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Euthanasia: A Medical Act to Relieve Pain and Suffering

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Abstract | Euthanasia is a medical act aimed at causing death to remove any pain. It consists in the intention of the will and in the procedures applied. It wants to remove the pain by intentionally interrupting a person's life, and appropriate means are used for that. Euthanasia, also called mercy killing by some, is a procedure by which a terminally ill person is knowingly and intentionally killed in a situation where his or her quality of life has fallen below human level due to severe pain or complete lack of consciousness.

Key Words: Euthanasia, Patient, Medicine, Ethics, Law

INTRODUCTION

Caring for people when the end of their life is approaching combines many of the legal, moral and ethical debates of our time [1]. The rise of the hospice movement, the acceptance of the idea of death with dignity and the care of the dying as a speciality have all made their contribution to legal and ethical issues related to the dying client. Some of the legal issues relating to the care of the dying are outlined and broadly related to the care situation. As medical science advances, a thin line is developing between those who are being prevented from dying and those who are being prevented from living, creating a legal and ethical maze for health care personnel. It is also necessary to consider the situation of those who have attempted to take their own life and the attitude of the law towards suicide.

Euthanasia

In modern health care, euthanasia has become one of the controversial issues of our time, being closely linked to the law of homicide [1]. One definition of murder is that 'there must be an unlawful killing of a human being under the Queen's peace with malice aforethought the victim dying within a year and a day'. It is possible then that the prescription and administration of lethal drugs or substances, if given deliberately to end the client's life, could be liable to investigation as murder. A slightly lesser offence under the law is termed 'manslaughter' and is divided into two areas: voluntary and involuntary. Voluntary manslaughter relies on the presence of provocation or diminished responsibility at the time of the offence. Involuntary manslaughter is when the client dies as a result of an act done intentionally but not necessarily with the aim of causing death. Involuntary manslaughter may also be a result of gross negligence.

The treatment and care of those with a terminal illness often involves high doses of pain-killing drugs - analgesics - the storage and prescription of which are covered by the Misuse of Drugs Act 1971 and its most recent Regulations. Drugs named in the Schedules of the Regulations are often described as 'controlled' drugs and are the drugs implicated in addiction and abuse, although they are used therapeutically for the control of severe pain. Regulations concerning these drugs are stringent in terms of their storage, their administration and the associated record-keeping. In hospitals, these drugs are kept in a locked cupboard inside another locked cupboard, the keys to which are held by the registered nurse in charge of the ward. The situation in the community will be dependent on the setting in which care is being delivered, for example a nursing home where security for medicines will resemble that of the hospital, or the client's own home where such measures may not be possible. In a nursing home, the registered nurse in charge at the time will be responsible for all drugs

including the controlled drugs, and the nurse's actions are governed both by the Misuse of Drugs Act 1971 (1985 Regulations) and the UKCC Code of Professional Conduct (1992) in the same way as for a nurse employed in a hospital.

Euthanasia is literally translated from the Greek as 'good death' [2]. Some classifications exist, and it is probably worth going over the different ways the phrases are used, even though some of them are nonsensical categories. The first distinction is between so-called 'passive euthanasia'—where death results from the withdrawal of treatments—and 'active euthanasia'—where a drug is given with the intention of hastening death. The withdrawal of treatment is sometimes in the patient's best interests, and is not viewed as euthanasia in UK law.

In addition, a distinction is sometimes made between 'voluntary' euthanasia—where the individual has made the request; non-voluntary euthanasia—where a person is unable to give their consent but has previously expressed a wish to die if he or she was in that state (e.g. those in a vegetative state); and 'involuntary euthanasia'—where a person does not want it, in which case it is murder under any definition. The distinction between 'voluntary euthanasia' and 'assisted suicide' is that the final action—of drinking a medication, or triggering a mechanism that will inject a medication—needs to be taken by the individual wishing to die in assisted suicide. If another individual does the act—even if requested explicitly by the patient—it is euthanasia.

In the current law in the UK all 'active' euthanasia is regarded as either manslaughter or murder and is punishable by law, with a maximum penalty of up to life imprisonment.

Euthanasia, the intentional ending of a patient's life, must be distinguished from letting the patient die [3]. If the intention of the agent in withholding treatment is not to kill the patient but to relieve the patient of the suffering caused by a procedure that has become too painful or is ineffective, then we are dealing with a different type of conduct, an omission that is rightly described as "letting die." From a moral point of view, as we shall see, there is also a significant difference between passive euthanasia and legitimate letting die.

The moral judgment on the different kinds of euthanasia, and on letting die, will follow a similar path to the one we trod in our discussion of suicide. When a physician engages in conduct that intentionally and actively seeks the death of the patient, there is a violation of nonmaleficence. The basic human good of life is attacked. Moreover, if the patient does not wish to die, the autonomy of the individual is also violated. This explains why involuntary euthanasia is almost universally rejected: it is a practice in which two basic moral principles are simultaneously violated. But does the fact that someone autonomously wishes to be deprived of the good of life make it morally permissible for the physician to comply with her wishes? Once again we encounter the limits of autonomy. Autonomy, as we have argued, does not guarantee morally right action. The physician must govern his actions primarily by the principles of beneficence and nonmaleficence. And in the presence of acute pain and suffering, these principles enjoin, first, medical treatment and, second, effective palliative care when recovery is no longer possible. The point is to attack what is bad in the condition of the patient (the illness and the pain, but not her life) and to let her die as peacefully as possible.

Limits to the power of medicine remain ethically important when the bright line is abandoned [4]. Although the goals of medicine arguably permit active euthanasia in some circumstances, they suggest limits on the appropriate use of this life-terminating medical practice. In view of the first goal of promoting and maintaining health, physicians should never agree to a request for active euthanasia from a healthy person. To comply with such a request would grossly violate the commitments to preserve life and promote health. Not only do healthy people lack any right to assisted death on request, but it would be wrong for physicians to comply, although it would not necessarily be a wrong to the requesting individual.

The patient's prognosis is relevant to the legitimacy of active euthanasia. The longer a patient may live, the more a life-terminating act conflicts with the goals of promoting health and avoiding a premature death. Limitation of active euthanasia to the terminally ill, however, would be arbitrary. If patients are suffering intolerably with no hope for relief, then a longer prognosis of continued suffering makes them worse off than those who are terminally ill. To be eligible for VAE (voluntary active euthanasia), patients should be incurably ill. Furthermore, in view of the resources of palliative care, VAE should be a last resort treatment, when the patient's persisting suffering cannot be relieved adequately by standard medical means. To be sure, sedation to unconsciousness is always possible; but, absent appeal to the sanctity of human biological life, it is hard to see a sedated existence pending death as preferable to a chosen death by active euthanasia for those who find their lives intolerable in the face of incurable illness. Incurably ill patients who request help in ending their lives before they reach a state of intolerable suff ering pose a greater challenge to professional integrity. For these patients, a clinician's pledge not to abandon the patient, coupled with an agreement to be available to consider this intervention when suffering becomes intolerable, may help to maintain (relative) health and serve to adequately relieve anticipatory distress.

The fine distinction between euthanasia and physicianassisted suicide involves the physician providing to the patient a lethal dose of medication, on the patient's request, with the intent to allow the patient to end his or her own life [5]. The patient independently must perform the final act. Physician assistance in dying may range from providing the patient with information about committing suicide to prescribing medication. Because the patient must carry out the deed, concerns about compelling a patient against his or her wishes and abusing the powers associated with being a physician and the physician's role are lessened, although still a potential consideration. Still, being relieved of the moral responsibility for the suicidal act does not relieve the physician of further moral responsibility in physician-assisted suicide. Each situation necessitates careful consideration of the intent, motivation, justification, and results of the decision. Again, as with most end-of-life decisions, discussion with the patient and his or her family is critical and allows for more effective and meaningful palliative care practices.

In practice, a physician is not, however, assisting with suicide if the physician is providing treatments to relieve pain and suffering even if the patient's death might be hastened. In such circumstances, the underlying illness, not the treatment provided or withheld, is the cause of the patient's death. The distinction between "killing" in the sense of euthanasia or PAS versus "allowing to die" in the sense of withholding or withdrawing care, or providing high doses of narcotics or sedatives to relieve pain but that also may result in patient death, is useful in practice.

PVS

PVS-patients (persistent vegetative state) still have the ontological status of being alive and deserving of the protection of the law, despite the absence of consciousness [6]. Whereas a stable new hyperblend, or mode of ordering, has emerged around potential heart-beating organ donors with dead brains, matters are quite different for people still in possession of a fully fledged autobio- graphical consciousness who wish to maintain control and a certain degree of self-direction over the time and manner of their death. With a few exceptions, physician-assisted suicide and euthanasia are illegal in most countries. Even national and professional guidelines that aim to regulate the use of palliative sedation for terminal, dying patients are quite restrictive. Criteria for this pharmacological reduction of consciousness in dying patients include intense and sustained suffering from physical symptoms that have been shown to be refractory to ordinary treatment. Arguing on the one hand that palliative sedation should be considered to belong to the repertoire of ordinary and legal medical treatments, these guidelines clearly mark, through restrictive safeguards, their distance from illegal practices of assisted suicide and euthanasia.

Despite the status of respect for a patient's autonomy as the first among the four principles of medical ethics, in texts of law, professional guidelines and codes of ethics, it is the much more restrictive cognitivist, frontal lobe notion of the human subject that has been inscribed. One problematic entailment of this is that it seems as if patients, in the face of death, cannot be trusted to know their own mind. The competence to make end-of-life decisions has been formally delegated and assigned to physicians, reducing the patient's autonomy into a right to be heard. Respect for the patient's autonomy has been made conditional upon health-care professionals assessment of a patient's cognitive capacity to give informed consent, applying criteria derived from the same truncated cognitivist frontal lobe notion of human subjectivity and personhood. In practice, critically ill and dying patients in health-care settings are often dependent on the generosity of physicians and other health-care professionals. That is, they depend on health-care professionals' understanding of legal regulations and guidelines in combination with their own understanding of the discretionary space and leeway that their professional autonomy grants them.

ADRT

An ADRT (advance decision to refuse treatment) is considered valid if it [2]:

- Is written by an individual aged 18 or over who had the capacity to make, understand, and communicate the decision when it was made
- Has clearly specified which treatments they wish to refuse
- Has explained the circumstances in which they wish to refuse them
- Is signed by the individual and by a witness if he or she wants to refuse life-sustaining treatment
- The individual has made the advance decision of their own accord, without any harassment by anyone else
- The individual has not said or done anything that would contradict the advance decision since it was made

Some proformas of ADRTs are available online, and the National Health Service (NHS) Improving Quality has published guidance in collaboration with the National Council for Palliative Care.

However, significant problems with ADRTs have been raised. There is no national registry for ADRTs, and so finding whether a patient has one can be difficult. Some general practitioners (GPs) are not aware of the legal constraints on validity, and some lawyers are not aware of the details of medical treatments, so that, of the few

ADRTs that are written, many are not valid. A simple wish not to have cardiopulmonary resuscitation (CPR) attempted, for example, may not be considered valid if the circumstances in which the arrest happened are not documented. To be legally binding, it would have to be written: 'should my heart stop, I would not want any attempts at resuscitation, in any circumstance. I understand that this is a refusal of life-sustaining treatment' and then have it dated and signed. But this kind of ADRT may force people into extremes they did not mean to instruct; what about a patient who is choking? So then someone might write: 'I do not wish to have resuscitation attempted unless there is a clear reversible cause'—but then is hyperkalaemia a clear reversible cause? Would you wait until you knew the potassium before stopping CPR?

One approach to this problem is to ensure that an 'advance statement' coexists with the ADRT. While patients do not have the right to request treatments, they can write about their treatment preferences (e.g. 'I would like to die at home if possible' or 'I would like all treatments to prolong life to be considered' or 'quality of life is the most important thing for me: please only give me treatments if you think I have a good chance of retaining my mental functions'). Providing treating clinicians with an 'advance statement' alongside an ADRT allows them to interpret the ADRT for the circumstances that exist. A new charity, 'Advance Decisions Assistance', has mocked up some appropriately legally and medically worded ADRTs and combined them with 'values statements' to go alongside them, to aid patients in understanding what might help ensure their wishes are respected.

Ethics

Modern philosophy links the definitions of morality and ethics [7]. In the simplest forms, morality is the difference between right and wrong, while ethics represents the critical study of morality. Individuals choose from a variety of sources of moral authority, such as religion, cultural norms, politics, and law. As such, persons may regard situations or objects differently, based on the value systems espoused by their source of moral guidance. Ethics represents the cognitive evaluation of a principle or situation, acknowledging the fact that individuals possess different moral backgrounds. Ethical dilemmas arise when there is a conflict of values between persons arguing for competing moral imperatives – when people cannot agree on what is right and what is wrong.

Medical ethics is a discipline that studies differences in value systems as they apply to clinical situations. Medical ethics is most commonly taught through classroom discussion, as a means to familiarize providers with common ethical principles. Applied health care ethics is the practical extension of such discussion, recognizing that like all clinical decision-making, ethical dilemmas require action. The word "applied" then refers to the reality that physicians mediate ethical dilemmas and make tough decisions every day. They are not philosophers, but practitioners of medical philosophy.

Most American physicians guide their ethical decision-making from duty-based concepts known as the "principles of biomedical ethics." These principles include respect for autonomy, non-malfeasance, beneficence and justice. Respect for autonomy is demonstrated when the patient is given the ability to exhibit self-governance, or self-determination. Patients should be allowed to make choices regarding their own health care. Non-malfeasance is loosely translated into the statement "do no harm." Physicians have an ethical obligation to limit the risks of poor outcomes that may result from diagnostic or therapeutic interventions. Beneficence in health care refers to the fundamental challenge to optimize a patient's condition and well-being; this may be through treatment of disease or provision of comfort care. Justice refers to the fair and equal treatment of patients, both in access to and quality of health care. Justice is also manifest through systems and institutional ethics, which in today's marketplace must respond to the reality of limited health care resources.

Religion

Religion offers metaphors and concepts that are essential to us, especially when we confront the newest borders of our medical capabilities [8]. Judaism and Christianity, although having a common origin, offer different sources of influence in this context. Judaism arguably presents a generally more affirmative view of medicine, for example in the context of the duty to use genetic testing to avoid suffering. There is no similar Christian view. While both religions oppose selective abortion in principle, only the Catholic Church bans pre-implantation genetic diagnosis, with some Christian thinkers encouraging the embracing of the "suffering presence" of those who are part of our community as an inherent part of human life. Judaism arguably embodies an alternative model to the Christian "stewardship model" that might be opposed to extreme medical intervening. A dominant Jewish perspective commands us to actively follow the example of the Creator in using our human capabilities to master nature and to improve upon nature (tikkun olam), as in "Fill the earth and conquer it" (Genesis 1:28). The Jewish view of the "pre-embryo" has promoted a supportive stance concerning IVF, PGD and stem cell research.

When thinking of how to proceed concerning RCO (religious conscientious objection), one does well to consider the legal autonomy left to caregivers concerning less existentially-pressing matters than religiously-informed conscience [9]. Physicians legally enjoy significant autonomy in the practice of medicine. For

example, they have great latitude in determining with whom they will establish a physician-patient relationship. Legally, a physician may choose not to establish a relationship with a patient based on the type of insurance the patient has. To take a more extreme case, absent a pre-existing physician-patient relationship or an emergency room setting, a physician typically has no legal obligation to care for a patient in need of emergent care. Understandably, some might think this ought not to be so. Perhaps physicians and caregivers more generally ought to have a legal duty to treat those in dire need. For our present purposes, the absence of such a duty serves as a salient feature of the current standards by which we should evaluate a caregiver's recourse to conscientious objection. When considering RCO in medicine, one does well to look at the existing legal, societal and professional norms governing the conduct of caregivers. Presumably, given the law's general hesitance to impose duties to act, a healthcare provider's RCO will enjoy a status similar to that granted to professional autonomy, individual liberty, personal preference, and mere convenience. While one may bemoan the costs of individual autonomy characteristic of our political association, a legal system cannot in a principled fashion allow whim and caprice—as, for example, boutiquebased medicine may instantiate—greater latitude than a sincere religiously-informed conscience. Of course, other healthcare professionals—such as pharmacists and nurses—typically act within a more institutionally-determined role. Indeed, this may become the more typical case for physicians as well, as more become employees of healthcare institutions. Regardless, the point still holds: namely, that when one considers RCO, one must do so in light of the autonomy granted.

Euthanasia equates to interfering with the right to life, which is one of the fundamental rights of every human being, and thus is related to perspectives on life, death, test, patience, trust and belief in God, belief in the Hereafter, and the value and inviolability of human life [10]. In particular, being very closely related to the perspective on life and death, euthanasia seems to question whether it is the quality or the inviolability of human life that should be given priority. Supporters of euthanasia who embrace the quality-of-life stance argue that it is meaningless to live a life that fails to comply with Man's honor and dignity. The belief that this world is the only place of life and truth brings with it the desire to get the greatest pleasure from life or to gain maximum advantage for worldly interests. According to Islam, the worldly life—which receives its meaning only with the existence of the Hereafter—should be lived in a manner that is worthy of the dignity of the human being, who is the most honorable of all creatures. In Islamic thought, death is a part of the worldly life and, as Sachedina said, for Muslims the meaning of death cannot be derived from medical facts or scientific investigation alone.

Law

To debate the legal status of euthanasia and physician-assisted suicide fruitfully, we need to have clearly in mind the medical context in which such behaviour would take place [11]. The time and manner of roughly half of all deaths are intentionally determined by something the patient's doctor does. We can call the medical behaviour involved 'medical behaviour that potentially shortens life' (MBPSL). There are a number of sorts of MBPSL, depending on the circumstances and on exactly what the doctor does. Their frequencies vary considerably over time and between countries.

Consent, though it renders many everyday contacts lawful, does not generally affect the unlawfulness of criminal homicide [12]. The reason for this is probably that the criminalisation of homicide, unlike crimes such as common assault and rape, does not owe its ultimate raison d'être to a respect for human autonomy. An act of killing a person, unlike, say, the act of intercourse, is deemed to be inherently wrong rather than contingently wrong. It is wrong because it is a negation of a value fundamental to the human condition, namely the idea that life is sacred. If killing is inherently wrong, it makes sense that consent cannot make it right. In recent years, the emergence of interest-based theories of right and wrong conduct have led some to argue that consent should be capable of rendering even homicide lawful, so long as sufficient safeguards are in place to ensure that voluntary 'euthanasia' is truly voluntary and is a route for leaving life with dignity rather than simply a means of escaping from an unpleasant life experience. The position traditionally adopted in criminal doctrine is that individuals have the right to refuse consent to treatment which prevents them dying, but no right to implicate others in a positive act of killing. If respect for individual autonomy is this strong, it might be thought that little cogent objection can be made against the provision of positive assistance based in such respect, particularly for those suffering from painful and terminal illness. In cases involving the withdrawal of life-sustaining therapy from those who have suffered brain death or are in the condition known as persistent vegetative state, the distinction between 'killing' and 'letting die' is becoming increasingly blurred. Nevertheless it remains the law that acts designed to kill and which do kill, however well intentioned, constitute murder.

CONCLUSION

Sooner or later, a man in his growth and maturation, more or less becomes aware of the course of his life and the fact that every day goes unstoppably to its end. A person on this path is often accompanied by suffering and pain, which are sometimes greatest at the very end of life. Pain is an uncomfortable feeling that is tried in every way to be avoided, and if that is not possible, then at least alleviated. Sometimes diseases are so advanced that pain is

impossible to avoid, so they resort to ending life - euthanasia, or merciful killing. In such an approach and procedure, questions arise about its ethics, and judgment on this has enabled legislative solutions that differ from country to country, and are reduced to prohibitions or admissibility of application, with differences in prescribing the procedure itself. In some countries, there has been a complete change since the initial ban on euthanasia, as the procedure itself has been decriminalized, but the manner and conditions of application have been prescribed. In countries where euthanasia is allowed, after many years of experience, but also in countries where euthanasia is not legalized, there are heated discussions about its morality and the consequences of its application are judged. Such discussions show deep divisions in society and point to the consequences of the use of euthanasia, which can change completely in a particular country.

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