Biomedical ethics - 30 March + 1 April: EUTHANASIA

1. Definitions of euthanasia;
2. The historical context for the emergence of the euthanasia debate;
3. Euthanasia and patient's consent;
4. Active and passive euthanasia;
5. Two arguments for or against active and voluntary euthanasia.

Davide Vecchi - Centro de Filosofia das Ciências da Universidade de Lisboa (CFCUL), Faculdade de Ciências da Universidade de Lisboa

dvecchi@fc.ul.pt

1.1 Definitions of euthanasia

Euthanatos = “easy death” in Greek.

It is instructive to consider dictionary definitions of euthanasia:

1. *The painless **killing** of a patient suffering from an **incurable and painful disease** or in an irreversible coma* (Apple dictionary).

2. *The **act of killing someone** who is **very ill or very old** so that **they do not suffer any more*** (Cambridge Dictionary).

3. ***Termination** of a very sick person's life in order to **relieve them of their suffering*** (http://www.bbc.co.uk/ethics/euthanasia/overview/introduction.shtml).

1.2 Definitions of euthanasia

The above definitions make reference to:

1. The nature of the condition affecting the patient: a painful and incurable illness.

Most legislations are restrictive in the sense that euthanasia is allowed if and only if the illness is terminal and the prospects of medical intervention (e.g., a new cure) are unlikely. Thus, not only existential suffering (e.g., severe depression) is generally not a sound basis for requesting euthanasia, but even suffering from conditions that are not terminal is not considered enough (e.g., “locked-in” syndrome).

2. The aim of euthanasia: the patient’s relief from pain.

Thus, utilitarian arguments in favour of the right to die are obviously important.

1.3 Definitions of euthanasia

<u>3a. The nature of the euthanasia relationship: between patient and medical practitioners.</u>

The form of euthanasia can be characterised by focusing on the **<u>patient</u>** and the **<u>level of expressed consent</u>** towards euthanasia.

Voluntary euthanasia occurs at the request of the person.

Non voluntary euthanasia occurs when the person is unable to make a competent choice, delegating another person to decide on her/his behalf.

Involuntary euthanasia occurs when the person chooses life but dies anyway.

1.4 Definitions of euthanasia

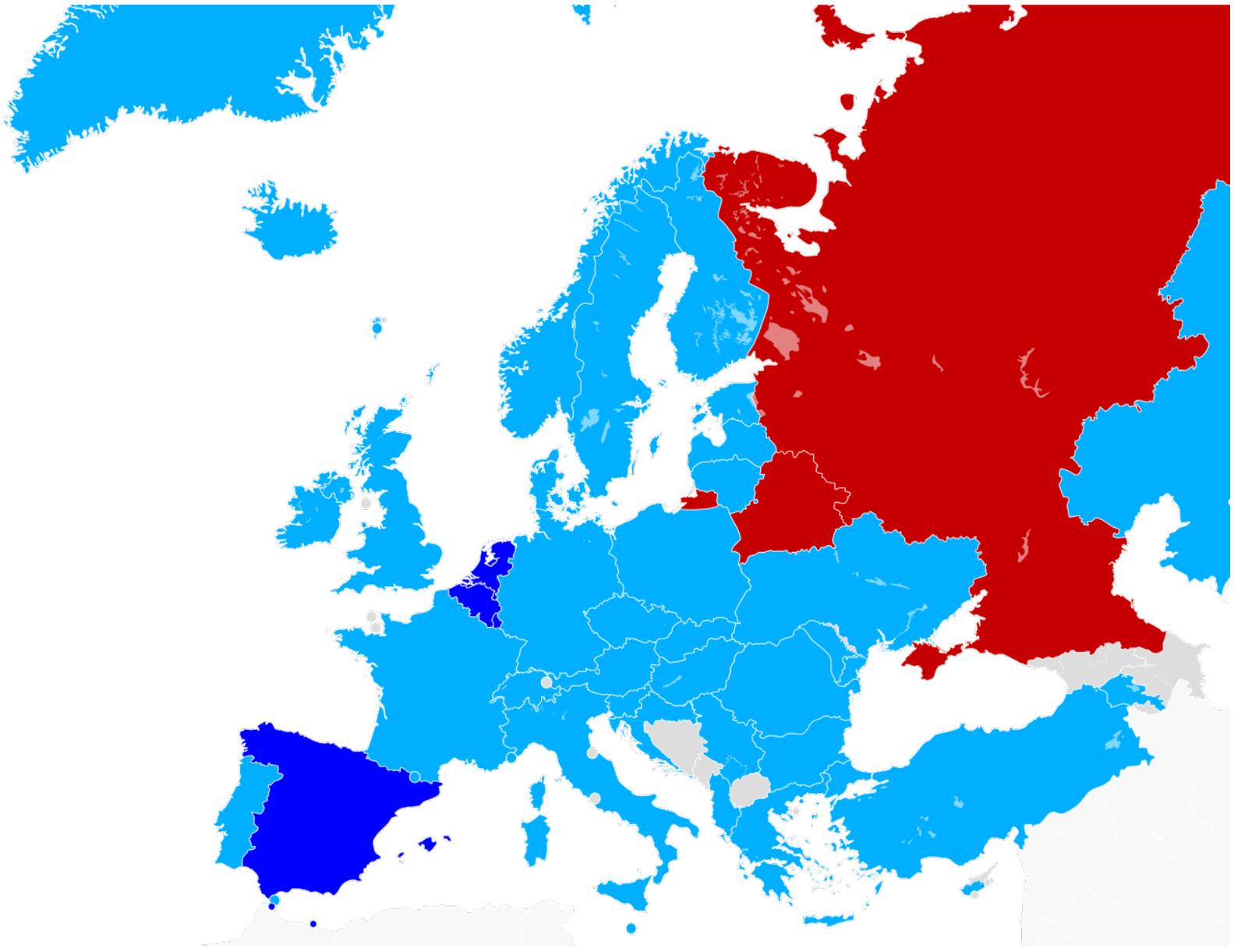
<u>3b. The nature of the euthanasia relationship: between patient and medical practitioners.</u>

The form of euthanasia can also be characterised by focusing on the **<u>nature of the medical intervention involved</u>**.

In **active euthanasia** a medical practitioner directly and deliberately causes the patient's death. Brought about by an **<u>act</u>** (e.g., an overdose of pain-killers). Sometimes called “mercy killing” (note the “killing”).

In **passive euthanasia** a medical practitioner doesn't directly take the patient's life, but allows the patient to die. Passive euthanasia can be performed by withdrawing/removing/taking away treatment (e.g., switching off a mechanical respirator) or by withholding/refusing treatment (e.g., by not administering antibiotics). Brought about by **<u>omission</u>**.

1.5 Definitions of euthanasia



Current status of euthanasia in Europe: Active voluntary euthanasia is legal
Passive euthanasia is legal Euthanasia is illegal Euthanasia status unknown

1.6 Definitions of euthanasia

<u>The current debate in Portugal is about the legality of active and voluntary euthanasia. This is because some forms of passive euthanasia are legal.</u>

Two crucial questions we shall tackle today:

1. One issue pertains to understanding the **nature of patient's consent** in the euthanasia debate (section 3);

2. Another crucial issue concerns the **distinction between active and passive forms of euthanasia** (section 4).

Before moving to these issues, we shall first consider the historical context that led to the emergence of the current debate.

2.1 The historical context

Plato: suicide is disgraceful and its perpetrators should be buried in unmarked graves.

However, there exist four exceptions:

(1) when one's mind is morally corrupted and one's character can therefore not be salvaged (Laws IX 854a3–5);

(2) when suicide follows a judicial order (e.g., Socrates drinking poison);

(3) when suicide is compelled by extreme and unavoidable personal misfortune;

(4) when suicide results from shame at having participated in grossly unjust actions (Laws IX 873c-d).

Plato, Laws, 2 vols., R.G. Bury (trans.), New York: G.P. Putnam's Sons, 1926.

2.2 The historical context

Aristotle (Nicomachean Ethics) argues that suicide does not amount to treat oneself unjustly so long as it is done voluntarily (for the reason that the harm done to oneself is consensual, by definition).

However, he concludes that suicide is somehow a wrong to the community, though he does not outline the nature of this wrong or the specific vices that suicidal individuals exhibit.

Aristotle, c. 330 BCE, Nicomachean Ethics (1138a5–14), Roger Crisp (trans.), Cambridge: Cambridge University Press, 2000.

2.3 The historical context

The Platonic and Aristotelian negative view of suicide changes with the advent of stoicism:

"*When a man's circumstances contain a preponderance of things in accordance with nature, it is appropriate for him to remain alive;* ***when he possesses or sees in prospect a majority of the contrary things, it is appropriate for him to depart from life****.... Even for the foolish, who are also miserable, it is appropriate for them to remain alive if they possess a predominance of those things which we pronounce to be in accordance with nature*." (Cicero, III, 60–61).

Cicero, 45 BCE, De Finibus, H. Rackham (trans.), London: William Heinemann, 1914.

2.4 The historical context

St. Thomas Aquinas defended the prohibition of suicide on three grounds:

(1) Suicide is contrary to natural self-love;

(2) Suicide injures the community of which an individual is a part;

(3) Suicide violates our duty to God because God has given us life as a gift and in taking our lives we violate God's right to determine the duration of our earthly existence (Aquinas 1271, part II, Q64, A5).

Aquinas, St. Thomas, 1273, Summa Theologica, in Basic Writings of Saint Thomas Aquinas, Anton Pegis (ed.), New York: Random House, 1945.

2.5 The historical context

Both Plato and Aristotle do not consider well-being or the rights of the person but only their social role and obligations.

For stoics, quality, not only quantity, of life matters. A morally virtuous person recognises that the lack of well-being is a justifiable ground for suicide.

By elaborating on the tradition set by Plato and Aristotle, St. Thomas Aquinas provides the foundation of the position of the Catholic Church:

1. suicide is a violation of self-preservation, which is the basis of biological self-maintenance;

2. suicide harms family and society at large;

3. suicide is an act against God because life is God's gift, hence sacred.

2.6 The historical context

The position of the Catholic Church is still influential. However, suicide is not considered anymore illegal in many European countries.

Furthermore, there's a clash between Christian religious ethics and stoicism.

What is a meaningful life? How should we characterise **well-being**? Being physically healthy, fully competent, fully conscious are surely necessary conditions. Being autonomous and not relying on others is another important aspect.

The concept of well being has become even more important given the tremendous developments of medical technologies for extending life expectancy.

2.7 The historical context

Medical definitions of death have changed through time because technological advances have led to different ways to characterise the concept of death.

In the past, human death was conceptualised unproblematically as a punctual event, generally cardiopulmonary failure.

Death df. = cardiopulmonary failure.

But technological advances have changed the definition of death: "*With the invention of mechanical respirators in the 1950s … it became possible for a previously lethal extent of brain damage to coexist with continued cardiopulmonary functioning, sustaining the functioning of other organs. Was such a patient alive or dead?*" DeGrazia 2016.

2.8 The historical context

Other definitions of death centre on brain function.

First option: **Death** df. **= irreversible cessation of the capacity for consciousness**.

Grounded on distinction between vegetative state and brain death: *"Reference to the capacity for consciousness indicates that individuals who retain intact the neurological hardware needed for consciousness, including individuals in a dreamless sleep or reversible coma, are alive. One dies on this view upon entering a state in which the brain is incapable of returning to consciousness*." DeGrazia 2016.

Being in a reversible vegetative state is not necessarily brain death.

2.9 The historical context

When it was discovered that the brainstem regulates basic physiological functions, it was possible to change the definition of death as to focus on brain-death:

Second option: **Death** df. **= brainstem failure** (the benchmark of legal death in many jurisdictions).

Thus, the state of death can be indicated by different organs' failure (e.g., heart, lungs, brain) and can be characterised differently with respect to the function of the same organ (e.g., as irreversible vegetative state and as brainstem failure).

2.10 The historical context

The regulation of the use of medical technologies (better palliative care, artificial life support such as respirators, dialysers, defibrillators etc.) has thus become paramount because, while such technologies can sustain bodily functions for a longer period of time, they also potentially increase patients' suffering and pain:

"*One of the nagging ironies of modern medicine is that while it has enormously extended life spans, it has also stretched out the dying process*." (Horgan, J. 1997, quoted in Pollard, I. 2009, p. 140)

2.11 The historical context

One reason for this regulation goes at the very heart of aim of medicine, particularly end of life care: what is the aim of medical practice aided by medical technologies? Is it preserving life at all costs with all available technologies or preservation of a meaningful life?

The Hippocratic oath founds the deontology of the medical profession: *“I will use those dietary regimens which will benefit my patients according to my greatest ability and judgment, and **I will do no harm or injustice to them**. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course*.”

https://www.loebclassics.com/view/hippocrates_cos-oath/1923/pb_LCL147.299.xml;jsessionid=00D156BCCA515D892BE2868A2463A715

2.12 The historical context

Because of technological developments, medical practitioners today inevitably face more complex end of life choices: where does the threshold between preserving life and abuse of medical authority lie?

In the past, “medical paternalism” was rife: doctors were often making decisions for the patient (see Cardoso et al. 2003 for a relatively recent example concerning Portugal).

There is a growing need for means to establish whether a medical intervention is an instance of over-treatment, for determining what level of intervention is morally acceptable.

As you can imagine, such determination should take into consideration the subjective experience of the patient.

2.13 The historical context

The patient's control on the end of life process is linked to a dignified dying process:

"*Because of the complexities of modern medicine, the sick, the frail or those in advanced old age are experiencing additional anxiety as they wonder whether they have lost the right to an earlier easier death, in harmony with human dignity*." Pollard 2009 p. 139

There is a growing need for patients to control the dying process in the face of changing attitudes towards suicide and the possibility, on the part of medical practitioners, to abuse the additional power they have on the end of life process given to them by medical technologies.

3.1 Euthanasia and patient's consent

An important tool to protect the rights of patients are **advance directives.**

For instance, in Portugal people have the right to refuse life-sustaining treatments (Lei 15, 21.03.2014, Artigo 3º, nº 2; https://dre.pt/home/-/dre/571943/details/maximized).

In addition to this, in many countries (including Portugal, Lei 25, 16.07.2012; https://dre.pt/pesquisa/-/search/179517/details/normal?q=Lei+n.º%2025/2012+de+16+de+julho) people can write a "living will" where they state what kind of medical treatment they expect in determinate future circumstances (e.g., ending up in vegetative state).

3.2 Euthanasia and patient's consent

In the case of legally competent patients, there is thus often the possibility, through advance directives, to refuse life-sustaining treatment and instruct medical practitioners to comply with specific patients' choices.

These are cases of **voluntary** and **passive** euthanasia:

1. voluntary because the choice is left to the patient instead of being taken by others;

2. passive because medical practitioners are merely instructed to withdraw or withhold treatment (see slide 1.5 and section 4).

3.3 Euthanasia and patient's consent

The practical need of regulating medical practitioners' behaviour (and power) is even more apparent when non voluntary forms of passive euthanasia are concerned.

When medical practitioners ask relatives to withdraw or withhold treatment or, in even more extreme situations, when medical practitioners directly decide to withdraw or withhold treatment in consultation within themselves and without asking relatives, we are facing, technically speaking, cases of non voluntary euthanasia.

These cases might be common. For instance, physicians used to take a disproportionate share of "do-non-resuscitate" decisions unilaterally back in 2003, involving patients just 9% of the times and relatives just 11% of the times (Cardoso et al. 2003)

3.4 Euthanasia and patient's consent

Voluntary and non voluntary forms of (passive) euthanasia already happen in medical contexts.

Advance directives fill a vacuum in this sense, releasing medical practitioners from legal responsibility (as well as limiting their power to intervene and decide for a patient's life) and giving a choice to patients for determining the path of their end of life process.

But in the cases of incompetent patients who have not or even cannot express their will through advance directives (from patients in vegetative state to those in advanced state of dementia to seriously disabled children and adults), the ethical, political, legal and medical complexity of the euthanasia debate remains intact.

3.5 Euthanasia and patient's consent

Patient's consent level

High ← Low

Euthanasia form	Voluntary Advance directive	Involuntary Consent to euthanasia denied	Non voluntary Consent not expressed by patient	Non voluntary Patient's incompetence but substituted judgment	Non voluntary Patient's incompetence but no substituted judgment
Active	**Under review**	Killing	Killing ?	Killing ?	Killing ?
Passive	Ok	Practiced at end of life care?	Practiced at end of life care but problems	Practiced at end of life care but problems	Practiced at end of life care but problems

Legalisation of active and voluntary euthanasia is at issue. Passive voluntary euthanasia is already legal.

4.1 Active and passive euthanasia

Committing suicide is not euthanasia, but any form of medical intervention leading to the death of the patient might be considered in a sense a form of assisted suicide.

However, active and passive euthanasia are legally distinguished, with the former often being considered as an ***act*** of killing while the latter is just ***omission*** or letting die.

This juridical distinction, however, is philosophically controversial.

Is there a morally significant difference between active and passive euthanasia?

4.2 Active and passive euthanasia

Consider a terminally ill patient in a hospital setting refusing nutrition and hydration.

If the patient were able to refuse nutrition and hydration without medical intervention, it would be suicide.

However, given that the patient will need the collaboration of medical staff, this is technically a form of assisted suicide because not force-feeding a patient, as you surely understand, is a kind of medical intervention.

You may quibble that it is rather lack of intervention or omission; but medical practitioners know that by not intervening, by not force-feeding, the patient will die.

4.3 Active and passive euthanasia

Medical intervention level

High

Active	Lethal injection performed by physician
	Preparing lethal injection performed by patient
	Terminal sedation performed by physician
	Withdrawing treatment: switching off respirator
	Withdrawing treatment: not replacing oxygen supply
	Withholding treatment: refusing antibiotic medication
	Withholding treatment: not dispensing nutrition and hydration
Passive	Delaying intervention on purpose

Low

Medical interventions can be graded along a continuum and there's probably no absolute distinction between active and passive euthanasia: if I don't water my plant, I cause the death of the plant; if I fail to help a person after an accident, I might cause the death of a person; but if I switch off a respirator (of a consenting patient), I do not cause the death of the patient but I simply let the patient die.

4.4 Active and passive euthanasia

Rachels (1975) has argued that between active and passive euthanasia there is no moral difference.

First argument: no moral distinction between killing and letting die.

Rachels argues that letting someone die when it would be possible to save someone's life is not less morally reprehensible than killing someone directly.

Suppose I want to teach bioethics alone next year and plan to kill Professor Jorge. Consider these two possibilities:

1. I kill Jorge directly in the middle of the night;

2. I go to the beach with Professor Jorge and, while he is accidentally drowning, I omit to save him and let him die.

According to Rachels, the two actions are equally deplorable.

4.5 Active and passive euthanasia

How does this apply to euthanasia?

Because, Rachels continues to argue, both giving a lethal injection to a patient (as in active euthanasia) and withholding treatment to a patient (as in passive euthanasia) are acts that ***intentionally aim to terminate the life of the patient*** (like not watering the plant and failing to assist a person involved in a car accident, slide 4.3 or not saving Prof. Jorge slide 4.4).

If it has already been agreed (by patient, family and medical staff) that it is desirable to terminate a patient's life, then it has already been decided that in this case death is no greater evil than the patient's continued existence.

Thus, under these conditions, there is no reason to morally prefer letting the patient die instead of killing the patient directly.

4.6 Active and passive euthanasia

A second argument Rachels uses is that active euthanasia is in some cases more humane than passive euthanasia.

Consider this situation:

1. a patient is dying of incurable cancer of the throat;

2. the patient is in terrible pain;

3. this pain cannot be alleviated;

4. the patient is certain of dying within a few days even if the treatment to which he is subjected is continued.

Suppose the patient asks the doctor to die and that his family joins in the request.

4.7 Active and passive euthanasia

In this case, merely withholding treatment (e.g., a form of passive euthanasia) will generate more suffering than giving a lethal injection (i.e., a form of active euthanasia):

"*… once the initial decision not to prolong his agony has been made, active euthanasia is actually preferable to passive euthanasia, rather than the reverse.* ***To say otherwise is to endorse the option that leads to more suffering*** *rather than less, and is contrary to the humanitarian impulse that prompts the decision not to prolong his life in the first place.*"

What kind of argument is it?

5.1 A version of the argument in favour of active and voluntary euthanasia

1. The greatest happiness principle of moral conduct should guide our action (cf. slides section 2 in class 3 of the Introduction to Moral Philosophy).

2. On the balance, poor quality of life due to incurable illness causes a decrease in aggregate happiness because it causes a great amount of suffering and pain (to the individual human as well as to her/his family) and no significant pleasure on the moral community.

3. Hence, every individual human should be allowed the right to active and voluntary euthanasia due to incurable illness whenever it increases aggregate happiness.

Thus, society should protect the right to die of patients in case of poor quality of life and regulate active and voluntary euthanasia.

5.2 A version of the argument against active and voluntary euthanasia

1. Suppose voluntary euthanasia in the case of terminally ill patients is legalised.

2. All health systems possess limited resources and doctors have to prioritise treatment of certain conditions, saving resources whenever possible. Palliative care costs in the case of all patients with no improvement of quality of life in sight are a “waste” of limited resources.

3. Terminally ill patients are not the only category of patients with no improvement of quality of life in sight (e.g., mentally incapacitated infants and adults).

Thus, in the cost-reducing and profit-driven environment in which we live, allowing voluntary euthanasia will lead us on a slippery slope towards extreme forms of voluntary euthanasia* and non-voluntary forms of euthanasia extended to non-consenting mentally incapacitated infants and adults, etc.**

* See the Noa Pothoven’s case in the Netherlands.

**See Onwuteaka-Philipsen et al. 2012.

Primary resource:

Rachels, J. 1975. Active and Passive Euthanasia. New England Journal of Medicine 292(2):78-80.

Additional resources used:

1. Pollard, I. Bioscience ethics. Cambridge: Cambridge University Press (pp. 135-144)

2.http://www.bbc.co.uk/ethics/euthanasia/

3.https://plato.stanford.edu/entries/suicide/

4. https://plato.stanford.edu/entries/death-definition/

5. Cardoso, T. et al. 2003. Life-sustaining treatment decisions in Portuguese intensive care units: a national survey of intensive care physicians. Critical Care 7:R167-R175 (DOI 10.1186/cc2384)

6. Onwuteaka-Philipsen, B. et al. 2012. Trends in end-of-life practices before and after the enactment of the euthanasia law in The Netherlands from 1990-2010: A repeated cross-sectional survey. The Lancet 380: 908–915.