Life Decisions in Australian Medical Practice", The Medical Journal of Australia 166, pp. 191-196. • A. McIntyre, 2001, " Doing Away With Double Effect", Ethics 111, pp. 219-255. • J. Rachels, 1986, The End of Life: Euthanasia and Morality (Oxford: Oxford University Press). • G. van der Wal, P. J. van der Maas, J. M. Bosma, B. D. Onwuteaka-Philipsen, D. L. Willems, I. Haverkate and P. J. Kostense, 1996, " Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands", The New England Journal of Medicine 335, pp. 1706-1711. • E. Winkler, 1995, " Reflections on the State of Current Debate Over Physician-Assisted Suicide and Euthanasia", Bioethics 9, pp. 313-326. • R. Young, 1976, " Voluntary and Nonvoluntary Euthanasia", The Monist 59, pp. 264-283.