

A Morally Justified Policy for Assisted Euthanasia

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DECLARATION

This degree is bestowed posthumously, since the candidate died a few days after completing this work. I, the supervisor, declare on her behalf that the work contained in this assignment is her own original work, and that she has not previously, in its entirety or in part, submitted it at any university for a degree.

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SUMMARY

- This study was undertaken to evaluate whether a mentally competent mature human being, who is suffering an intolerable, irremediable existence resulting from an incurable agonising *or* devastating paralysing disease, has a moral, personal and civic right to end that life or have it ended by requesting assistance in meeting death in a humane, compassionate and dignified manner.
- The righteousness of such assistance can only be gauged if it follows the repeated and voluntary request of someone who is presently not suffering from any psychiatric disorder, is presently mentally competent *or* had made such a written or verbal witnessed advance directive while mentally competent to do so.
- This study will not deal with assistance in dying either active or passive which is performed on severely mentally and physically handicapped new-born babies with scant prospect of survival; nor with euthanasia for the relief of malignant or paralysing disease in those with life-long [anoxic, congenital, inflammatory or traumatic] mental incompetencies who have never had decision-making capacity.
- This study will not address issues of aid-in-dying for mentally incompetent persons suffering from senile dementia, Alzheimer's disease, or permanent vegetative states due to brain pathology following anoxic, circulatory, infective, malignant or traumatic events, who have *not made* advance directives and who had *never* stated preferences concerning assisted euthanasia.

- The aim of this study is to outline the moral case advanced by those in favour of legalising Voluntary Assisted Euthanasia [VAE] also called Assisted Euthanasia [AE] and to develop ethically sound and practical proposals for policy and actions contributing towards the resolution of the moral dilemma faced daily by doctors when asked by mentally competent patients suffering from irremediable malignant or paralysing diseases or the agonising symptoms of end-stage Acquired Immune Deficiency Syndrome (AIDS) for assistance to end their lives.
- This study will cover and discuss the more important objections of those opposed to the legalising of assisted suicide for mentally-competent terminal patients who are irremediably suffering in their bodies or from dehumanising incurable end-stage paralysing diseases and are near to an inevitable death.
- The insights of philosophers, theologians, physicians and sociologists on the subject of suicide and aid-in-dying, have been researched in the extensive literature that exists (both in print and in cyberspace) on these subjects and are presented with the study.
- The study tries to show that a competent adult in certain grim circumstances should have an inalienable human right, if not a constitutional one, to request assisted euthanasia or aid-in-dying or assistance in ending their lives.
- Such assistance must be subject to peer review, after careful assessment by a multidisciplinary team in the healing [both physical and spiritual] professions.

- This paper will try to determine whether the actionalisation of voluntary assisted suicide or assisted euthanasia is murder or an act of compassion and empathy performed out of respect for a fellow human being's autonomy and in deference to their right to self-determination and self-realisation.

- The relevance of this situation is that aid-in-dying is becoming one of the major, moral, religious, philosophical and bio-medical dilemmas at this time.

- The author's position is that it is neither just nor ethical to prevent a mentally-competent human being, who is tormented by agonising, incurable terminal physical or irremediable paralysing disease, from deciding to chose to die when he/she can no longer bear the torment and asking for professional assistance to effect this. This relief should be given not only to those who are able to make an enduring, informed contemporaneous decision, but also to those who [when they still had decision-making capacity] had previously made a considered informed advance directive about the use of ordinary and extraordinary medical methods of sustaining a life that had become merely an existence.

OPSOMMING

- Die studie is onderneem om te evalueer of 'n bevoegde, volwasse mens wat 'n onverduurbare en ongeneesbare bestaan het a.g.v. 'n ongeneesbare, folterende of vernietigende siekte, 'n morele, persoonlike of burgerlike reg het om daardie lewe te beëindig of hulp te vra om dit te laat beëindig, ten einde die dood op 'n menswaardige wyse tegemoet te gaan.
- Die regverdigbaarheid van bogenoemde hulp kan slegs bepaal word as dit volg op die herhaalde en vrywillige versoeke van iemand wat nie, wanneer hy/sy dit versoek, ly aan 'n geestesiekte nie, wat bevoeg is of wat so 'n geskrewe of mondelinge versoek, met getuies, gemaak het terwyl die persoon kompetent was.
- Die studie handel nie oor bystand-in-sterfte, aktief of passief, waar dit uitgevoer word op fisies of psigies ernstig gestremde pasgebore babas met 'n skrale kans op oorlewing nie; ook nie oor genadedood ter verligting van kwaadaardige of verlamme siekte in diegene met lewenslange [anoksiese, kongenitale, inflammatoriese of traumatiese] geestelike ongesteldhede, wat nog nooit besluitnemende kapasiteit gehad het nie.
- Die studie ondersoek nie gevalle van bystand-met-sterfte waar inkompetente persone wat ly aan seniliteit, Alzheimer se siekte, of permanente vegetatiewe toestande a.g.v. brein patologie n.a.v. anoksiese, sirkulatoriese, infektiewe, kwaadaardige of traumatiese gebeure, *nie* direk gevra het vir genadedood of *nooit* die voorkeur vir geassisteerde genadedood uitgespreek het nie.

- Die doel van hierdie studie is om die morele saak van diegene ten gunste van die wettiging van Vrywillige Geassisteerde Genadedood, ook bekend as Geassisteerde Genadedood, te stel en om praktiese sowel as eties verantwoordbare voorstelle te maak vir beleid en optrede wat kan bydra tot die oplos van die morele dilemma wat dokters daagliks in die gesig staar wanneer hulle deur geestelik bevoegde pasiënte wat ly aan ongeneesbare, kwaadaardige of verlamme siektes, of die folterende simptome van die finale stadium van Verworwe Immunitets Gebrek Sindroom [VIGS], gevra word vir bystand in die beeindiging van hulle lewens.
- Die studie sal die belangriker besware van diegene aanspreek wat teen die wettiging is van geassisteerde genadedood vir geestelik bevoegde terminale pasiënte wat ongeneesbaar ly of van dehumaniserende ongeneesbare finale stadium siektes en wat naby is aan 'n onafwendbare dood.
- Die insigte van filosowe, teoloë, dokters en sosioloë oor bystand-met-sterfte en selfmoord, is nagevors in die wye literatuur beskikbaar is (beide in druk en kuberruimte) oor hierdie onderwerpe en word saam met die studie aangebied.
- Die studie probeer aantoon dat 'n bevoegde volwassene in sekere erge omstandighede 'n onvervreembare mensereg, indien nie 'n konstitusionele reg nie, behoort te hê om bystand tydens genadedood te versoek.
- Sulke bystand moet onderworpe wees aan groepevaluasie, na versigtige ondersoek deur 'n multi-dissiplinêre span in die gesondheidsprofessies [beide fisies en psigies].

- Die studie sal probeer bepaal of die uitvoering van vrywillige geassisteerde selfmoord of geassisteerde genadedood moord is, of 'n aksie van empatie, uitgevoer uit respek vir 'n medemens se outonomie, sy/haar reg tot self-determinasie en self-realisasie.

- Die relevansie van hierdie situasie lê daarin dat bystand-met-sterfte besig is om een van die belangrikste morele, religieuse, filosofiese en biomediese dilemmas van ons tyd te word.

- Die outeur se posisie is dat dit nie regverdig of eties is om te verhoed dat 'n geestelik bevoegde mens, wat ly aan folterende, ongeneesbare terminale fisiese of ongeneesbare verlamme siekte, self kies om te sterf wanneer hy/sy nie meer die lyding kan verdra nie en vir professionele bystand vra om dit uit te voer. Die verligting behoort gegee te word, nie net aan diegene wat in staat is om 'n bindende en ingeligte besluit te maak nie, maar ook aan diegene wat [toe hulle nog besluitnemende kapasiteit gehad het] vroeër 'n oorweegde, ingeligte vroegtydige versoek gemaak het aangaande die gebruik van gewone en buitengewone mediese metodes vir die verlenging van 'n lewe wat bloot 'n bestaan geword het.

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1. ANNOTATED GLOSSARY OF TERMS

1.1. **ASSISTED EUTHANASIA:** This expression should always be labelled Voluntary Assisted Euthanasia (VAE) as it describes: when after repeated requests from a mentally competent patient, assistance is given to this person to reach the end of her/his intolerable life earlier rather than condemning her/him to suffer all the way to death later. This desperate desire is precipitated either by an irremediable, agonising *terminal disease* [see 2.13 page 11]: for example advanced metastatic cancer or end-stage Acquired Immune Deficiency Syndrome (AIDS), OR an *intractable unbearable illness*, [see 2.4. page 4] of a generalised paralysing nature such as end-stage Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS), Huntington's Disease, Motor Neurone Disease (MND), permanent Guillan-Barré Syndrome or high-level damage to the spinal cord with quadriplegia necessitating a respirator.

1.2. **DOUBLE EFFECT** (the Principle of). “Briefly stated, this is the principle that if an act is expected to have two effects, one good & one bad, it is *permissible* if the agent's intention was to produce the good effect [the bad effect being merely a foreseen but unintended consequence] but not if it was to produce the bad effect. Thus a doctor may not kill his patient to end his pain but may act to relieve the pain even though he knows that his action will kill the patient.” (Nowell-Smith: 1989:125) When the pain and distress from a *Terminal Disease* is such that *Palliative Care* is no longer effective; in attempting to control suffering, the physician may choose to administer abnormal amounts of morphine-type opioids. She does this in spite of the probability that these excessive quantities will suppress respiration and cause death

earlier than otherwise would have occurred. The principle of *double effect* means although death is *not* sought directly as an end nor is it intended, it is however foreseen and the strong probability of it occurring as a double effect of pain therapy is admissible. The author believes it is a hypocritical façade of self-delusion to believe that the use of the double effect in palliative care is the only ethical intervention.

1.3. **EUTHANASIA:** The word euthanasia comes from ancient Greek, meaning a 'good death'. The interpretation of the term is "the intentional termination of life by another at the explicit request of the person who dies." The term euthanasia normally implies that the act must be initiated by the person who wishes to die. When one speaks of a good and easy death, one also implies dying with dignity. Only later was euthanasia regarded as a mixture of murder and self-murder and thus repugnant on communitarian, ethical, legal, moral and religious grounds.

1.3.1. The patient's release can be caused by acts of omission or

PASSIVE EUTHANASIA

[a] Withholding Therapy:

A doctor deliberately does not commence any procedure that may prolong life allowing the disease process and nature to take their course and hasten the death of a person. This is effected by withholding some interference of medical expertise: respirators, cardio-pulmonary resuscitation, haemodialysis, radical surgery, the transfusion of blood, fluids and nutrition or the use of antibiotics, radiotherapy or chemotherapy.

[b] Withdrawing Therapy

The doctor deliberately stops or gives orders for the withdrawal of any, some

or all of the above procedures, for instance, artificial respiratory support.

1.3.2. The patient's release can be effected by surreptitious acts of commission or

ACTIVE EUTHANASIA

[a] the doctor **personally** administers sufficient intravenous or oral medication which in standard quantities is therapeutic but toxic in overdose, or which is lethal in combination with other non-toxic therapeutic agents.

[b] alternatively, the doctor knowingly **prescribes** an anti-emetic drug, a tranquilliser and an overdose of oral barbiturates in the certain knowledge that the patient (either alone or aided by friends and/or family) will ingest the combination to kill her/himself.

[c] or the doctor instructs the patient of the most efficacious use of already available means for the sole purpose of assisting the patient to end his/her own life, either alone or with the assistance of family and/or friends.

1.4. **INTRACTABLE AND UNBEARABLE ILLNESS:** This is an irreversible bodily illness that cannot be cured and is not appropriate for palliation and is caused by total de-humanising incapacity as a result of an acute generalised traumatic or inflammatory paralysing diseases or chronic generalised degenerative paralysing diseases.

1.5. **INVOLUNTARY EUTHANASIA:** This is when death is brought about against the will of sentient persons. The *final solution* promulgated during the era of Nazi fascism subverted the benevolent definition of euthanasia from a scenario describing 'a good death' into one of noxious portent with the use of *involuntary* euthanasia to

rid the Third German Reich of all whom their ideologues had decided were *üntermenschen*. *Üntermenschen* were those possessing acquired, congenital or hereditary incurable handicaps or aberrations of the mental, physical (including ethnic) political, psychological, sexual or sociological variety. Involuntary euthanasia was, is and always will be immoral, unethical and illegal and an act of murder.

1.6. LETHAL EUTHANASIA: The utilisation of lethal substances cannot for any reason be permitted in the permanent resolution of terminal pain assuagement. It would be a travesty of altruism, beneficence and compassion, were doctors to administer materials of execution to bring about a good death in an innocent person. In some of the United States of America, lethal injections are given to kill criminals convicted of capital offences. "The ethical norms of relieving suffering and respecting patients' rights to self-determination support the permissibility of voluntary physician-assisted death as a last resort for terminally or incurably ill patients. The availability of the extraordinary option of lethal treatment, however, must be accompanied by careful regulation to minimise the risk of abuse." (Miller et al: 1994: 119).

1.7. LIVING WILL OR ADVANCE DIRECTIVE: The term "living will" was created by Louis Kutner in 1969 for a document where a mentally competent adult can indicate her/his wishes regarding future medical intervention in the event of future incapacitation and incompetence. This document is a will in the sense that it clarifies one's wishes. It is "living" because it takes effect before death. Should one lose the capacity to make decisions or to communicate one's wishes, the only way one has control over the level and extent of any future medical intervention and resuscitation is through a previously declared *advance directive*.

Some people wrongly assume that treatment directives are used only to refuse treatments and thus shorten life. However, people use directives to request treatment as well --- the point is that treatment directives are a way to express the patient's preferences for treatment, whatever they may be. These declarations should be written, witnessed and lodged with one's family, doctor, hospital and (if applicable) aged home. The most useful form for both patients and providers is a one-page document that sets forth all information in easily comprehensible language. The living will, like an ordinary will, is revocable and should be updated at intervals, to ensure that it continues to give one's wishes in the light of the latest medical advances.

Covered in an advance directive are whether or not one wishes to spend one's last months of existence attached to mechanical life-support apparatus, invasive catheterisation (for feeding and micturition) all of which may prolong life in a way inconsistent with one's own personal values. The witnesses to this declaration should be of full age and not beneficiaries of one's will. "The traditional right to accept or reject medical or surgical treatment which is available to an adult while competent, should be so that in the event that such adult becomes unconscious or otherwise incompetent to make decisions, such adult would more easily continue to control decisions affecting their health care." (Danforth: 198:32)

1.8. NONVOLUNTARY EUTHANASIA: Best defined as ending another person's life without explicit request in the belief that it is the only compassionate thing to do. Here death is brought about without the consent of the sufferer, who is neither mentally

competent at this time nor was nor will ever be able to express an informed wish about assistance in dying. This is when a severely mentally and/or physically handicapped newborn baby or a mentally incompetent adult with an irremediable terminal disease is allowed to die. One may also describe this action as a *mercy killing*; however, as this imprecise term does not differentiate between the assisted and merciful death that is requested by a patient and the assisted death that the doctor *thinks* will be merciful; for the sake of accuracy *mercy killing* is a term that should be avoided.

1.9. **PALLIATIVE CARE:** This refers to the care and non-curative treatment of a person who is terminally ill. Palliation endeavours to address the symptoms of disease and to make life more bearable but it cannot cure the cause. The physical pain of the sufferer and any emotional and psychosocial problems s/he may have are also addressed. Spiritual support, narcotic sedation and companion drugs can be most effective in controlling pain, nausea and vomiting. Anxiety can be minimised with consequent pain experience with self-administration of opioids --- whenever the patient considers it necessary --- via an implanted delivery-mechanism. One has seen bad deaths in spite of excellent hospice care. There is an unsubstantiated view that adequate hospice care halts the desire of most people to die earlier, making euthanasia unnecessary, however this opinion needs to be supported by evidence that such care is available to all who need it. . "Although pain can be controlled [though frequently it is not], suffering cannot" (Thomasma: 1996: 189). The media frequently trumpets the news of another miraculous medical triumph but ignores the sombre fact that there are no vaccines to immunise wo/man against the inevitability of suffering and death.

1.10 **RIGHT TO DIE:** popular general term reflecting a basic belief that end-of-life decisions should be an individual choice but a more accurate term is **RIGHT TO CHOOSE TO DIE.**

1.11 **RIGHT TO LIFE:** Popular general term for belief that death should only come about by the will of a deity, or the belief that life is the prevailing value, regardless of medical conditions or desires to end it for whatever reason.

1.12 **SELF DELIVERANCE [OR RATIONAL SUICIDE] FOR THE TERMINAL SUFFERER:** Is a term coined by Derek Humphry (founder of the Hemlock Society and author of *Final Exit* a best-selling do-it-yourself book describing many ways to successfully kill oneself). The phrase refers to self-deliverance -- or assisted suicide by family/friends - of one who is suffering from an irremediable agonising or paralysing disease, who has been *refused* assistance by a physician. That there is a need and a market for do-it-yourself suicide literature, reveals that the stake some ethicists have in preventing death is greater than the hardship to terminally ill patients who want to die. This DIY literature gives information on how to sever vital arteries and use stockpiled prescription drugs, carbon monoxide gas and plastic bags. "The plastic bag is getting the same sort of public-relations reputation as the wire coat hanger did in the abortion debate, except the bag is 100 percent effective." (Humphry: 1994:1017)

1.13 **SLIPPERY SLOPE:** It is often pointed out that VAE is a slippery slope sliding towards moral decay and the intellectual anarchy of voluntarism. Some believe if assisted suicide is made legal, in the beginning doctors will help *only* the mentally

competent with irremediable, agonising terminal or incurable paralysing diseases, who have decided their lives are no longer worth living; but thereafter doctors will no longer feel obliged for anguished soul-searching nor require the patient's request before making such a decision for patients who have *not* requested it. The "pernicious precedent proponent" says that if doctors are accustomed to act on the right-making characteristics of **A** which **B** does not share; they will later act on the wrong-making characteristics of **B** which **A** does not share resulting in what is morally acceptable and what is morally unacceptable become conjoined in a greasy continuum resulting in gross abuse. Some religionists believe that the sanctioning of an act which in itself may not be morally repugnant or illegal on a small scale, but could lead to other similar and wider actions which are, e.g. allowing VAE could soon lead to the coercion of the old and ill and a hastening of their death to suit the living.

1.14 TERMINAL DISEASE: This is an irremediable bodily illness that within a short time will inevitably cause the death of the subject. Irreversible illness: Another way of saying terminally ill but also likely to be a lengthier dying process. Some of these victims, despite palliative measures, continue to experience unbearable pain and unfortunately there is no way of making that suffering bearable which is acceptable to the patient apart from causing a drug-induced "near coma". Some of those suffering from intractable afflictions for instance end-stage malignancies, AIDS, or severe trauma (75% bodily burns) may prefer the option of death to continuation of their unendurable existences.

2. INTRODUCTION

“Biomedical ethics emerged principally in response to various issues and devices that were created by the new medical technologies. The traditional values and ethical principles of the medical profession came to be regarded as inadequate in those new situations, because they often seemed to require decisions which appeared to be clearly wrong.” (Winkler and Coombs: 1993:1). Among the bioethical issues attracting most debate, is the morality of any action intended to bring a victim-requested death-with-dignity earlier rather than later to one that is inevitably going to die from a malignant disease. There is debate too about the morality of voluntary assisted euthanasia [VAE] for persons with incurable, progressive motor paralysis, who are dehumanisingly and totally dependent on others for every function and while they are not in irremediable pain, are suffering intensely existentially.

We will all die; death is a given and not an option. Yet, however certain our deaths are, normally none of us can predict exactly when we will die, from what cause nor what our own particular end of life scenario will be. We cannot know if we will die in agonised suffering; in dehumanising reliance for every physiological necessity on others or if we will be fortunate enough to leave this life gently and with dignity. We do however know that the advances in medical technological interventions over the last forty years have changed [and those of the future will change] forever the way all issues of dying and death can be regarded; and technology will effect how drawn out the dying stages of

will extend the period of serious mental and bodily degeneration, with impairment of the quality of life which as a result becomes a burden and no longer worth pursuing.

This study will deal only with the morality of voluntary assisted euthanasia (VAE): when a competent person suffering from an incurable illness [either terminal and irremediably painful or paralysing and dehumanising] makes an informed enduring request to be aided by an act of omission or commission to achieve her/his deepest wish for an end to her/his torment so that s/he may die earlier than the probable natural progression of the disease *or* if presently the sufferer has no decision making capacity would have made an informed, advanced directive to this effect.

The study will not deal with nonvoluntary euthanasia [cf. p. 11] – where death is brought about without the consent of the sufferer. Such assistance in dying takes place by acts of either omission or commission and is given ---

- 1) To unsalvageable severely mentally and/or physically handicapped new-born babies who have no chance of viable life.
- 2) To an adult with a terminal irremediable disease, either painful or paralysing who never was competent to make an informed advance direction and therefore had no decision-making capacity in this regard previously nor has at present.
- 3) To a formerly mentally competent adult, who has never made an oral or written declaration of their advance directives, and who now as a result either of degenerative, infective, traumatic or vascular brain derangement, no longer has the

decision-making capacity to express an informed, voluntary request for help in dying.

Neither will this study deal with In-voluntary Euthanasia [cf. p.8] when death is brought about *against* the will of any person, whether possessed of adequate decision-making capacity or not. This is an immoral and unethical act and should be regarded as murder.

Controversy about the morality of VAE is a phenomenon of the latter half of this century, and there have been many attempts to have it legalised but from 1950 -1970 these were without success. Until in 1973 when Dr. Gertruida Postma, in the Netherlands, gave her dying mother a lethal injection and received in consequence a light sentence and the ensuing furore launched the euthanasia movement in that country. Subsequent to several court cases in that country, since then, there is an arrangement where no physician will be prosecuted for assisting a patient to die as long as the specific rules are strictly followed. These rules provide that doctors can perform VAE when:

1. A mentally competent patient has repeatedly requested death following an informed decision.
2. The patient's suffering is unbearable, and there is no way that is acceptable to the patient of making that suffering bearable.
3. The doctor's diagnostic verdict and prognostic estimate must be substantiated in consultation with another physician.

The first legislation that actually permitted VAE was promulgated in the Northern Territory of Australia, but this bill has since been repealed by the Federal government. Following a referendum in the state of Oregon in the USA legislation was passed allowing VAE to be practised in that state under similar conditions as those in the Netherlands, with the added provisos that the medication used is not lethal, but an overdose, the patient or family administers the drug orally therefore the patient must be able to swallow, the patient is not depressed and has no financial problems connected with an extended course of dying.

A person facilitating VAE or PAS is helping to bring about the death of another human being at that person's enduring, informed, and voluntary request, with the certain knowledge and convinced belief that this particular person's existence is so abominable that s/he would be better off dead; *or* that unless compassionate intervention occurs, this life will soon become so bad that s/he would be better off dead. The motives of those who assist victims of unbearable diseases to curtail the inevitable and inescapable dying process include respect for human dignity, unbiased beneficence and disinterested compassion. This act accords with the notion that one should do unto others, as you would have them do unto you ie "...and you shall love your neighbour as yourself"(Leviticus: 19: 18).

The law, medicine and ethics agree that competent, autonomous adults, have the right to decide to make medical decisions for themselves. If someone is seriously ill with a poor prognosis her/his decisions are honoured before beginning any treatment that is

thought unacceptable; the patient may refuse to give consent for a blood transfusion, surgery, radiotherapy, chemotherapy, antibiotics or to be put onto a life-support apparatus. There are many motives for rejecting medical treatment (among them religion, tradition and fear) but most common is the alarm at the prospect of an extended death tied down by, or hooked up to, respirators, electrocardiographs, invasive catheters for nutrition, or naso-gastric feeding tubes and urinary catheters. Moreover, patients who are dependent on life-support systems and in irremediable, physical torment and suffering from an incurable terminal illness may choose to have aid in dying by insisting that their machines be switched off. Whether one deliberates from the perspective of utility or seeks the support of rules and duties of the Kantian, it is indisputable that this human considers that this tortured life is no longer worth living and s/he needs assistance in ending it.

There is of course the paternalistic objection to an advance directive whether anyone can ever form a rational, enduring and voluntary wish about being better off dead, *before* actually suffering that illness. One cannot truly know beforehand whether one would want to spend the last months of existence in life-extending ways quite inconsistent with one's own personal values. Many people have sufficient inductive evidence based on the experiences concerning the deaths of fellow-sufferers, family or friends who, despite efficient medical care, experienced horrible deaths resulting in them knowing their own minds and therefore acting accordingly. It is very common that the home-care for victims suffering the terminal stages of AIDS is given by those who are HIV positive and consequently, they know the humiliating degradation of the body that occurs with

symptoms of constant biliousness, extremely painful swallowing from monilial infections of mouth and oesophagus, recurrent respiratory and skin infections, severe vomiting, diarrhoea, incontinence and the dementia at the end-stages of this disease. They are thereby in a very good position to make a realistic and informed decision.

3. SUFFERING

Suffering is a global experience of severely impaired quality of life, it describes a condition of intense spiritual and/or physical distress usually brought about by a combination of events that “threaten the intactness of the person” (Portenoy: 1992: 3). Suffering includes feelings of vulnerability, despair and vitiating demoralisation. While pain and suffering are generally associated, it is quite possible for pain to occur without causing suffering and anguished spiritual suffering can occur in the complete absence of physical pain.

The suffering that threatens the intactness of personhood is usually one that poses a “threat to the person’s existence or integrity, to maintaining his or her role in the family or in society, or to his or her sense of self and identity” (Cassell: 1982: 640). Distressing physical symptoms and disabilities can lead to intense suffering for patients with degenerative disorders such as amyotrophic lateral sclerosis (ALS), or those who are quadriplegic as the result of a high spinal cord injury. Moreover, suffering is not limited to terminal medical patients.

“Suffering may arise from many causes, including physical incapacity, social isolation, fear, the death of a loved one, or frustration of a cherished goal.” (Cassell: 1982: 640). In addition to physical symptoms, the patient’s emotional, social, and economic concerns can contribute to the patient’s experience of pain and are often a direct cause of suffering “It is not possible to make a distinction between physical & mental suffering. The actual cause of the suffering does not, after all, indicate the

extent to which suffering is experienced. If the suffering cannot be alleviated, it is no longer relevant whether it is mental or physical". (Hagenouw: 1996: 3-4)

"Even more so than with pain, an individual's experience of suffering reflects his or her unique psychological and personal characteristics. Suffering is in effect the experience of severe psychological pain, arising from medical or personal causes. Because the experience of suffering is subjective, people are often unaware of the causes or extent of another person's suffering. Ultimately, suffering is a distinctly human, not a medical, condition." (Portenoy: 1992:184)

The religionist concerned with the protection of life fails to realise that its Creator does not necessarily want this life prolonged regardless of the amount of suffering it would entail. Often even with the best of palliation or the most efficient of quadriplegic care the patient's suffering is unbearable, and no way can be found of making that suffering bearable, which is also acceptable to the patient. Some do not consider that the life led by someone under terminal sedation is in fact any sort of life but an anaesthetised existence. Since there is no chance of reprieve, a happy-ending or a miracle cure, is there any purpose in narcotised torture?

"It was also indicated that VAE denies patients the final stage of growth. It is often through facing hardship that human character and maturity develop most fully. According to the teaching of the Catholic Church (Second Vatican Council) 'it is in the face of death that the riddle of human existence becomes most acute.' It is the suffering endured which brings a person to salvation. (SALC: 1999: 4.148: p102)"

This is an illuminating insight into the thought processes of those who believe

suffering is good for shaping the dying soul to enable it to pass through those imaginary pearly gates.

What if one does not believe in a heavenly creator nor in a life hereafter? What if one queries the utility of fortifying the character of one who no longer has influence on the ethos of society? Will the distress of a terminal patient improve the moral fibre of his world or even the integrity of those who wait at the deathbed? When we speak of suffering, there is little mention of the anguish and deep sadness of those friends and family who cannot bear to see an animal in agony and much less one whose blood and lives they share.

“We can justify euthanasia for our pets precisely because they cannot possibly understand suffering or dying. They cannot die in a ‘human’ way. But humans can grow morally even with negative experiences. A good death contributes something valuable to the whole human community.... A good death is the last act of the drama, which euthanasia artificially terminates before the drama is really completed.” (Pellegrino: 1992:97). Surely those who have been in an intolerable situation for a long time have a moral right to decide that for them it is futile to delay the fall of their own final curtain if they do not want to wait around for the last act of this drama.

This is an example of the reply to a young person whose aunt is suffering terminally from lung cancer: “yes, suffering is awful, but as the Book of Job teaches, all of us suffer. The real evil is not responding to the suffering. Your love is all the more important to her because she is in such pain. For now, the best thing you can do is continue to let her know how wonderful she has been to you. This may give her a sense that she can finally leave you. But whatever happens, remember that her love

will stay with you and yours with her, and love is what makes us immortal. If she knows you can let her go, Judy can die surrounded by loved ones.”

Apart from the misery and suffering for the patient undergoing chemotherapy, [severe weakness, anorexia, vomiting, a feeling of doom, mouth ulcers, opportunistic infections and anxiety about the chances for therapeutic success] simultaneously the empathetic loving family experiences all the stress, anguish and torment associated with the futile battle to maintain life.

Futility is a judgement that treatment is not beneficial but, in practice we must also consider the possibility of causing harm through pain, suffering, risks of prolonged ventilator dependence, persistent vegetative state, etc. These effects of treatment bring us into the area of burden versus benefit as part of a continuum with futility however, we should never use the claim of futility to justify rationing of resources. [Kuhse; 1987:]

There are cases where someone who has requested assistance to die and is allowed to die, rather than killed, where it is morally worse to allow to die because all that does is prolong the patient's suffering. The second point to make (noted already in connection with the doctrine of double effect) is that despite the longstanding legal doctrine that no one can justifiably consent to be killed, it surely is relevant to the justification of an act of killing someone that she has autonomously decided that that would be best for her.

If the patient is truly suffering from persistent anxiety, as with depression, severe anxiety in a dying patient merits psychiatric care consider using anxiolytic medications in addition to antidepressants.

The Greek Orthodox Church 1996 US Supreme Court case "opposes murder, whether it be suicide, euthanasia or whatever, and regardless if it is cloaked in terms like 'death with dignity.' A person contemplating ending it all because of despondency instead should turn to God for strength and support. The Book of Job serves as a prime example of how someone overcomes extreme suffering by staying focused on God."

Many faith groups believe that human suffering can have a positive value for the terminally ill person and for caregivers. For them, suffering can be "a divinely appointed opportunity for learning or purification." A Roman Catholic document mentions that "some Christians prefer to moderate their use of painkillers, in order to accept voluntarily at least a part of their sufferings and thus associate themselves in a conscious way with the sufferings of Christ crucified".

These may be meaningful suggestions to some Christian believers. Life is a gift from God, and that "each individual [is] its steward." Thus, only God can start a life, and only God should be allowed to end one. An individual who commits suicide is committing sin. God does not send us any experience that we cannot handle. God supports people in suffering. To actively seek an end to one's life would represent a lack of trust in God's promise.

The Lutheran Church - Missouri Synod: In 1979, their Commission on Theology and Church Relations issued a report on euthanasia. It condemned euthanasia because it involves suicide and/or murder and is thus contrary to God's law. Suffering "provides the opportunity for Christian witness and service."

4. THOU SHALT NOT MURDER (NOT EVEN THYSELF): PERSPECTIVES ON SUICIDE

“Although there has been little public discussion of the morality of suicide, philosophers have always been fascinated by the subject. As is the way with philosophers, many have often come to diametrically opposite conclusions. Aristotle condemned it. David Hume defended it. Jean-Jacques Rousseau called the right to suicide a ‘clear and self-evident principle.’ For Ludwig Wittgenstein it was an ‘elementary sin,’ a challenge to any moral system. “If suicide is allowed, then everything is allowed. If anything is not allowed, then suicide is not allowed,’ he concluded. (Economist: 1999:www)

In researching the literature, one is not able to discover with absolute certainty whether the religious, moral and philosophical opprobrium attached to voluntary assisted euthanasia has its focus chiefly on the act of *self-murder*. In other words, is the essence of opposition to the fact that a *mere mortal* has requested assistance in ending an intolerable life before the predetermined expiry date; or is the main reason for rejecting voluntary assisted euthanasia a knee-jerk rejection of a situation where a *mere mortal* may justifiably end another’s life?

In Biblical times justified self-murder was not condemned for example, when King Saul fell on his sword so that the Philistines would find only a dead body to desecrate and decapitate. “Saul did not sin in killing himself...because he knew that in the end

he was bound to die in that war...It was, therefore, better for him to take his own life, rather than the uncircumcised make sport with him." (Telushkin: 1994:273). Moreover King Zedekiah, was criticised in later years for *not* committing suicide, as: "knowing that his eyes would soon be put out (at Nebuchadnessar's command) he did not have had the sense to dash his head against the wall until his life left him" (Ibid: 273). Even when death would not necessarily result, it was considered more virtuous that one should choose martyrdom rather than compulsory conversion, and suicide rather than be forced to live an immoral and shameful life.

How literally can we take the events recorded in the Bible? Martin Buber suggests that at Sinai in 1236 BCE, the Israelites came together into the presence of 'Good', in an intense immediate way and as a result, understood with a clarity that they never had before, how human beings were meant to live. The first five commandments concerned humanity's duties to their supernatural and natural creators. The last five concerned humanity's duties to their fellow wo/men prohibiting those deeds that would destroy the loyalties and integrity of the tribe. Consequently in the Second Book of Moses, (Exodus XX: 13) the sixth commandment proclaims: Thou *shalt not kill*. However, long before this event (that is merely the first to be documented), we know that in many societies, there was a definite proscription on the taking of human life and the life not be taken included one's own.

While killing became universally prohibited, it remained and remains permissible in certain contexts and societies, for instance:

- in defence of one's own life or that of immediate kin, self-preservation is an obligation in the Jewish faith.

- in protecting the well-being and survival of the nation or tribe namely:
 - via the extermination of the enemy in times of war;
 - via the execution of murderers and traitors;
 - via ceremonial human sacrifice in some tribes, in order to placate, thank or acknowledge the powers of the supernatural.

Whereas the only justified grounds for self-murder or suicide apparently were:

- as proof of the depth and sincerity of one's faith in other words martyrdom.
- when disgrace was inevitable, tacit approval was given to those choosing "death before dishonour"

The western ideation that murder is a sin and a crime originated in the legalisation of the Judeo-Christian ethos, based on an ostensible divine decree, supposedly given to the Hebrews through Moses at Sinai. However both the Christian and Jewish condemnation of self-murder does not derive directly from scripture but dates from the fourth century CE. Nowhere in the bible is disapproval of suicide to be found --- in fact the act is judged meritorious in the cases of Samson, King Saul and the Zealots at Masada and Judas Iscariot's self-murder is reported on but not judged.

Pythagoras reportedly said: "we must not seek to escape by self-murder; for we are the chattels of God who is our herdsman and without his command we have no right to escape" (Russell: 1991:52) In *Phaedo*, Socrates is reported by Plato as saying: "There is a doctrine whispered in secret, that a man is a prisoner who has no right to open the door and run away; this is the great mystery which I do not quite understand" and at another time "There may be a reason in saying that a man should wait and not take his life until God summons him, as he now summons me" (Ibid:

148). Socrates is an example of a convicted criminal who was allowed in Grecian times to take his own life and drank deadly hemlock choosing *death with dignity*, maybe because he thought *dying rightly* was more important than death at the hands of executioners. The Stoic Seneca declared that suicide was the last action of a free man and did so in 62 BCE.

Pelagius in the 5th century committed suicide believing “human freedom is the capacity of a neutral agent to make choices unconstrained and un-coerced, to contemplate options without internal or external restraints. Equipoised between good and evil, undetermined even by their previous choices; neutral selves can will what they will.” (Verhey: 1996:255). Augustine wrote “God permitted rapes because the victims had been too proud of their continence and it is wicked to commit suicide in order to avoid being raped.” In addition, Aquinas condemned suicide because “it violates one's natural desire to live, it harms other people and because life is the gift of God and is thus only to be taken by God”.

Michel de Montaigne one of the first sceptics thought suicide to be a matter of personal choice, and possibly a rational option under some circumstances. (Montaigne: 1579:2) Whereas Thomas More in his imaginary *Utopia* wrote that “in the case of an incurable disease, the patient is advised to commit suicide, but is carefully tended if he refuses to do so”. (Russell: 1991: 507) David Hume's scathing scepticism caused a backlash against church dogmatism and boldly stated “I believe that no man ever threw away a life, while it was worth keeping”. (Hume: 1784: 26)

Both John Stuart Mill and Bentham regarded suicide as a victimless act and were

sympathetic to the cause of euthanasia; the latter requested VAE on his deathbed. Rule utilitarianism or act consequentialism have two different philosophical approaches, and although their overlap may only be minimal, the exercise of either has the same result as in the 'double effect' of a palliative overdose or the honesty of VAE.

"Immanuel Kant would frown on the moral laxity of someone who opted for suicide however he might find it hard to deny a patient's freely chosen right to decide his/her own fate: Kant places a high value on autonomy. He thought suicide wrong, although his arguments against it are not very convincing. Permitting euthanasia universally would destroy our understanding of the intrinsic value of human life." (Robinson: 1996:168) Whereas Frederich Nietzsche declared that one should "die proudly when it is no longer possible to live proudly" (Nietzsche 1964:88)

However, John Wesley reckoned that Judas' suicide was a more heinous sin than his betrayal of Christ. On the other hand the French Montagnards believed suicide was an honourable and perfectly rational option for anyone who found that they could no longer pursue a life that was meaningful to them or consistent with their self-respect.

In India the Brahman caste honour one who voluntarily frees her/himself from their body, the Hindu widow was expected to immolate herself on her husband's funeral pyre in the act of suttee. Noblemen in Japan committed hara-kiri or self-disembowelment to escape the humiliation of being punished for wrongdoing. As a form of social protest, Buddhist monks and nuns have committed sacrificial suicide by burning themselves alive. In primitive societies, severely wounded, diseased or

frail aged commit altruistic suicides, so as not to be a burden to their tribe. The Koran severely censures self-murder as a graver crime than murder and countenances suicide only in the defence of one's faith or as proof of one's faith. The martyr is responding to Allah's will, with an act of heroic obedience.

In the Western media at present, every commandment that is broken makes headline news, every gruesome, homicidal, incestuous rape and mutilating *muti*-murder is described in stomach-turning detail. However, there still remains some genteel reticence when someone has actually murdered her/himself and committed suicide. Suicide is sensitively reported using phrases such as, 'no crime is suspected', 'the fatal gunshot was apparently self-inflicted' or 'he died by his own hand'. One has yet to read 'she blew her head off and made an awful mess on the walls and furniture.'

Moreover, although suicide is no longer a crime nor a sin in most countries, it has become instead a modern disease, a symptom of mental illness. Being regarded as a manifestation of psychiatric instability, it is not believed that it can ever be rationally chosen. But the taboo surrounding it remains, and the distaste and opprobrium encompassing it persist. However, regardless of the media reticence and social disapproval around self-murder many people continue to choose it as a solution to their angst, financial or physical woes. "Because current attitudes towards suicide are such an incoherent medley of views inherited from the past, both sides of any such debate would have a rich fund of arguments to draw upon. Although there has been little public discussion of the morality of suicide, the fact that suicide is utterly irrevocable just adds to the obligation to intervene." (Editorial: 1999: www)

On Golgotha, in 29 CE, at about three in the afternoon on the first Friday of the

Passover festival, Jesus of Nazareth, was *in extremis* and complained of thirst; thereafter a compassionate bystander, possibly influenced by the behest 'love thy neighbour as thyself' gave him a sponge soaked in some sour wine [we are not told if this was the sedative draught of wine mixed with gall that Jesus had earlier refused] "Having received the wine, he said, 'It is accomplished!' he bowed his head and gave up his spirit". (John: 19:30), similarly (Matthew: 27:50) and (Mark: 15:38). However in Luke: 23:46 we find: "Then Jesus gave a loud cry and said, 'Father into your hands, I commit my spirit'; and with these words, he died" (The New English Bible: 1970: pp 139, 41, 66 and 108)

The most famous case of active physician-assisted dying [APAS] was in 1935 when King George V of Britain was on his deathbed. We are told that the royal family did not want the first news of his death to appear in an afternoon (lower-class) tabloid newspaper. Consequently, his physician, Lord Dawson of Penn was requested to ensure his royal patient died late in the day with an overdose of morphine so that the first news of the King's death was in the morning (upper class) broadsheet, *The Times*. In the House of Lords, the following year, Lord Dawson confessed what he had done saying that "all good doctors did this", however he was opposed to the legislation of APAS on the grounds that, when necessary, good doctors did it anyway and it was always preferable to keep the law out of doctor-patient relationships as far as possible.

Ironically, the Christian Church, encouraged by the arguments of St Augustine, adopted a strict prohibition against suicide precisely because it had become so popular among Christians. A vogue for martyrdom, and even collective suicide, had

popular among Christians. A vogue for martyrdom, and even collective suicide, had by then begun to threaten the Church. Any religion which preaches that life on earth is a vale of tears, a mere prelude to a better after-life, would seem to be inviting its adherents to kill themselves, unless it can offer a good reason for them to delay their departure for paradise. Declaring suicide a mortal sin was the solution of the Church. Islam took the same path, forbidding it outright. Other religions, such as Buddhism and Hinduism, are less condemnatory.

A more sophisticated religious argument promulgated in the 18th century and still heard frequently today, is that suicide is “unnatural” in that it violates the natural order of the universe. God has created the world and its physical laws, and placed man in it. Suicide frustrates the divine scheme. In a celebrated essay on suicide, Hume, a great Scottish philosopher, thoroughly demolished this view. He pointed out that almost any human action alters the natural order. “If I turn aside a stone which is falling upon my head, I disturb the course of nature, and I invade the peculiar province of the Almighty by lengthening out my life beyond the period which by the natural laws of matter and motion He had assigned it.” He also wrote: “It would be no crime in me to divert the Nile or Danube from its course, were I able to effect such purposes. Where then is the crime of turning a few ounces of blood from their natural channel?” To the argument that human life is a special exception, Hume’s reply was blunt: “the life of man is of no greater importance to the universe than that of an oyster.” If one accepts the deist view of God as a “watch maker” who sets the world ticking and then does not intervene, Hume’s conclusion seems irrefutable.

It is often expressed in religious terms, as the “sanctity” or “sacredness” of life, but does not necessarily require religious sanction to command respect. Immanuel Kant relied on man’s rationality and capacity for moral choice to argue that it is wrong to treat any human being, even ourselves, as a means to some other end, and therefore wrong to kill ourselves to avoid pain or misery.

5. THE RIGHT TO DIE

“There is a desire of many people to control their dying as a way of finding meaning in their death. The desire for control over dying usually surfaces in talk about patient autonomy, professional power or the appropriate balance between individual self-determination and society's responsibility to care for its members. To carry on the discussion through debates about principles such as autonomy and beneficence misses the point, however for many people how they die, organically and technically, as well as emotionally and spiritually has come to represent a measure of life's final value. Too often under the current institutionalisation and medicalisation of death in our culture, the perception reigns that death is a meaningless affair. People want a good death, how to achieve it is another affair” (Hamel and Dubose: 1996:6).

Advances in medical technology over the past forty years have put a growing number of mentally competent people in the unenviable position of being attached to a machine but wanting to die. The Netherlands has passed laws allowing doctor-assisted suicide and the state of Oregon in the USA and Switzerland allow some forms of PAS, a practice which goes on everywhere no matter whatever the law says. Like it or not, the idea that people have a “right to die” is no longer considered outlandish. Indeed, it is gaining support.

So far, this “right” is usually discussed in a single, strictly limited context: terminal illness. Yet, if this right exists, what about suicide in general? Why should the right to die be confined only to the terminally ill or those in great pain? Does not everyone, including the robust, have the right to choose the timing and manner of their own

death? In addition, if they do, what right do the rest of us have to disapprove of suicide, or to try to stop it? The consensus is that suicide in other contexts can never be the choice of a healthy mind.

“In the case of the terminally ill patient who wishes to die earlier with dignity rather than later without it, the utilitarian approach is quite straightforward. We simply need to ascertain the consequences of insisting upon saving that person...he will have to suffer the pain and indignity he wants to avoid...impose a great personal and financial burden on his family...several substantial losses that result from the paternalistic decision to disregard the patient’s wishes”. (Brody: 1983:176).

One wonders if there is any real distinction whether legal or moral that can be drawn between withholding treatment and withdrawing treatment. Theorists speak obdurately that there is indeed a difference between the morality of passively ceasing therapy to cause death (by probable cruel and inhumane means) and the immorality of active, compassionate assistance to die (by gentle and kind means). I am unable to discover the moral divide between allowing to die and aid-in dying, and I find the former cruel and almost sadistic whereas I find the latter civilised. “The most obvious purpose in this article is to contend that these arguments based on causation and intention fail to do the work we ask of them, but in the end the failure does little to illuminate what public policy ought to be on PAS or active euthanasia. The less obvious purpose is to try to illustrate and develop a key concept in the rediscovery of casuistry as a methodology in medical ethics.” (Brody: 1993:113)

A fierce opponent to assisted death (Callahan: 1992:53) insists: “Does active suicide

have a different ethical significance to refusing medical treatment? The PAS debate is not just a moral debate, another one in a long list of arguments in our pluralistic society. It is profoundly emblematic of three important turning points in Western thought. The first is that of the legitimate conditions under which one person can kill another. The second turning point lies in the meaning and limits of individual self-determination. The third turning point is to be found in the claim being made upon medicine that it should be prepared to make its skills available to individuals to help them achieve their private vision of the good life." Callahan also says, "Euthanasia is not a private matter of self-determination. It is an act that requires two people to make it possible and a complicit society to make it permissible."

"Every vaccination of a baby interrupts the natural course of events." (Brack: 1991:1055). A common objection in religious quarters is that suffering is part of the divine plan for the good of man's soul, and therefore must be accepted. If this innocent and naive idea of the purpose of suffering were a valid one, then no ethicist could give moral sanction to any form of medical or scientific abatement of any disease, physical, emotional pain or infertility. Moreover, if life is intrinsically valuable, the question arises: valuable to whom? The value of human life must consist in more than mere biological existence. If the holder of any individual life finds it no longer of value, then surely objections to that person's suicide based solely on the value of life carry little weight. (Robertson 1999)

There are caring and perceptive doctors who after careful assessment would honour a dying patient's final request however: "It would be irrational not to regard certain cases of being an accessory to murder being as bad as murder, as involving a guilt

as great as that of actually carrying out the killing. This is because to hand a murderer the gun which he is to use to carry out his crime may, in certain circumstances, be to participate in what he does to such an extent that two persons are equally involved as agents and share equal responsibility”(Casey: 1971:351)

In addition someone like Brian Childs realises that a narrative approach to understanding assisted suicide has been compromised by the notion that all narratives must be both coherent and unified and writes: “what are we to do with those narratives that cannot seem to cohere or be other than full of disunity? Is suicide the only way to make meaning out of suffering?” He then proposes that “the narrative found in the Gospel of Mark leads Christians to a life in hope and compassion in spite of apparent incoherence and disunity and threats of abandonment and suffering”. (Childs, 1997: 21)

Some opponents believe that the large proportion of people in the US who are supposed to support the legalisation of VAE “is due to the widespread fear and confusion over the tortuously prolonged and painful process of dying countenanced by contemporary medicine...Does the energy directed towards palliation-by-death mean that our society is more compassionate now or more just than in the past? To the contrary, I believe that the movement toward assisted death reflects inadequate palliative care, poor patient-physician communication, great confusion about the right to refuse treatment and profound inequity in US health care. Legalisation of assisted death diverts us from answering these questions.” (Coulehan: 1997: 799)

Others write: “There are cases where the consequences are equivalent and cases

where the consequences of killing are preferable, yet it is still wrong to kill. The distinction as I have drawn it has some moral bite: it seems intuitively clear that causing a death is morally somewhat more reprehensible than knowingly refraining from altering conditions which are causing the death. Bennett has not refuted the conservative position because the question of whether an act is one of killing or letting die is relevant in determining the morality of the act." (Dinello: 1971:358).

However when we look at Jürgen Habermas belief that a society's structure can only be changed by discussion leading to communicative agreement and finally to the formation of consensus; in the case of PAS I think one has to prioritise the judgement of the person on the spot. "The lesson Habermas suggests for the euthanasia debate and for medical ethics generally can be simply stated: When ethical principles lose touch with local narratives of experience, then their attempted universalism has no popular moral consensus behind it. When principles lack consensus, they lack legitimacy. *Ethics* becomes an activity for specialists: abstract, administrative and perceived as just another imposition on people's lives" (Humphry: 1992:64).

In an article about the decisions which are made in the care of the terminally ill, Kass (1991:474) writes: "No fixed rules of conduct apply; instead, prudence - the wise judgement of the man-on-the-spot - finds and adopts the best course of action in the light of the circumstances." However, in place of his traditional model of moral top-down reasoning and justification, *contextualisation* is a better approach as it endorses the concept of working from the bottom up before making an informed moral conclusion.

Three hundred and fifty years later, John Donne's insights were rephrased (plagiarised?) thus: "A self does not amount to much but no self is an island; each exists in a fabric of relations that is now more complex and mobile than ever before. Young or old, man or woman, rich or poor, a person is always located at 'nodal points' of specific communication circuits, however tiny these may be." (Lyotard: 1984:15). No one can deny that each man's death diminishes 'me', but this is not valid when that life is no longer worth living nor of use to anyone

"The distinctly postmodern ethical problematic arises primarily from two crucial features of the postmodern condition: pluralism of authority and the centrality of choice (or enhanced autonomy) in the self-constitution in post-modern agents" (Baumann: 1994:201). The postmodern birth of this multiplicity of significantly different discourses and aspirations has given rise to even more doubt about what is actually legitimate in our socio-ethical humanity to-day. Postmodernism is acutely aware of the problem that there are certainties no more and that past all-embracing rules and grand narratives for ethical actions no longer exist. "Doubt seems to be the central condition of the human being in the twentieth century. One of the things that has happened to us is to learn how certainty crumbles in our hands." (Salman Rushdie said this on the day of the imposition of the *fatwa*).

"Scepticism about the possibility of normative theory on the grand scale and growing doubts about the feasibility of solving moral problems by deductively applying general principles has given rise to a plurality of approaches and ways of conceptualising problems within the field of applied ethics. One general approach to practical moral

decision making currently gaining favour is *contextualism*...which is primarily critical of established beliefs about ethical theory rather than constructive of better or deeper models of moral reasoning and justification." (Winkler and Coombs: 1994: 4)

Since before Hippocrates' time medical ethics has focussed on the doctor-patient relationship, but the postmodern loss of this dyadic interdependence has blurred the decision making implicated in caring for the terminally ill. What was once a lineal doctor-patient relationship is now a multifaceted one because of the variance of conceptions and the diversity of values, taken from cultural, individual, religious and moral beliefs.

A prognosis of three months of a cruel, so-called existence is demoralising and dismaying. Must one take such a long time to die knowing that the only cure will be an inevitable death, when most of us dread an inescapable protracted, degrading process of dying that lies ahead and the prescience of being condemned to suffer unbearably and hopelessly to that end. Patients requesting VAE have passed through each stage of the Kübler-Ross scenario of denial, anger, bargaining and depression and have now reached the stage of acceptance. Their view of the situation is no longer compounded by resentment and there is no self-pity in their sincere belief that there really is no purpose in lingering on for the final act of this drama. He is not in denial having accepted the inevitability of his death and would truly welcome an early escape from his tormented body. He asks his doctor for palliative physician-assisted aid-in-dying, namely an overdose of some medication that will help him die with a little dignity and as soon as possible.

There are many arguments against VAE: the main being that it violates the categorical prohibition against killing, the integrity of medicine, the patient's trust in the doctor who is hired to seek only health and healing and therefore undermines the patient-physician relationship. However, these objections are largely concerned with the paternalistic, Hippocratic concept that death is a defeat and this enemy must be rigorously battled to the savage end. The teleological justification for the use of the extraordinary weapons of war is valid where there is a remote prospect of vanquishing the enemy. However compassionate and honest doctors often see little value in this approach, as it will only prolong the conflict at the price of further injury, dehumanisation and torment, allowing a cruel postponement of the inevitable defeat while causing more physical and spiritual damage. Prolonged, agonising deaths in which a patient's personality and sense of self-worth disintegrate can be degrading. Without these, life can seem meaningless. No one should be forced to continue suffering if they find their plight humiliating, their sense of selfhood destroyed. There are human values, which trump even continued life.

Another category of arguments against suicide is secular and involves, in one form or another, claims that we owe it to other people - family, friends or society as a whole - not to kill ourselves. In this view, suicide is always a supremely selfish act in that it ignores genuine obligations that all human beings have towards others. It is undeniable that most suicides have a devastating impact on family and friends. "Suicide kills two people," Arthur Miller wrote famously in "After the Fall." "That's what it's for!"

Once sacrifice, or self-sacrifice, is conceded as a morally acceptable exception to the intrinsic value of human life, the principle collapses as an effective objection to suicide in general. Many suicidal people might, if they were disposed to argue their case, claim that they were, indeed, sacrificing themselves to save others, if not from imminent death, at least from a life blighted by the need to care for them. (Economist).

What is the nature of the right to die? Is it a “negative” or “liberty” right, such as the freedom of speech or religion, requiring that others should not interfere with someone exercising it as long as that person is not injuring others? Or is it a “positive” right, such as the right to health care, education or a minimum standard of living, requiring that others, usually via the government, assist anyone exercising it? Many voluntary euthanasia campaigners believe that the right to die should be a positive right, requiring doctors to assist those who want to die.

6. THE MORALIST'S VIEW OF SELF-MURDER

In many languages, the word suicide implies a moral wrong or psychological aberration. "The German term *freitod* (a free death or voluntary death) is a positive term, free from connotations of either moral wrongdoing or pathology... their practice of assisted suicide, as shaped both by law and by linguistic expectation, tends to minimize the role of the physician." (Battin: 1994:45) "Although philosophers do not agree on whether moral agents have positive duties of beneficence, including duties to those in pain, members of the medical world are not reticent about asserting them. These are not simply assertions that the physician "do no harm" as the Hippocratic Oath is traditionally interpreted, but assertions of a positive obligation. It might be argued that the physician's duty of mercy derives from a special contractual or fiduciary relationship with the patient, but I think this is an error: rather, the duty of medical mercy is generally binding on all moral agents, and it is only by virtue of their more frequent exposure to pain and their specialised training in its treatment that this duty falls more heavily on physicians and nurses than on others." (Battin: 1994:102)

Most competent adults are usually concerned about where their lives are at present and where their lives are headed in the near future. In the exercise of self-determination and autonomy, thinking people take responsibility for their lives and since dying is a part of life, they are frequently interested in the manner of their deaths. Many are curious about how the last stages of their lives will be played, are we going to spend our last years in poverty or relative comfort, are we going to spend

our last months with dignity and as much control over our bodies as previously, or are we going to 'suffer our way to death' or be totally dependent on others and machines for every physiological need, finally dying stripped of quality, dignity and humanity? Do we ultimately want to extend our almost inevitable mental and physical decay so that life becomes a burdensome curse and is no longer worth living?

When one can no longer alleviate the agony and have decided to desist from struggling to save a severely injured soldier or a terminally diseased citizen, is it more virtuous to merely stop the treatment of this person *or* to ease a terminal patient's demise with an excess of opiates? To these historical problems have now been added a large number of predicaments wherein a doctor is expected to make just and validated life and death decisions or in fact "to play God."

An example of a virtue ethics approach to euthanasia is Philippa Foot's argument "that wanting to die does not necessarily make death a good for that person; rather, death can only be a good to a person only when their life lacks a minimum of basic human goods, such as autonomy, friendship and moral support". Foot argues that the virtues of justice and charity allow one to fulfil a competent individual's request to be killed, where such basic human goods are absent. Foot also argues that analysing end-of-life decisions in terms of these virtues can bring out an important moral difference between killing and letting die. In normal circumstances, both justice and charity require that we do not let people die when we could reasonably have helped them. Furthermore, where someone whose life lacks a minimum of basic human goods expresses a sincere request to be killed, both justice and charity

would permit such an action to be carried out. However, where such a person demands not to be killed, and, wishes to be left to die in agony, the requirements of these virtues diverge – that is, justice would forbid us from carrying out the act of killing which charity would normally permit us to perform in such circumstances”(Oakley: 1998:92).

Objections Raised against the Morality of Voluntary Euthanasia

Opponents of voluntary euthanasia counter the straightforward desire of those who wish to be released from an incurable illness earlier than the natural course of that disease is assumed to take place. Medical expertise is becoming more skilled at providing effective palliative care, and therefore it is said that no-one has to die nowadays while suffering from intolerable or overwhelming pain and it is true that good palliative care can transform the plight of the dying. However, there are flaws in this argument. The achievement of the best palliation of pain can take some time to get right and unfortunately in some cases an equitable balance between pain relief and side-effects is never to be resolved in this particular person as each patient is different. Highly effective analgesia is often complicated by side effects such as anorexia, nausea and vomiting, incontinence or retention of urine, faecal obstruction accompanied by spurious diarrhoea, a drugged dream like state, the utterance of strange statements, bizarre patterns of forgetfulness and remembering and an alteration of thought ideation that is as worrying to the sufferer as to the carers.

The care that is available in hospices is excellent, but it is only to a small proportion of the terminally ill and admission is often only in the last stages of the illness. Not everyone wishes to receive palliative terminal care and most people want to die at home in their own way and in their own time and not in a hospice. Not everyone who

wishes to die is suffering as a result of pain caused by an illness and effective pain control is quite irrelevant for someone whose source of deep distress and frustration of autonomous control is her/his intolerable dependence on others or on machinery.

Battin M, *The Least Worst Death*. 1994 New York Oxford, Oxford University Press. p. 102. "Although philosophers do not agree on whether moral agents have positive duties of beneficence, including duties to those in pain, members of the medical world are not reticent about asserting them. " Relief of pain is the least disputed and most universal of the moral obligations of the physician," writes one doctor. "Few things a doctor does are more important than relieving pain," says another. [Refs. E D Pellegrino, "The clinical ethics of pain management in the terminally ill," *Hospital Formulary* 17 (Nov 1982): 1495-96; Marcia Angell, "The Quality of Mercy," *New England Journal of Medicine*, 306 (Jan 1982): 98-99].

There is a warranted doubt about some doctors' ability in accurately predicting the expected non-quality of life or to assess the patient's mental status and motivation for this request. Some authorities question the right of mere mortals to assume the functions of the divine designer and say this is murder and others insist that there is no way of accurately evaluating the external pressures on the patient and the doctor. Another objection to the possible legalisation of voluntary euthanasia is that one should not believe that a dying person's request to be helped to die could ever be genuinely voluntary or rational. Most other suicidal attempts are cries for help and reflect difficulty with social problems, or temporary despair and when the problem is resolved they never try to kill themselves again. This is why there is an insistence that the request is enduring and Oregon requires a mandatory 14 day "Change-of-mind" period.

All agree that a patient distressed by pain, nausea and bedsores and confused due to medication is not able to think clearly and cannot be assumed to have a rational, enduring and genuinely voluntary desire to die. However, this is definitely not the case with most candidates for AE many of whom know where they will be going and make their requests before this advanced stage. Why cannot a person have sufficient inductive evidence (e.g. based on the experience of the deaths of friends or family) to know her own mind and act accordingly?

The moral permissibility of intentional killing can only be evil and morally indefensible if it causes wrongfully inflicted damage or harm. On the latter understanding consent becomes crucial from that person's standpoint (it is, in fact, beneficial). There is a widespread belief that passive (voluntary) euthanasia 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 pragmatics 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 where 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.

One way to show that it is in most cases implausible to think that the withdrawal of life sustaining measures involves no intention to terminate the patient's life is to consider the growing practice of withholding artificial nutrition and hydration in those instances where a decision has been made to cease aggressive treatment, and then to see if we can generalise to cases like that of the motor neurone sufferer (cf. Winkler, 1995). It is my assessment that those who withdraw artificial nutrition and hydration do intend the deaths of their patients and that sense can be made of what they do only on that basis. Permanently withdrawing nutrition from someone in, say, an irreversible coma (a persistent vegetative state), thereby starving the patient, is not merely to foresee that death will ensue, but to intend the death. No sense can be made of the action as being intended to serve to palliate the disease, or to keep the patient comfortable, or even, in the case of a person in a permanently vegetative state, as allowing the underlying disease to carry the person off. The loss of brain

activity is not going to kill the person. What is going to kill the patient is the act of starving her to death. That is the clear intention, not merely something foreseen as an unfortunate side effect, but in no way the intended result.

Can this claim be extended to other circumstances? The giving of massive doses of morphine, way beyond what is needed to control pain, or the removal of a respirator from a sufferer from motor neurone disease would seem, by parallel reasoning, to amount to the intentional bringing about of the death of the person being cared for.

There are circumstances where doctors can truthfully say that without them intending that those patients should die there are actions which they perform, or omissions which they make which do lead to the deaths of their patients. Thus, for instance, if a patient refuses life prolonging medical treatment because she considers it useless, it might reasonably be said that the doctor's intention in complying is simply to respect the patient's wishes. For that reason alone the medical profession has long found psychological comfort in the belief that even if killing cannot be justified it is quite another thing to allow a patient to die (where that involves no negligence) because there the cause of death is natural. This underlying assumption is one that is open to challenge (and has been challenged in e.g. Rachels, 1986, chaps. 7, 8; Kuhse, 1987). First, there will be cases, namely those where someone who has requested assistance to die and is allowed to die, rather than killed, where it is morally worse to allow to die because all that that does is prolong the patient's suffering. There is a legal doctrine that says that no one can justifiably consent to be killed. This is surely relevant to the justification of an act of killing someone who has autonomously decided that that is what would be best for them.

It is often said that if society allows voluntary euthanasia to be legally permitted we will have started on a slippery slope that will lead us inevitably to support other forms of euthanasia, especially non-voluntary euthanasia. Whereas it was once the common refrain that that was precisely what happened in Hitler's Germany, nowadays the claim tends to be that the experience of The Netherlands in the last decade or so confirms the reality of the slippery slope. Slippery slope arguments come in at least three different versions: logical, psychological and arbitrary line. What the different forms share is the contention that once the first step is taken on a slippery slope the subsequent steps follow inexorably, whether for logical reasons, psychological reasons or to avoid arbitrariness in 'drawing a line' across a person's actions. (For further discussion see e.g. Rachels, 1986, Ch. 10; Brock, 1992, pp. 19ff).

There is nothing logically inconsistent in supporting voluntary euthanasia but rejecting non-voluntary euthanasia as morally inappropriate. Since the two issues are logically separate there will be some advocates of voluntary euthanasia who will wish also to lend their support to some acts of non-voluntary euthanasia (e.g. for those in persistent vegetative states who have never indicated their wishes about being helped to die or for some severely disabled infants for whom the outlook is hopeless). Others will think that what may be done with the consent of the patient sets a strict limit on the practice of euthanasia. The difference is not one of logical acumen. It has to be located in the respective values of the different supporters.

As regards the alleged psychological inevitability of moving from voluntary to non-voluntary euthanasia, again it is hard to see the supposed inevitability. Why should

those who value the autonomy of the individual and so support provision for voluntary euthanasia be psychologically driven to support cases of euthanasia which have no connection with the exercise of patient autonomy?

Since the publication of the Rummelink Report in 1991 into the medical practice of euthanasia in The Netherlands it has frequently been said that the Dutch experience shows decisively that legally protecting voluntary euthanasia is impossible without also affording protection to the non-voluntary euthanasia that will come in its train. Unfortunately, many of those who have made this claim have paid insufficient attention to the serious studies carried out by van der Maas, et al. (1991), and van der Wal, et al. (1992a and 1992b) into what the Report revealed. In a second nationwide investigation of physician-assisted dying in the Netherlands carried out in 1995, a similar picture emerged as had in the earlier Rummelink Report. Again no evidence was found of any descent down a slippery slope toward ignoring people's voluntary choices to be assisted to die (see van der Maas et al. (1996); van der Wal et al. (1996)). The true picture is that, of those terminally ill persons assisted to die under the agreement between the legal and medical authorities, a little over one half were clearly cases of voluntary euthanasia as it has been characterised in this article. Of the remainder, the vast majority of cases were of patients who at the time of the assisted death were no longer competent. The deaths of some of these were brought about by withdrawal of treatment, that of others by interventions such as the giving of lethal doses of anaesthetics. But the critical point about this vast majority of such cases is that the decision to end life was nearly always taken after consultation between the doctor(s) and family members. If active euthanasia is widely practised but in ways that are not legally recognised there is apt in fact to be more danger that

the distinction between voluntary cases and non-voluntary ones will be blurred or ignored than in a situation where the carrying out of euthanasia is transparent and subject to monitoring.

There needs to be safeguards against potential abuse of any legal protection for voluntary euthanasia. This is particularly important for those who have become incompetent by the time decisions need to be taken about assisting them to die. As was mentioned very early on, there are ways of addressing this issue (such as by way of advance declarations or living wills) which are widely thought to be effective, even if they are not perfect. The main point to be stressed at the present, though, is that there is surely no need for anyone to be frightened into thinking that the legalisation of voluntary euthanasia will inevitably end in her having her life snatched away from her should she become incapable of exercising a competent judgment on her own behalf. Second, it is of course possible that the reform of any law will have unintended effects. It is sometimes said in discussions about legalising voluntary euthanasia that experience with abortion law reform should remind us of how quickly and easily practices can become accepted which were never among the reformers' intentions, and that the same thing could occur if voluntary euthanasia were to become legally permitted. No amount of theorising, it is said, can gainsay that possibility. One can't deny that it is possible that reform of the laws that presently prohibit voluntary euthanasia could have untoward consequences. However, if the arguments given above are sound (and the Dutch experience is not only the best evidence we have that they are sound, but the only relevant evidence), that does not seem very likely.

The final objection being considered here is that it is often claimed that whatever the morality of an individual who is deciding for herself that her life is no longer of value to her is, that that provides no basis for the formulation of public policy. The fear of the slippery slope is no doubt, part of the concern expressed here. But, as well, there are concerns about the role of the law and more particularly, its contribution to the regulation of medicine.

What of the right of self-determination by the patients? We have already had occasion to note that the law does not presently permit an individual to consent to her/his own death. Nevertheless, the very same fundamental basis of the right to decide about life-sustaining treatment - respect for a person's autonomy - underpins voluntary euthanasia as well. Indeed, the fact that suicide and attempted suicide are no longer criminal offences in many jurisdictions indicates that the central importance of individual self-determination in a closely analogous setting has been accepted. The fact that assisted suicide and voluntary euthanasia have not yet been widely decriminalised is probably best explained along the lines that have frequently been offered for excluding consent of the victim as a justification for an act of killing, namely the difficulties thought to exist in establishing the genuineness of the consent.

6.1 The ethical dimension

“While physicians, then, may not disconnect life support systems where they shorten life thereby, they may do so to shorten the death process. Since however we ‘begin dying the moment we are born’ [with the closure of the ductus arteriosus in the heart which allows the venous blood to bypass the lungs] and more to the point it is difficult to ascertain the difference between shortening a life and shortening a death, the principle is a moral one rather than a practical one.” (Feldman;1988:73)

Surely we should respect individuals and enable them to make conscientious autonomous decisions in their final agonising decisions. Most of us want to die peacefully and without pain. Mentally competent and free of psychosis or major depression

“There is a desire of many people to control their dying as a way of finding meaning in their death. The desire for control over dying usually surfaces in talk about patient autonomy, professional power or the appropriate balance between individual self-determination and society's responsibility to care for its members. To carry on the discussion through debates about principles such as autonomy and beneficence misses the point, however: for many people how they die, organically and technically, as well as emotionally and spiritually-has come to represent a measure of life's final value. Too often under the current institutionalisation and medicalisation of death in our culture, the perception reigns that death is a meaningless affair. People want a good death, how to achieve it is another affair”(Hamel and Dubose: 1996:6)

Because there is something deeply embedded in most doctors' consciousness to retain their patient's trust, to practice as s/he knows best and to avoid any unjustified hurt to a patient, VAE accordingly cannot violate the doctor's professional integrity and ethos; nor can it be used to demonstrate the doctors' power or bolster their ego.

Theorists speak obdurately that there is indeed a difference between the morality of passively ceasing therapy to cause death (by cruel and inhumane means) and the immorality of active, compassionate assistance to die (by gentle and kind means). I am unable to discover the moral divide between allowing to die and aid-in dying, and I find the former barbaric whereas the latter civilised.

"The most obvious purpose in this article is to contend that these arguments based on causation and intention fail to do the work we ask of them, but in the end the failure does little to illuminate what public policy ought to be on VAE. The less obvious purpose is to try to illustrate and develop a key concept in the rediscovery of casuistry as a methodology in medical ethics." (Brody: 1993:113)

Does anyone have the right to tell anyone else what goodness is and what wickedness is? Even though acting with respect for personhood, within the context of established values and in the recognition of the fact that a physically and spiritually tortured person is a fellow human of inestimable worth, the morality of doctors who actively help their patients to die is often questioned. This is a skewed viewpoint, because no conscientious, caring physician will assist a competent human-being to die unless the case is terminal, incurable and agonising and unless the sufferer is competent and has repeatedly and with cruel justification has pleaded for this.

When condemning VAE and refusing to allow anyone's complicity in self-murder for any reason, I see the cruelty of the fundamentalist and the bigot, whether a doctor, a religionist or an ethicist; in fact I see the exercise of perverted power in the refusal to hasten the death of someone who wants to die sooner and peacefully rather than later and unmercifully from a terminal, incurable and agonising disease. When one reads about the sadistic endorsement of suffering by the opponents of assisted suicide, one queries if this is a programme written by a computer or by a sensate human.

While Plato "when expressing his views on whether and when a person may choose to leave this life, used two main criteria: What would a virtuous person do in such circumstances, and what does a person in such circumstances owe the community? Both the individual's responsibilities to live a good life and the individual's responsibility for the good of the community were considered. The notion of a right to freedom of choice did not enter into any of the criteria." (Tauer: 1996:45)

Hume, a great Scottish philosopher, thoroughly demolished the view that God has created the world and its physical laws, and placed man in it, consequently suicide frustrates the divine scheme. He pointed out that almost any human action alters the natural order. To the argument that human life is a special exception, Hume's reply was blunt: "the life of man is of no greater importance to the universe than that of an oyster." If one accepts the deist view of God as a "watch maker" who sets the world ticking and then does not intervene, Hume's conclusion seems irrefutable.

A successful defence of rational suicide lies in a more subtle argument often used by those advocating voluntary euthanasia and doctor-assisted suicide for the terminally ill. Prolonged, agonising deaths in which a patient's personality and sense of self-worth disintegrate can be degrading. Without these, life can seem meaningless. No one should be forced to continue suffering if they find their plight humiliating, their sense of selfhood destroyed. There are human values that trump even continued life.

6.2. The medical dilemma

(Can Doctors Accurately Predict A Dying Persons Length of Surviving?)

“By default society has assigned the physician the role of theologian and moralist – a role for which he has no competence. The fear of sickness and death, aided by the intentionally cultivated aura of mystery and the deep respect of the laity for scientific achievement, has resulted in this unwritten election of the medical community as the arbiter of the most fundamental truths of Torah morality and of Western Civilisation.... As Will Durrant so rightly said: ‘Science tells us how to heal and how to kill; it reduces the death rate in retail and then kills us wholesale in war; but only wisdom can tell us when to heal and when to kill’” (Tender: 1998.)

Many patients with terminal advanced cancer or those suffering from a chronic intractable and unbearable illness undergo distressing physical symptoms and problems in addition to pain. These can include anorexia, constipation, diarrhoea, dyspnoea, nausea, urinary tract and chest infections and demoralising fatigue. Often symptoms and infections “do not occur in isolation but several may be present simultaneously and interact so as to produce a ‘crescendo’ effect. The dyspnoeic patient will experience increasing anxiety and rapid breathing, which may then exacerbate pain arising from metastases in the ribs and spine.” (WHO: 1990:41). “Her pain was so intense and her impending death so obvious that he agreed to give her a fatal drug overdose. Grateful for Dr Rasmussens help, but fearful of the legal consequences should his act be discovered, the womans family acquired the drugs themselves to end her ...”

A study by Emanuel surveying cancer patients with pain or depression showed how differences in their attitudes toward physician-assisted suicide would effect their choice of physicians. Patients with pain reported they would change physicians if they knew their physician participated in physician assisted suicide. Those with depression were more likely to seek out such physicians. "He feels physically and spiritually exhausted by this fight and sees no purpose in living out the final chapter. He is not religious in a traditional sense, but he has a clear sense of spirituality related to human dignity and compassion. His fight so far has embraced enough human interaction to compensate for the profound losses, but for him the future promises only further degradation and loss. The only relief he can see is death. He has thought deeply about his options and has reached an acceptance of his own dying. His view of the future is realistic and not distorted by depression. He is not in pain. His physical symptoms include profound weakness, chronic nausea, incontinence and confusion." (Cassell)

To a pragmatic person a good death and dying with dignity means exactly that. A gentle slipping away from consciousness, without pain or anxiety and not tethered by monitors, tubes, respirators and intravenous drips. "Of course people on the spot cannot act without principles. The issue between the languages of principles and experience will never be either/or, but rather which language is now the foreground and which the background. Euthanasia decisions cannot be made without principles; ethicists like Kass, Pellegrino and Callahan make valuable contributions. But the principles they advance must constantly be held accountable to the experiential narratives of people with real names, in real relationships, suffering both in their bodies and in the dramas of their lives." (Frank: 1996:97)

At present in our country, we frequently make this kind of ethical decision around the patients' sickbed at home; and thus they are completely atypical of the usual milieu of the biomedical ethical debates around VAE, which occur within a particular institutional setting. "The pragmatic nature of ethical decisions that change daily has moved away from safe theoretical discussions in secluded conference rooms to hazardous decisions that will be implemented on the playing fields of wards and intensive care units". (Shalit: 1997:18)

People against euthanasia believe that legalising it will reduce or even remove the incentive for further improvements in palliative patient care. "Heroic life-saving techniques are not always desired by those to whom they are administered. In these cases the patients are well aware that they will not be able to live much longer and that this technique simply offers a somewhat extended span of life in hospital. To many this modest and limited extension of life is not worth the loss of dignity they experience by being totally dependent on machinery and requiring constant care. ...For many reasons, many people who find themselves in this type of situation prefer not to be kept alive" (Brody: 1983:162-3).

The British Medical Association's guidelines on withdrawing treatment state: "Where a particular treatment is no longer benefiting the patient, continuing to provide it would not be in the patient's best interests and, indeed, might be thought to be morally wrong. This document is not about euthanasia, it is not a charter or a document about intentionally ending a life. What this document is about is a clear assessment of the benefits of particular treatment and whether that treatment should

be withdrawn or withheld. Death cannot be postponed indefinitely. There comes a point where treatments, including artificial nutrition, are more of a burden than a benefit to the patient". When asked if the guidelines could be in conflict with those who thought that just staying alive was a goal of medicine, the co-author replied "We don't think so. Just staying alive is no good unless it is a means to an end of a flourishing life. If not, then it is normally reasonable to withdraw . . . The intent is not to kill but to allow someone to die with compassion."

(Gillon:www.timnwshea02005.htm)

6.3 Religious dilemmas

The Good Samaritan was moved by compassion and recognised the injured man by the wayside as his neighbour, as a fellow human being, and treated him as he would have wanted to be treated himself. Dr Russell McIntyre, a Catholic professor of ethics expressed his thoughts on the unnecessary prolongation of the dying process wrote, "My conservative nature requires that I cling fast to the sanctity of life principle, given to us in trust by a loving God. Nevertheless, I must also recognise that this gift, and the sacredness, which accompanies it, also has limits; i.e. there comes a point in time when the gift is withdrawn and with that action the sacredness diminishes. For me, this Biblical distinction applies to life and death. The Spirit of God is given to create life; it is also withdrawn as life loses its vitality, its entelechy... My more moderate nature forces me to recognise that under the rubric of care, excruciating and intractable pain is also destructive to the sanctity of life." (McIntyre: 1978: 49)

There is a well-established tradition in the Jewish faith that a physician's binding religious obligation is to heal. The physician's duty is to provide service to a person in a life-threatening situation, and one who shirks the task of healing another is guilty of bloodshed (*shefikut damim*). However, "In the case of a dying patient one is permitted to do such things which do not involve action at all, but merely remove that which hinders his death" (Shulchan Aruch, Yoreh Deah 339:1)

In the Christian religions, suffering has a divine purpose, because wo/man is supposed to experience the suffering of Christ and hereby experienced growth of the

character. Probabilism is considered to be acceptable in the more liberated visions of orthodox thought. It could be permissible for an agent to act from an assumption that has a probability of correctness although aware a more inflexible opinion is held to be more probable. This involves the use of rationality on issues that do not have an absolute heritage; morality is no longer about obeying the rulings of biblical mandate, but about thinking carefully and intuitively about outcomes and their consequences.

“In Michel Foucault’s terms, the domination typical of ‘pastoral power’, is one of the most insidious of the many shapes of domination, as it blackmails its objects into obedience and lulls its agents into self-righteousness by representing itself as self-sacrifice in the name of ‘the life and salvation of the flock’ “ (Bauman: 1998:103). However Foucault’s fascination with the amoral Marquis de Sade, makes one wonder if sexual stimulation is not a component of most desires for power and especially that which takes pleasure in the torment and torture of humanity; whether single individuals or ethnic or religious powerless minorities.

Of the other churches the Episcopalian (Anglican) Unitarian, Methodist, Presbyterian and Quaker movements are amongst the most liberal, allowing at least individual decision making in cases of active “EUTHANASIA”. Hindu and Sikh Dharma may also leave it to individual conscience. Nowadays few faiths prohibit passive “EUTHANASIA”, or refusal of treatment decisions. Those that do tend to oppose it include conservative Evangelicals, Islam, and the Mormon Church.

Suicide (self-deliverance) is accepted by a number of faiths. There is a Jaina ethic of voluntary death through fasting, for instance. It is often thought that the Roman Catholic Church absolutely prohibits suicide, but Catholic theologians have confirmed that the prohibition, whilst being the Vatican's current position, is not an inviolable one. Church hierarchies are generally not amenable to reasoning and arguments, however well they are constructed, from the laity. Cultural forces and public opinion appear to have an effect over time.

A common objection in religious quarters is that suffering is part of the divine plan for the good of man's soul, and therefore must be accepted. If this innocent and naive idea of the purpose of suffering were a valid one, then no ethicist could give moral sanction to any form of medical or scientific abatement of any disease, physical, emotional pain or infertility. The British Christian Medical Fellowship stated that "Voluntary euthanasia denies patients the final stage of growth. It is often through facing hardship that human character and maturity develop most fully." The 'Right to Live' campaign in Kwazulu Natal quoted The Second Vatican Council of the Catholic church "it is in the face of death that the riddle of the human existence becomes most acute". (SALC:1999:1020). The Christian Coalition believes that: "it is the suffering endured that brings a person to salvation".

Many devout branches of Christianity believe that it is God's wish that we suffer on earth in order to truly know and understand Jesus' suffering while he lived on earth and thus earn our places in the world to come and be enabled to spend eternity

there; “until the Lord in his infinite wisdom decides wo/man has suffered enough and takes her/him home to rest.”

Thomas **Aquinas** (circa 1225-1274) condemned suicide because: ‘it violates one's natural desire to live & it harms other people & life is the gift of God and is thus only to be taken by God’. However, Michel de Montaigne (1533-1592) was the first major dissenter among European writers. He wrote 5 essays which touched on the subject of suicide, arguing that suicide should be considered a matter of personal choice, and that it is a rational option under some circumstances.

A common objection in religious quarters is that suffering is part of the divine plan for the good of man's soul, and must therefore be accepted. Does this mean that the physician's Hippocratic Oath is opposed to Christian virtue and doctrine? If this simple and naive idea of suffering were a valid one, then one would not be able to give our moral approval to anaesthetics, or to provide any medical relief for human suffering. Such has been the objection of many religionists at every stage of medical conquest, for example the use of anaesthetics at childbirth by the ethicist, Joseph Fletcher. Abortion and “EUTHANASIA” are thus crimes which no human law can claim to legitimise. In the case of an intrinsically unjust law, such as a law permitting “EUTHANASIA”, it is never licit to obey it, or to “take part in a propaganda campaign in favour of such a law, or vote for it”; (John Paul II, *On the Value and Inviolability of Human Life, Evangelium Vitae*, 73) “For it is a question of the violation of the divine law, an offence against the dignity of the human person, a crime against life, and an attack on humanity “- Roman Catholic Declaration on “EUTHANASIA”

English law, whilst paternalistic towards minors, respected the autonomy of adults, and quoted the decriminalisation of suicide as a recognition that the principle of self-determination should in that case prevail over the sanctity of life. We should also remember that doctors generally are not trained as ethicists in any real sense of the word, even though many of them arrogate a high moral ground to their personal beliefs.

The finely balanced judgement of a modern day Roman Catholic professor of ethics, Dr Russell McIntyre, who came close to a personal confession of his understanding of the truth when he wrote, "My conservative nature requires that I cling fast to the sanctity of life principle, given to us in trust by a loving God. However, I must also recognise that this gift, and the sacredness which accompanies it, also have limits; i.e., there comes a point in time when the gift is withdrawn and with that action the sacredness diminishes. For me, this Biblical distinction applies to life and death. The Spirit of God is given to create life; it is also withdrawn as life loses its vitality, its entelechy... My more moderate nature forces me to recognise that under the rubric of care excruciating and intractable pain is also destructive to the sanctity of life." [McIntyre R (1978) "EUTHANASIA": A Soft Paradigm for Medical Ethics. In: *Linacre Quarterly*, the Official Journal of the National Federation of Catholic Physicians' Guilds 45:41-54. Quoted by Gerald Larue in "EUTHANASIA" and Religion (1985) published by the Hemlock Society].

Conclusions

These illustrations point out the differences between a rights ethic and an ethical theory that demands compliance with higher moral standards. A rights ethic is a

minimalist ethic based on only one common value - namely the protection of individual liberties and the sanctioning of any reference or behaviour as long as it does not disturb the peaceable community. This approach disregards all other shared societal values. In contrast, Jewish ethics subscribe to moral self-fulfilment through the obedience of moral-religious norms and requirements commonly shared by all observant Jews, patients and physicians alike. From "Medical Ethics: Secular and Jewish Approaches" by Avraham Steinberg, M.D. (Chapter 2 of Medicine and Jewish Law, Vol. I by Fred Rosner, M.D.)

Religionists have raised objections at almost every stage of medicine's conquest over human pain, psychological suffering or infertility. There were religious and moral objections to the use of anaesthesia in childbirth, (because this was allegedly Eve's punishment for obtaining sexual knowledge from the serpent); similarly to in-vitro fertilisation (because the creation of life should be only in the hands of the creator), and to abortion and heart transplants (because these too interfered with divine purpose).

Scriptural or clerical injunctions do not weigh very heavily with the secular-minded or the occasional churchgoer. However, a range of other religious arguments hold greater sway. Life is said to be a gift from God, one that therefore should not be destroyed. Similar analogies based on property or personal relations—man is made in the image of God; the body is the "temple" of God; human beings are the servants or sentinels of God on earth—are often expressed.

All these notions aim to say that God has entrusted us with our lives, and that we have no right to repudiate that trust. But all are vulnerable to the objection that God has also supposedly given man free will, and if the “gift” of life has become so onerous, if it is one of excruciating pain and unending misery, for example, is the recipient really obliged to be so grateful? Who is morally culpable in this case, the person who wants to return this poisoned chalice or the omnipotent and omniscient God who has chosen to impose it on the hapless recipient?

“It is important to recognise that Buddhist attitudes to suicide have always been much less harsh than Christian ones. Suicide from despair has been seen in Buddhism as a prudential error since, given their unresolved karma, suicides will just be reborn in situations similar to those they were seeking to escape from.” (Perrett:1996:310). The Dalai Lama is quoted as stating the following: “In the event a person is definitely going to die & he is either in great pain or has virtually become a vegetable, & prolonging his existence is only going to cause difficulties & suffering for others, the termination of his life may be permitted according to Mahayana Buddhist ethics.” (Perrett: 1996: 310)

7. CANDIDACY

Firstly, when trying to establish candidacy for euthanasia the following factors which determine whether treatment will benefit a patient should be considered:

- Physical, psychological, and existential needs
- The patient's own wishes and values (where these can be ascertained)
- Clinical judgment about the effectiveness of the proposed treatment and the likelihood of the patients experiencing severe, unmanageable pain or suffering.
- The level of awareness the individual has of his or her existence or surroundings as demonstrated by an ability to interact somehow with others.
- An ability to take control of any aspect of his or her life.
- The likelihood and extent of any improvement in the patient's condition if treatment is provided and whether the invasiveness of the treatment is justified in the circumstances.
- The views of people close to the patient, especially close relations, partners and carers, about what the patient is likely to see as beneficial.

One needs to establish some guidelines before assessing a patient's eligibility for assistance in dying. After much careful deliberation by proponents of assisted euthanasia certain criteria were identified as being essential in making assisted suicide ethically and legally permissible and in ensuring the righteousness in establishing the principles of this action. Advocates of voluntary euthanasia believe that patients suffering from a terminal illness and satisfying the following criteria should be allowed to die or to be legally assisted to die:

- If they are suffering from a terminal illness although they may have complete pain relief but still have to endure side effects that for them make life unbearable. Others may not have to cope with pain but instead be totally incapable of living without life support which at the same time rob their lives of all human characteristics and quality; as in incurable paralysing diseases.
- If they are quite unlikely to benefit from a discovery of a cure for that illness during what is expected to remain of their life. We are able to say that someone's illness is incurable, even if on very rare occasions "miracle cures" may happen; but it is definite that not everyone's death is to be delayed thus.
- If as a direct result of the illness, they are either suffering intolerable pain or have to endure an unacceptably burdensome existence (because their dehumanising illness can only be treated by means that make them totally dependent on others and/or on technological life-support machines) it is not only release from pain that leads people to want to be helped to die.
- If they have a steady, informed and sensible desire to die (or who before losing

competence, have expressed a wish to die in the event of the first two criteria being present.) Autonomy requires that the choice to die not only be voluntary but that it be made in an enduring (not merely a one-off) way and be rational. 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 rationality is on those who refuse to accept the person's choice. There is no need to deny that it can sometimes be met (e.g. by pointing to the person's being in a state of clinical depression). The claim is only that the onus falls on those who deny that a normal adult's choice is not competent.

- If they are unable to commit suicide without assistance although this restricts access to voluntary euthanasia by excluding those capable of ending their own lives. Some think physician-assisted suicide a better course to follow, but will be considered morally much harder to justify by those who think professionals may never justifiably kill their patients.

Comment

One realises that these conditions are quite restrictive because the conditions concern access only to voluntary euthanasia for those who are terminally ill. While the adjective "terminal" is not free of ambiguity, for present purposes can it be agreed that it does not include the bringing about the death of, for example high spinal level victims of motor, mine and sport accidents, advanced Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Motor Neurone Disease, who are rendered quadriplegic?

“Of course people on the spot cannot act without principles. The issue between the languages of principles and experience will never be either/or, but rather which language is now the foreground and which the background. Euthanasia decisions cannot be made without principles; ethicists like Kass, Pellegrino and Callahan make valuable contributions. But the principles they advance must constantly be held accountable to the experiential narratives of people with real names, in real relationships, suffering both in their bodies and in the dramas of their lives.” (Frank: 1996:97).

Let us hypothesise that you are suffering from a chronic progressive motor paralysis caused by Guillain-Barre Syndrome. For almost two-and-a-half years since the onset of the disorder, you have been intubated and living on a respirator. You cannot breathe for yourself. You now depend on this respirator support treatment to live, since your respiratory muscles have atrophied. You are unable to talk because you are on a respirator. A year ago, the chief neurologist at your hospital diagnosed a nervous disorder resulting in complete loss of the motor nerves. You cannot move. You have been literally "nailed" to your bed. You have been told there is no cure for your condition. You pass the time watching television and your mother and the few friends who still come round read to you. You are very sad about what has become of your life because of your illness. You do not want to continue living this way. It is "not enough". Now you depend on others for everything, you have no privacy, and you feel this kind of life is not "liveable." This would surely make you determined to be taken off the respirator and to let nature take its course.

The positive moral arguments in favour of VAE

The central ethical argument for voluntary euthanasia is directly connected with the issue of competence (cf. Brock, 1992). People have an interest in making important decisions about their lives in accordance with their own conception of how they want their lives to go. In exercising autonomy or self-determination people take responsibility for their lives and, since dying is a part of life, choices about the manner of their dying and the timing of their death are, for many people, part of what is involved in taking responsibility for their lives. Most people are concerned about what the last phase of their lives will be like, not merely because of fears that their dying might involve them in great suffering, but also because of the desire to retain their dignity and as much control over their lives as possible during this phase.

There is no single, objectively correct answer, which has application to everyone, as to when, if at all, life becomes a burden and unwanted. However, that simply points up the importance of individuals being able to decide autonomously for themselves whether their own lives retain sufficient quality and dignity. In making such decisions individuals decide about the mix between their self-determination and their well-being that suits them. Given that a critically ill person is typically in a severely compromised and debilitated state, it is, other things being equal, the patient's judgement of whether continued life is a benefit that must carry the greatest weight provided always that the patient is competent.

A person's exercise of her/his self-realisation warrants respect, if it does not harm others in its execution. If professional assistance is to be requested to aid a person achieve her/his autonomously chosen goal of an easeful death (because s/he cannot

end her own life), the right of the patient self-determination does not carry with it an entitlement compelling that professional to act contrary to her/his moral or professional values and responsibilities. If voluntary euthanasia is to be legally permitted, it must also respect the professional's independence of perception.

THE COUNTER-ARGUMENTS

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 palliative care and hospice care is available. Given these considerations it is urged that voluntary euthanasia is unnecessary.

There are several flaws in this counter-argument. First, while both good palliative care and hospice care make important contributions to the care of the dying neither is a panacea. To get the best palliative care for an individual involves trial and error with some consequent suffering in the process. But, far more importantly, even high quality palliative care commonly exacts a price in the form of side effects such as nausea, incontinence, loss of awareness because of semi-permanent drowsiness and so on. A rosy picture is often painted as to how palliative care can transform the plight of the dying. Such a picture is misleading according to those who have closely observed the effect of extended courses of treatment with drugs like morphine, a point acknowledged as well by many skilled palliative care specialists. Second, though the sort of care provided through hospices is to be applauded, it is care that is available only to a small proportion of the terminally ill and then usually only in the very last stages of the illness (typically a matter of a few weeks). Third, the point of greatest significance is that not everyone wishes to avail themselves of either

palliative care or hospice care. For those who prefer to die in their own way and in their own time neither palliative care nor hospice care may be attractive. For many dying patients it is having their autonomous wishes frustrated that is a source of the deepest distress. Fourth, as indicated earlier when the conditions under which voluntary euthanasia is advocated were outlined, not everyone who is dying is suffering because of the pain occasioned by their illness. For those for whom what is intolerable is their dependence on others or on machinery, the availability of effective pain control will be quite irrelevant.

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 rational, enduring and genuinely voluntary.

Notice first that a request to die may not reflect an enduring desire to die (cf. some attempts to commit suicide may similarly reflect temporary despair). That is why advocates of voluntary euthanasia have agreed that normally a cooling off period should be allowed. But that said, the objection claims 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. But, it might be said, what if a person is racked with pain, or befuddled because of the measures taken to relieve her pain, and so not able to

think clearly and rationally about the alternatives? It has to be agreed that a person in those circumstances whom wants to die cannot be assumed to have a rational, enduring and genuinely voluntary desire to die. However, there are at least two important points to make about those in such circumstances. First, they do not account for all of the terminally ill, so even if it is acknowledged that such people are incapable of agreeing to voluntary euthanasia that does not show that no one can ever voluntarily request help to die. Second, it is possible for a person to indicate in advance of losing the capacity to give rational, enduring and voluntary consent, how she would wish to be treated should she become terminally ill and be suffering intolerably from pain or from loss of control over her life.

Thirdly, according to the traditional 'doctrine of double effect' it is permissible to act in ways which it is foreseen will have bad consequences provided only that: (a) this occurs as a side effect (or indirectly) to the achievement of the act which is directly aimed at or intended; (b) the act directly aimed at is itself morally good or, at least, morally neutral; (c) the good effect is not achieved by way of the bad, that is, the bad must not be a means to the good; and (d) the bad consequences must not be so serious as to outweigh the good effect.

In line with the doctrine of double effect it is, for example, held to be permissible to alleviate pain by administering drugs like morphine which it is foreseen will shorten life, whereas to give an overdose or injection with the direct intention of terminating a patient's life (whether at her request or not) is considered morally indefensible. This is not the appropriate forum to give full consideration to this doctrine. There is however one vital criticism to be made of the doctrine in relation to the issue of

voluntary euthanasia. With that point made we will be able to turn to the more general question of the moral permissibility of intentional killing.

A patient requesting assisted suicide may also feel that the request is less likely to be granted if the physician feels that the patient is making the request because he or she cannot afford proper care. Certainly with an assisted suicide request, one would expect physicians to inquire about the patient's ability to afford adequate care whether or not the patient raises the question, and the criticism of the relevance of the doctrine of double effect to any critique of voluntary euthanasia is simply this: the doctrine can only be relevant where a person's death is an evil or, to put it another way, a harm. Sometimes 'harm' is understood simply as damage to a person's interest whether consented to or not. At other times it is more strictly understood as wrongfully inflicted damage. On the latter understanding consent becomes crucial. Unless paternalistic interference is judged appropriate, the giving of consent removes any suggestion of wrongfulness. So, if the death of a person who wishes to die is not harmful (because from that person's standpoint it is, in fact, beneficial), the doctrine of double effect can have no relevance to the debate about the permissibility of voluntary euthanasia.

Fourthly, there is a widespread belief that passive VAE 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 VAE 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 VAE), is generally a matter of pragmatics not

of anything of deeper importance. If, for instance, a patient refuses life prolonging medical treatment because she considers it useless, it might reasonably be said that the doctor's intention in complying is simply to respect the patient's wishes. However, the point we have been considering is much wider and suggests that it is utterly stilted to claim, as many doctors do, that their actions and omissions are not intended to bring about death and so cannot count as killing.

Fifthly, as mentioned earlier, it is often said that if society allows voluntary euthanasia to be legally permitted we will have set foot on a slippery slope that will lead us inevitably to support other forms of euthanasia, especially non-voluntary euthanasia. Whereas it was once the common refrain that that was precisely what happened in Hitler's Germany, nowadays the claim tends to be that the experience of The Netherlands in the last decade or so confirms the reality of the slippery slope. Slippery slope arguments come in at least three different versions: logical, psychological and arbitrary line. What the different forms share is the contention that once the first step is taken on a slippery slope the subsequent steps follow inexorably, whether for logical reasons, psychological reasons or to avoid arbitrariness in 'drawing a line' across a person's actions. (For further discussion see e.g. Rachels, 1986, Ch. 10; Brock, 1992, pp. 19ff.).

I shall first say something about why at the theoretical level none of these forms of argument appears powerful enough to trouble an advocate of the legalisation of voluntary euthanasia. I shall then, second, comment on the alleged empirical support from the experiences of Hitler's Germany and present day Holland for the existence of a slippery slope beginning from voluntary euthanasia.

There is nothing logically inconsistent in supporting voluntary euthanasia but rejecting non-voluntary euthanasia as morally inappropriate. Since the two issues are logically separate there will be some advocates of voluntary euthanasia who will wish also to lend their support to some acts of non-voluntary euthanasia (e.g. for those in persistent vegetative states who have never indicated their wishes about being helped to die or for some severely disabled infants for whom the outlook is hopeless). Others will think that what may be done with the consent of the patient sets a strict limit on the practice of euthanasia. The difference is not one of logical acumen. It has to be located in the respective values of the different supporters (e.g. whether self-determination alone or the best interests of a person should prevail). As regards the alleged psychological inevitability of moving from voluntary to non-voluntary euthanasia, again it is hard to see the supposed inevitability. Why should those who value the autonomy of the individual and so support provision for voluntary euthanasia be psychologically driven to support cases of euthanasia which have no connection with the exercise of patient autonomy?

Finally, if there is nothing arbitrary about distinguishing voluntary euthanasia from non-voluntary euthanasia (because the line between them is based on clear principles) there can be no substance to the charge that there is a slide from voluntary to non-voluntary euthanasia that can only be prevented by arbitrarily drawing a line between them.

What, though, of Hitler's Germany and today's Holland? The former is easily dismissed as a provider of evidence for an inevitable descent from voluntary

euthanasia to non-voluntary. There never was a policy in favour of, or a legal practice of, voluntary euthanasia in Germany in the 1920s to the 1940s. There was, prior to Hitler coming to power, a clear practice of killing some disabled persons. The justification was never suggested to be that their being killed was in their best interests, rather it was said to be society that benefited. Hitler's later revival of the practice and its widening to take in other groups such as Jews and gypsies was part of a programme of eugenics, not euthanasia.

Since the publication of the Rummelink Report in 1991 into the medical practice of euthanasia in The Netherlands it has frequently been said that the Dutch experience shows decisively that legally protecting voluntary euthanasia is impossible without also affording protection to the non-voluntary euthanasia that will come in its train. Unfortunately, many of those who have made this claim have paid insufficient attention to the serious studies carried out by van der Maas, et al. (1991), and van der Wal, et al. (1992a and 1992b) into what the Report revealed. In a second nationwide investigation of physician-assisted dying in the Netherlands carried out in 1995, a similar picture emerged as had in the earlier Rummelink Report. Again no evidence was found of any descent down a slippery slope toward ignoring people's voluntary choices to be assisted to die (see van der Maas et al. (1996); van der Wal et al. (1996)). The true picture is that, of those terminally ill persons assisted to die under the agreement between the legal and medical authorities, a little over one half were clearly cases of voluntary euthanasia as it has been characterised in this article. Of the remainder, the vast majority of cases were of patients who at the time of the assisted death were no longer competent. The deaths of some of these were brought about by withdrawal of treatment, that of others by interventions such as the

giving of lethal doses of anaesthetics. Nevertheless, the critical point about this vast majority of such cases is that the decision to end life was nearly always taken after consultation between the doctor(s) and family members. In a very few cases, there was no consultation of this kind. It seems that sometimes, at least, this was because families in The Netherlands strictly have no final authority to act as surrogate decision-makers for incompetent persons. That there has only been one prosecution of a Dutch doctor for failing to follow agreed procedures, and that the Dutch public have regularly reaffirmed their support for those agreed procedures suggests that, contrary to the claims of some critics of The Netherlands' experience of legally protecting voluntary euthanasia, social life has not broken down.

We can bring this discussion of the fifth objection to a close with two observations. First, nothing that has been said should be taken as suggesting that there is no need to put in place safeguards against potential abuse of any legal protection for voluntary euthanasia. This is particularly important for those who have become incompetent by the time decisions need to be taken about assisting them to die. As was mentioned very early on, there are ways of addressing this issue (such as by way of advance declarations or living wills) which are widely thought to be effective, even if they are not perfect. The main point to be stressed at the present, though, is that there is surely no need for anyone to be frightened into thinking that the legalisation of voluntary euthanasia will inevitably end in her having her life snatched away from her should she become incapable of exercising a competent judgement on her own behalf. Second, the reform of any law may have unintended effects. It is sometimes said in discussions about legalising voluntary euthanasia that experience with abortion law reform should remind us of how quickly and easily practices can

become accepted which were never among the reformers' intentions, and that the same thing could occur if voluntary euthanasia were to become legally permitted. No amount of theorising, it is said, can gainsay that possibility. There is no need to deny that it is possible that reform of the laws that presently prohibit voluntary euthanasia could have untoward consequences. However, if the arguments given above are sound (and the Dutch experience is not only the best evidence we have that they are sound, but the only relevant evidence), that does not seem very likely.

I turn now to the final objection to be considered here. It is often claimed that whatever the morality of an individual's deciding for herself that her life is no longer of value to her, that provides no basis for the formulation of public policy. The fear of the slippery slope is no doubt, part of the concern expressed here. Nevertheless, as well, there are concerns about the role of the law and more particularly, its contribution to the regulation of medicine.

Legal permission for doctors to perform voluntary euthanasia cannot simply be grounded in the right of self-determination of patients. We have already had occasion to note that the law does not presently permit an individual to consent to her/his own death. Nevertheless, the very same fundamental basis of the right to decide about life-sustaining treatment - respect for a person's autonomy - underpins voluntary euthanasia as well. Extending the right of self-determination to cover cases of voluntary euthanasia would not, therefore, amount to a dramatic shift in legal policy. No novel legal values or principles need to be invoked. Indeed, the fact that suicide and attempted suicide are no longer criminal offences in many jurisdictions indicates that the central importance of individual self-determination in a

closely analogous setting has been accepted. The fact that assisted suicide and voluntary euthanasia have not yet been widely decriminalised is probably best explained along the lines that have frequently been offered for excluding consent of the victim as a justification for an act of killing, namely the difficulties thought to exist in establishing the genuineness of the consent. The establishment of suitable procedures for giving consent to assisted suicide and voluntary euthanasia would seem to be no harder than establishing procedures for competently refusing burdensome or otherwise unwanted medical treatment. The latter has already been accomplished in many jurisdictions, so the former should be capable of establishment as well.

If in time the moral case for permitting voluntary euthanasia is considered more realistic and benevolent than the case against it and voluntary euthanasia is made legally permissible; should only doctors perform voluntary euthanasia? An appropriate practice of medicine needs to consider both the patients' welfare and to respect their self-determination. These are the virtues that should influence the profession, and not a commitment to preserving life at all costs, or preserving life without reference as to whether the victims want their lives prolonged long after that life has any value or good for themselves.

Every person is created in the image of God (Genesis:1:26) and therefore every life is as precious to Him, as any other, even those individuals in a permanent comatose vegetative state, completely paralysed and totally unable to understand or communicate, the grossly mentally retarded and severely physically handicapped and those suffering from end-stage senile dementia.

8. POLICY RECOMMENDATIONS

Only prudence can lead one to the best and most fulfilled human existence. We now realise that the values of each particular case must be pinpointed and its concrete problems addressed; and only then can a justified moral judgement for this case, at this time and in this place be made. Thereafter one tries to visualise if and how the decisions made within these precise boundaries can be used for others in the same situation, subject of course to the interpretations and preferences of their historic, cultural, institutional and societal structures.

One must beware of far-reaching complications that we cannot foresee. One must draw up practical and feasible guidelines by providing built-in mechanisms for revising such guidelines even drastically if necessary. Advance directives cannot replace the contemporaneous decision-making of a competent individual, but it should replicate a thoughtful, informed, contemporaneous decision by the patient “No practical discussion is going to take place unless you understand the relevance of prudence. But no practical philosophy can be adequate for our time unless it confronts the analysis of power and how it operates in our daily lives” (Bernstein: 1993:11 in Winkler and Coombs)

“Decision-making capacity” or decision-making ability should be preferred to competence because competence; information and voluntary advance directives are no better than the counselling which preceded them and may even change substantially with time. The trade off between an earlier death and a short delay in dying is that the latter is bought with great suffering by patient and family. To establish what exactly is in “the best interests” is an almost intuitive determination that requires an evaluation of what a reasonable person would want. “There is a fear that abuses will occur especially in this society where we have so many categories of people that are undervalued. Because we do not have national health insurance,

there is a risk of undue pressure to reduce the cost of caring for uninsured dying patients by hurrying the process along, not always with their consent" (Cassel: 1996:133).

9. CONCLUSION

Arguments based on social obligations are curiously double-edged. For every case in which a suicide is opposed or condemned on grounds that it repudiates an obligation to others, a contrasting situation can be conjured in which suicide might actually fulfil such obligations. The frail, old or seriously ill person whose care is a prolonged financial and emotional burden on others might, if social obligation is the primary yardstick, feel not only justified in killing themselves, but required to do so. Social obligation is a poor basis for a general condemnation of suicide because it can just as easily be used to justify, and even promote, suicide in certain circumstances.

There is also something peculiar about the very notion of “rational” suicide. Because no one really knows what comes after death, the idea that a rational weighing of costs and benefits can ever be made seems nonsensical. Whatever comes after death, even if it is nothingness, may be worse than continuing to live even with the most excruciating pain; on the other hand, it may be better than anything that life has to offer even to the healthy and successful. No one this side of death really knows.

Davies Jean writes that just like raping and making love are different concepts: so are killing and voluntary euthanasia. (Journal of medical ethics, 1988, 14:148-149). No one is in any doubt about what constitutes the difference between lovemaking and rape; it is the consent of the receiver of the act. Therefore, it seems that we do need two very different words for what may be an identical sexual act, the crucial difference being whether or not it takes place by consent. It is time that the law in this country recognised that there is a great difference between killing and helping to die, and that is that it consists in the dying person's consent.

I believe that physician-assisted suicide should be legalised with adequate safeguards to protect all vulnerable persons and to maintain the expertise and integrity of the medical profession. Prospective recipients of this aid should fulfil four of the five qualifications for “candidacy” (see chapter 7). The more I research the

facts on the subject of physician-assisted suicide, the less I am convinced that the anti-PAS caucus has a good case for denying autonomy and self-realisation to a sufferer or to the exercise of compassion by her/his doctor in this problematic moral situation.

All thinking people should be strongly advocated to make a living will and this advance directive should be not only legislatively encouraged but also legally enforceable and not subject to emotional blackmail by organised religion or academic ethicists with no knowledge of the people involved.

There must be peer audit by others in the medical and spiritual healing fields and an ombudsman to ensure accountability to the public. Therefore we need the formation of an unpaid board of caring, prudent and experienced persons to whom the doctor and a "devil's advocate" can present an individual case, sharpened down to its specifics with all the unbiased details that are possible.

Although few situations in life can be precise, undistorted, free of ambivalence or doubt, one must try to make the practice of PAS more transparent; and the input of others who are enlightened and hopefully clairvoyant can only be beneficial and result in error reduction.

There is absolutely no justification for involuntary active euthanasia; although possibly in time redistributive justice and the financial constraints imposed by the present mismanagement of financial resources may demand the allocation of the health budget to where it is erroneously thought to be most beneficial; however I could never be party to any final solution of this nature!

Most bio-ethicists justify the use of excessive amounts of morphine-type opioids, because the use of these drugs not only controls severe pain but also represses the central nervous system. This is the principle of the so-called "double effect" because although death is apparently *not* sought directly, the doctor realises that there is a strong probability and possibility of it occurring as a result of this therapy.

To obviate future censure of the family, friends and doctor by mischief-making “do-gooders”, a witnessed affidavit of the request for aid-in dying by the dying patient should be made; to which should be appended the opinion of a psychologist or psychiatrist that the patient was not depressed and was mentally competent at that time and understood exactly what s/he was requesting and what would be the consequences should this request be granted.

"Those who believe strongly that death must come without physician assistance are free to follow that creed...They are not free...to compel those whose values differ with theirs to die painful, protracted and agonising deaths. " Justice Stephan Reinhardt, 9th Circuit WA v Glucksberg, 1996

10. BIBLIOGRAPHY

- Battin, Margaret. *The Least Worst Death*. 1994. Oxford, Oxford University Press.
- Battin, Margaret. Going early, going late: the rationality of decisions about suicide in AIDS. *Journal of Medicine and Philosophy*. 1994 **19** (6) 571-594. From *Must We Suffer Our Way to Death?* Editors Hamel, Ronald P. and Dubose, Edwin. 1996. Dallas Texas. Southern Methodist University Press.
- Bauman, Zygmunt. *Intimations of Postmodernity*. London and New York. Routledge 1994.
Postmodern Ethics. Oxford. Blackwell Publishers. Reprinted 1998.
- Brack, Barbara. Rational Suicide: My Mother's Story. *Christian Century*. 13 November 1991(1054)
- Brody, Baruch. *Ethics and Its Applications*. New York: Harcourt Brace Janovich. [1983].
- Brody, Howard. Causing, intending and assisting death. *Journal of Clinical Ethics*. 1993 Summer **4** (2): 112-117
- Brock, D. Voluntary Active Euthanasia, Hastings Centre Report: 1993. **22** no. 2: 10-22.
- Buber, Martin. *Ten Rungs: Hasidic Sayings*. New York: Schocken (1962:7).
- Callahan, D. When self-determination runs amok. *Hastings Centre Report* 1992:22 (2): 52
- Casey, John. Killing and Letting Die: A Reply to Bennett. From T.L.Beauchamp. "*Ethics and Public Policy*". Englewood Cliffs: Prentice Hall [1971:351].
- Cassel, Christine: Meier, Diane E. Morals and moralism in the debate over euthanasia and assisted suicide. *New England Journal of Medicine*. 1990 **323**(11): 751-752
- Cassell, Christine K. Physician Assistance at the End of Life: Rethinking the Bright Line. From *Must We Suffer Our Way to Death?* Editors: Hamel, Ronald P. and Dubose, Edwin. 1996. Pp.120-141 Dallas Texas. Southern Methodist University Press.
- Cassell, E.J. "The Nature of Suffering and the Goals of Medicine," *New England Journal of Medicine* **306** (1982): 640. From www.http\nysdoh\provider\death.htm
- Childs, Brian H. The last chapter of the book: who is the author? *Christian Reflections on Assisted Suicide*. *Journal of the Medical Humanities*. 1997 **18** (1): 21-28.
- Commission on the Study of Medical Practice Concerning Euthanasia: Medical Decisions Concerning the End of Life (**The Hague: SdU, 1991**) -also known as `The Rammelink Report'.
- Danforth, John. *The Patient Self-Determination Act*. (United States Congress, December 1990) In John J. Lynch and Sue Shevlin Edwards. *Cancer care providers have an obligation to participate in advance care planning and advance directives*. *Oncology Issues* 1998: **13** (2): 31-32, ACCC/OncIssues/public/archive/1998/toc-1302.html
- Dinello, Daniel. [1971:358] "On Killing and Letting Die." From T.L.Beauchamp. *Ethics and Public Policy*. Englewood Cliffs: Prentice Hall
- Donne, John. [1624] *Devotions on Emergent Occasions*. 1998 Bartlett's Quotations. <http://www.columbia.edu/acis/bartleby/bartlett>

- Feldman, David M. *Health and Medicine in the Jewish Tradition*. 1988. New York. Crossroad.
- Frank, Arthur. The Language of principle and the Language of experience in the Euthanasia Debate. *From Must We Suffer Our Way to Death?*
- Gillon, Raanan. The Times Newspaper. Health (timnwshea02005.htm: 24 June 1999).
- Hagenouw, Ruud. Choosing to End One's Life. *The Journal for the Medical and Dental Defence Union of Scotland*, Spring 1996 edition, p.3-4.
- Hamel, Ronald P. and Dubose, Edwin R. Editors. *Must We Suffer Our Way to Death? Cultural and Theological Perspectives on Death by Choice*. 1996. Dallas Texas. Southern Methodist University Press.
- Hardwig J. SUPPORT and the Invisible Family. *Hastings Centre Report*. [1995 July/August. Special Supplement].
- Hippocrates: *The Sacred Disease: The Art*. Edited and translated by W.H. Jones. 1962. Cambridge. Harvard University Press.
- Holy Scriptures of the Old Testament, Hebrew and English*. London. Printed for The British and Foreign Bible Society [1939].
- Humphrey, Derek. *Dying with Dignity*. New York: Birch Lane Press [1992].
- Humphry, Derek. Suicide by Asphyxiation. *New England Journal of Medicine* (Letters, Replies) 1994, **330**(14): 1017.
- Kass, Leon R. "Why Doctors Must Not Kill." *Commonweal*, [9 August 1991 474].
- Kuhse, Helga. *The Sanctity-of-Life Doctrine in Medicine: A Critique*. 1987.Oxford: Clarendon Press.
- Kuhse, Helga, Singer, Peter. Editors *A Companion to Bioethics*.1998 Oxford U.K. Blackwell publishers.
- Loewy, E. Compassion, Reason, and Moral Judgement. *Cambridge Quarterly of Healthcare Ethics* [1995 4: 466-475].
- Lytard, Jean-Francois. 1984. *The Postmodern condition: A Report on Knowledge*. Minneapolis. The University of Minneapolis Press.
- Miller, Franklin; Quill, Timothy; Brody, Howard; Fletcher John; Gostin; Lawrence; Meier, Diane. Regulating physician assisted death. *New England Journal of Medicine*. [1994 331(12) 112-123].
- McIntyre, Russell. 1978. Euthanasia: A Soft Paradigm for Medical Ethics. In: *Linacre Quarterly*, the Official Journal of the National Federation of Catholic Physicians' Guilds **45**:41-54. Quoted by Gerald Larue in *Euthanasia and Religion*. 1985 .The Hemlock Society.
- New English Bible*. 1970. Oxford. U.K. Oxford University Press.
- Nietzsche, Frederich. "The Twilight of the Idols." from *The Complete Works of Frederich Nietzsche*. Translated by Anthony M. Ludovici. New York. Russell & Russell [1964 16:88].
- Nowell-Smith, Patrick. Euthanasia and The Doctors. *Journal of Medical Ethics*, 1989: **15**:124-128.
- Oakley, Justin. A Virtue Ethics Approach. From Kuhse, Helga and Singer, Peter. Editors. *A Companion To Bioethics*. Oxford. U.K. Blackwell Publishers. 1998: **10**:92.

- Pellegrino, Edmund. 1992. Doctors Must Not Kill. *Journal Of Clinical Ethics* [3 (3) 95-102].
- Perrett, Roy W. Buddhism, Euthanasia and the Sanctity of Life. *Journal of Medical Ethics*. 1996: 22:309-313.
- Portenoy, R. K. Pain Assessment in Adults and Children. From *Why Do We Care?* Syllabus of the Postgraduate Course, Memorial Sloan-Kettering Cancer Centre, New York City. 1992, 4-5.
- Portenoy R. K. Overview of Symptom Prevalence and Assessment. From *Why Do We Care?* Syllabus of the Postgraduate Course, Memorial Sloan-Kettering Cancer Centre, New York City: 1992: 184.
- Rachels, James. *The End of Life: Euthanasia and Morality*. 1986:Oxford: Oxford University Press.
- Reinhardt, Justice Stephan 9th Circuit. *WA v Glucksberg*, 1996.
- Robertson, Bruce A. 1999. Euthanasia and Physician Assisted Death.
- Robinson, Dave. 1996. *Ethics for Beginners*. Cambridge. Icon Books.
- Rorty, Richard. 1991. *Objectivity, Relativism and Truth: Philosophical Papers*, v. 1. Cambridge. Cambridge University Press.
- Rothfork, John. 1998. *John Rothfork's Index Page*. Rothfork@nmt.edu. 04.01.98.
- Russell, Bertrand. *History of Western Philosophy*. First edition 1946. Second edition. 1961. London. Routledge. Reprinted 1991.
- South African Law Commission. 1999. DISCUSSION PAPER 71. Project 76. EUTHANASIA AND THE ARTIFICIAL PRESERVATION OF LIFE: <http://www.law.wits.ac.za/salc/report/euthansum.html>.
- Telushkin, Rabbi David. 1994. *Jewish Wisdom*. New York. William Morrow and Company. p273 quoting (a) David Kimhi's commentary on I Samuel 31:4) and (b) quoting Rabbi Judah in Lamentations 1:16 "For these things I weep."
- Tender, Rabbi Dr Moses. 19980201. From heritage@virtual.co.il and innernet@virtual.co.il 1/2/98.
- The Economist*. 16th October 1999. Let Death be my Dominion http://www.economist.com/editorial/freeforall/16-10-99/index_mo5606.html.
- Thomasma, David C. When Physicians Choose to Participate in the Death of Their Patients: Ethics and Physician-Assisted Suicide. *Journal of Law, Medicine and Ethics*, 24 (1996): 183-197.
- Toulmin, Stephen. 1992. *COSMOPOLIS. The hidden agenda of modernity*. Chicago 60637. University of Chicago Press.
- Van der Maas, P.J., van Delden J.J.M., Pijnenborg L., Looman, C.W.N. 1991. Euthanasia and other Medical Decisions Concerning the End of Life. *The Lancet*. 338:1991: 669-674.
- Van der Maas, P.J., van der Wal, G., et al. Euthanasia, Physician-Assisted Suicide and other Medical Practices Involving the End of Life in the Netherlands, 1990-1995. *The New England Journal of Medicine*: 1996: 335: 1699-1705.
- Van der Maas P J. End of life decisions in mentally disabled people. *British Medical Journal*, July 12 1997 315, 12. 73.
- Van der Wal, G., van Eijk, J.Th.M., Leenen, H.J.J., Spreeuwenberg, C. Euthanasia and Assisted Suicide, I: How Often is it Practised by Family Doctors in the Netherlands. *Family Practice*: 9 (1992a): 130-134.

- Van der Wal, G., van Eijk, J.Th.M., Leenen, H.J.J., Spreeuwenberg, C. Euthanasia and Assisted Suicide, II: Do Dutch Family Doctors Act Prudently, *Family Practice*: **9** (1992b): 135-140
- Van der Wal, G., van der Maas, P.J., Bosma, et al. 1996. Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands', *The New England Journal of Medicine* 1996: **335**: 1706-1711.
- Van Niekerk, A.A. Ou wyn in nuwe sakke: werk die ou etiek vir die nuwe geneeskunde? *Koers* 1997 62(3): 255-276
- Verhey, Allen. Assisted Suicide and Euthanasia: A Biblical and Reformed Perspective. From *Must We Suffer Our Way to Death?* 1996.
- World Health Organisation, Cancer Pain Relief and Palliative Care: Report of a WHO, Expert Committee, WHO Technical Report Series 804 (Geneva: World Health Organisation, 1990), 41
- Winkler, Earl R. and Coombs, Jerrold R. Editors. *Applied Ethics a Reader*. Cambridge Mass Blackwell Publishers. 1993
- Winkler, Earl R. Reflections on the State of Current Debate Over Physician-Assisted Suicide and Euthanasia. *Bioethics*. 1995: **9**: 313-326.
- Young, Robert. 'Voluntary and Nonvoluntary Euthanasia', *The Monist*: 1996: **59**: 264-283 from: Robert Young, La Trobe University in Stanford Encyclopaedia of Philosophy

OTHER RESOURCE LITERATURE

- Aristotle. The Nichomachean Ethics. Harmondsworth: Penguin 1976. From Winkler, Earl R. and Coombs, Jerrold R. Editors. *Applied Ethics a Reader*. Cambridge Mass. Blackwell. 1993.
- Bacon, Francis. *De Argumentis Scientiarum: The Philosophical Works of Francis Bacon*. Editor. J. M. Robertson. New York. Books for Libraries Press 1970
- Coulehan, Jack. The man with the stars inside. *Annals of Internal Medicine*. 1997: **126** 10 799-802
- Newsweek*. 1998. New York. Newsweek Incorporated [CXXXII: (24). 1998]