

The Ethics of Ending Life: Euthanasia and Assisted Suicide, Part 1

The Language of Ending Life

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Last November, New Zealand forensic scientist Sean Davidson was sentenced to five months' detention for assisting a suicide. His crime? At the request of his 85-year-old terminally ill mother, he crushed up a bottle of morphine tablets, dissolved them in a glass of water, and handed it to her so that she could voluntarily drink it to end her life. The original charge of attempted murder eventually was reduced to counseling and procuring a suicide because of public outcry including the testimonial support of such luminaries as Bishop Desmond Tutu. Such stories are becoming increasingly common.

The moral limits of relieving suffering at the end of life, and where our responsibilities as physicians should lie, are more frequently debated as populations age and the diseases and disabilities of old age present increasing challenges. In the balance are crucial issues: personal autonomy, dignity, compassion, ending suffering, protection of the vulnerable, promotion of good palliative care, and redefinition of the role of the physician in death and dying. In the last 15 years, the Netherlands, Belgium, and three states (Oregon, Washington and Montana) have passed laws permitting physician-assisted suicide and/or euthanasia. In Switzerland, the law even permits assisted suicide by non-physicians. Debate about assisted suicide is currently in full swing in Great Britain, where prosecution of family members who have assisted desperate patients to travel abroad to commit suicide has elicited public outcry.

As moral dilemmas about ending life become increasingly common, physicians of all specialties will be confronted with questions from patients and their families, from our own friends and families, and from our legislators and the media. We need to know precisely what is meant by "assisted suicide" and "euthanasia," understand why some societies have legalized such actions, and anticipate what ethical questions remain to be answered. Part I of this discussion reviews common terminology and definitions relevant to assisted suicide and euthanasia, while Part II (to appear in the Spring 2012 *CSA Bulletin*) reviews ethical issues about ending life and details legislative differences regarding physician-assisted suicide and euthanasia in various countries.

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The term “euthanasia” comes from Greek roots *eu* (good) and *thanatos* (death). In modern usage, the term always refers to an act of killing that meets certain criteria described in this article. Not every killing is an act of euthanasia, but all euthanasia is killing. Furthermore, even though the Greek roots appear to imply moral “goodness,” the term “euthanasia” itself has no intrinsic moral value: an act of euthanasia may be moral or immoral depending on the context and on society’s values.

Suicide and Assisted Suicide

Suicide is “self-killing,” which may or may not require the aid of another person. “Assisted suicide” is a suicide that does require the aid of another person. In the United States, legally permitted suicide is almost always discussed in the context of physician-assisted suicide (for example, by writing a lethal prescription of barbiturates).

However, not every act *by* a physician is carried out *as* a physician. In Switzerland, for instance, any citizen can legally assist suicide, yet a Swiss physician cannot ethically assist a suicide *as* a physician but may do so as a *private* person. Indeed, it may be reasonable to assume that a suicide in which a physician provides aid that a non-physician would not have been able to provide *does* constitute physician-assisted suicide. Purchasing a gun for another person for purposes of suicide is assisting them, but does not constitute physician-assisted suicide even if the purchaser is a physician. Almost any citizen can provide the service. However, writing a prescription is a privilege afforded to physicians and only a few other allied health professionals, such as some nurse practitioners and some physician assistants. Prescriptive assistance by a physician in a suicide requires that the physician use his or her unique privileges as a physician, and therefore this does constitute physician-assisted suicide.

Euthanasia

Euthanasia *always* requires the act of another party. When more than one person is involved in a sequence of actions that results in death, then that death is termed a suicide when the last person who acts in the sequence is the one who dies. If the last “actor” is someone other than the one who dies, the death is termed a homicide (one human being killing another), even if the person who dies agreed to it.

Euthanasia always involves a special *motive*. Intentions are the specific goals and desired outcomes of an act; “motives” are the reasons for which we have those intentions. In the case of euthanasia, the motive always is required to be *mercy*, and the core value supporting that motive must be *altruism*. This concept is so engrained in our society that euthanasia often is referred to as

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“mercy killing.” Harold Shipman, a British physician and serial killer, committed murder and not euthanasia when he injected elderly patients with lethal doses of narcotics so that he could inherit money left to him in their wills. Even if his actions actually relieved suffering in some, his motive invalidates a claim of euthanasia.

When is a homicide considered euthanasia? The term “euthanasia” implies a “good” death, and therefore the act should meet commonly agreed criteria for “goodness.” Such criteria may be that it is swift, relatively painless, and causes minimal if any psychological suffering, such as fear, anguish or deep regret. The death should not intentionally inspire horror or revulsion, nor be accompanied by signs of suffering from the dying person. The motive should not be to punish. Beheading, for example, might be swift and even relatively painless, but because it is usually intended to inspire horror in victims and witnesses alike and to punish the recipient, then it would generally not be considered an act of euthanasia.

“Passive” Euthanasia: A Problematic Term

Intention and *foresight* are critical aspects in both the moral and the legal considerations of whether an act constitutes euthanasia, represents another kind of homicide, or is even an act of killing at all. Euthanasia and suicide both require the primary *intention* of causing death. *Foresight* involves conceiving of possible outcomes, some of which we may neither desire nor intend. Certain acts can be reasonably foreseen to result in death, but may nevertheless be committed primarily for reasons other than death.

One example is discontinuing medical treatments at the request of an autonomous patient. Patients have the legal right in the U.S. to say what will be done to them, and in withdrawing such treatments we not only respect their autonomy, but obey the law. Because our intention is to respect autonomy and not to kill, withdrawal of medical treatments under those circumstances is neither suicide nor euthanasia, and it does not even constitute killing because death is *not* the primary intention even though it is a foreseen result. Some authors use the term “passive euthanasia” to describe withdrawal of life-sustaining treatments when death is a virtually certain outcome, but not the primary intention.

Karen Ann Quinlan survived nine and a half years after her parents won the legal right to end her ventilator therapy. Her parents commented that their intention had never been to *kill* Karen, but rather to allow her to live her life, however shortened it might turn out to be, without the indignity of unwanted therapy. The law itself recognizes the crucial difference between intention and foresight: premeditated (intentional) murder is punished differently from

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negligent homicide (carelessness or negligence that results in a death that might be predictable, but isn't intended). The *primary and necessary intention* of euthanasia is *always* to cause death. Without that primary intention the act is not euthanasia.

The term "passive euthanasia" is therefore problematic. In the first place, euthanasia is an act, and therefore it cannot be passive. The term is further misleading in that it confuses foresight with intention. For these reasons "passive euthanasia" is a term that often confuses rather than enlightens and should not be used.

Competence, Autonomy and Voluntarism in Euthanasia

Patient voluntarism is not necessary for euthanasia. Patients who are incompetent and non-autonomous as a result of medical conditions, or who never were competent or autonomous due to age or other medical issues, may nevertheless be suffering in ways in which a merciful death is desirable, even though they cannot ask for it or agree to it. Yet if a patient is competent to make decisions, killing them against their will violates other necessary criteria for euthanasia (kindness, mercy, preservation of dignity, and avoidance of distress). Furthermore, euthanizing a patient who is capable of making a decision and refuses euthanasia is prohibited by other primary ethical principles, such as respect for autonomy, beneficence and nonmaleficence.

Some authors have coined yet other terms such as "voluntary euthanasia" for patients who are competent and agree to be euthanized; "non-voluntary euthanasia" for those who have never been competent; and "involuntary euthanasia" for which a competent or previously competent patient's wishes are unknown. While commonly used, these terms add nothing to a simpler definition of euthanasia (as a morally neutral term) that requires, in the case of competent patients, that their permission be obtained and, in the case of incompetent patients, that deliberation is undertaken by the appropriate surrogate decision-makers and after review of the patient's advance directive, if available.

"Physician Aid-in-Dying": A Term of Uncertain Meaning and Limited Value

In the theater of political debate, terminology is often used to polarize or to unite. When the debate involves such a fundamentally morally uncomfortable concept as whether certain forms of killing should be legalized, one might expect that vocabulary will develop to enable comfortable discussion, or to ignite debate. However, it is important to understand that such political terms often have little moral, ethical, or medical meaning and not only may not add

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to, but may even obfuscate, our understanding of underlying issues. “Physician aid-in-dying” is one such term, because it is ambiguous and encompasses a host of morally *dissimilar* actions while simultaneously implying that those actions are morally the same—and therefore should be treated similarly.

“Aid-in-dying,” for example, could include such diverse actions as sitting at the bedside and holding the hand of a dying patient, administering medications to relieve symptoms such as pain, discontinuing life-sustaining medical interventions, providing a lethal prescription for a patient to take voluntarily, or injecting a non-autonomous or incompetent patient with a lethal medication. These acts are morally dissimilar, and yet the term might imply that they can be discussed, understood, and managed as though they were morally the same. Discourse about legalized killing can be uncomfortable, but debating “aid-in-dying” as a morally equivalent group of actions is impossible. Whenever ethical debate is held regarding the ending of a life, vocabulary that is sufficiently procedurally and morally specific should be employed to facilitate meaningful discussion and avoid confusion. The term “aid-in-dying” is far too vague and associates too many ethically diverse actions to be truly useful or enlightening in either political or medical discussion.

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For Further Reading

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