

Is there a place for voluntary active euthanasia in modern-day medicine?

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Keywords: euthanasia, voluntary active euthanasia, physician-assisted suicide, death

Abstract

This article discusses various ethical and legal concepts regarding euthanasia and includes notions such as physician-assisted suicide, assisted suicide, voluntary active euthanasia, killing versus letting die, indirect euthanasia and terminal sedation. Is there a difference if death is foreseen, but not intended? This article opens up the debate and addresses pertinent issues for the family practitioner.

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Introduction

Euthanasia is usually defined as a good (“eu”) death (“thanasia”). To be good, death should be desired and it ought to be peaceful and painless. The concept of euthanasia does not apply to a person who slips away peacefully and painlessly without any intervention after a fulfilled life, because euthanasia involves an intervention by the person, or by a person acting on his or her behalf, to hasten a wanted death. The word euthanasia has three meanings: a quiet and easy death, the means of procuring it, and the action to induce this. What is missing is the exclusion of the good of the person whose death is in question and the fact that the death is desired for that person’s sake. Euthanasia cannot be morally justified unless it benefits the person who dies.¹

Discussion

Euthanasia is classified according to four criteria: “voluntary” versus “involuntary”, and “active” versus “passive” involvement. What might be confusing is that in The Netherlands, the term “euthanasia” is no longer further specified because it means voluntary active euthanasia, which is legal, as opposed to physician-assisted suicide, which is illegal.² According to the subclass, euthanasia has various ethical and legal implications. Some forms are only tolerated, i.e. they are not legally permissible, but not subject to prosecution in some countries, while they are legal in others. To date, most countries have not legalised any form of euthanasia. From an ethical vantage point, most of the debate centres on the active (commission) and passive (omission) dilemma, or killing versus letting die.³ Killing involves causing the intentional and unjustifiable

death of another, or taking the life of a person who does not wish to die.^{4,5} Some argue that what matters is not the manner of causing the death (omission or commission), but the circumstances in which the death is caused.⁶ Others insist that there is a morally fundamental difference between omission and commission and between killing and letting die.⁷

Voluntary active euthanasia refers to a clearly competent patient making a voluntary and persistent request for aid in dying.⁸ In this case, the individual or a person acting on that individual’s behalf (the physician or lay person, according to the law of the country) takes active steps to hasten death.⁹ That active step can be either the provision of the means, i.e. a lethal drug for self-administration orally or parenterally, or administration by a tier. The provision of the means to die is called assisted suicide, assistance in dying, or physician-assisted suicide. The patient acts last. In the case of voluntary active euthanasia, the assistant acts last. Doctor Jack Kevorkian’s (dubbed “doctor death”) “Mercitron” is an example of assisted suicide. The contraption is attached to the incumbent who initiates the delivery of the lethal drug. In the case of voluntary active euthanasia, the lethal drug needs to be administered by an assistant because the incumbent is physically unable to proceed unaided. In both circumstances, the individual expresses a competent and voluntary wish to die, and the conditions that would make it acceptable to allow or assist a suicide need to be satisfied. In both cases, the aim is to spare that person pain, indignity and emotional and financial burdens. Yet suicide is seen to be morally reprehensible, but is not prohibited by any law, while voluntary active euthanasia is illegal in most countries, and is the object of conflicting and polarised moral debate.

Patient-assisted suicide involves an affirmative act, such as writing a prescription, or providing the lethal drug. Voluntary active euthanasia requires the acts of providing and administering the lethal drug. In the case of patient-assisted suicide, the individual who wishes to die commits the final act, while in voluntary active euthanasia, because that individual is unable to pose the last act, a proxy acts on his or her behalf. The difference relates to the person who acts last. The intention and motivation are the same. Therefore, it could be debated whether the distinction is not hypocritical hair-splitting. It calls to mind the omission and commission debates, and the doctrine of double effect.

The doctrine of double effect states that for an action with two consequences, one good and one bad, to be morally permissible, the bad consequence may be foreseeable but not intended, and the bad cannot be used to achieve the good. The Dutch debate about indirect euthanasia illustrates the point. "Terminal sedation" is legally permissible. It consists of administering large oral doses of barbiturates to induce coma, followed by a neuromuscular blocking agent to cause death on the request of patients who wish their death to be hastened.² Death is foreseen, and in fact wished for by the incumbent, but not intended. Furthermore, the incumbent takes the first step actively. The second step inevitably requires the active intervention of an assistant. So, here we have two actors with the same motives. Both foresee the result. To claim that it is not intended is sheer casuistry.

Many bureaucratic procedures need to be overcome by those wishing to die. The main reason is to avoid the legendary "What if?" In spite of good evidence against it, the most commonly advanced reason is that of avoiding the slippery slope. For instance, in Switzerland, assisted suicide and voluntary active euthanasia have been tolerated (they are illegal, but not prosecutable if the assistant has

no hidden agenda) since 1918, and account for 0.45% of deaths (only a little more than the 0.3% in the Netherlands).¹⁰ The candidate has to activate the "death machine" or has to swallow the lethal drug. In other cases, the incumbent first ingests the drug, but the final blow is administered by a tier. The death is foreseen, but not intended. Who is the actor? What is active (commission) and what is passive (omission)? Removing a feeding tube is an act of commission, and since the intention is death, it is killing. Not pouring sustenance in the tube is omission, or letting die. The intention is the same, but the type of action is different. Does it really matter? As pointed out by Sullivan, the debate places the doctor at the centre, instead of the applicant.¹¹ It leaves out the good of the person who wishes to die.

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