Euthanasia: A critical Analysis of the Physician’s Role.

- MADU BENEDICT CHINWEZE-
  Master’s Thesis in Applied Ethics
  Centre for Applied Ethics
  Linköping University
  Presented May 2005

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**Abstract**

Sometimes relatives have taken me on one side and told me they cannot bear it any more: "Isn't there something you can do to end it all?" More often requests for euthanasia have come from those who are ill. I remember visiting a man with lung cancer. He asked his wife to leave the room. As she closed the door he leaned over and grabbed my arm. "I want to die", he said. "Please can you give me something." He felt a burden on his wife and wanted euthanasia for himself.

Often in their duty, physicians are faced with euthanasia requests of this kind. Death is the inevitable fate of all humans but how we die is an issue of great concern for many of us. Fear of pain, loss of control and being a burden to our loved ones are common issues surrounding dying and death of patients. This has led to varying circumstances of patients’ death, and of a significant remark, the involvement of physicians in bringing about these deaths through an act of euthanasia. Euthanasia involves the intentional killing of a patient by the direct intervention of a physician (or another party) ostensibly for the good of the patient, and the most common form that this comes is through lethal injection. The ethics of euthanasia and of a physicians’ involvement have been a contentious issue from the beginnings of medicine. This for the most part is as a result that the ethical code of physicians has long been based in part on the Hippocratic Oath, which requires physicians to “do no harm”. Thus, the focus of this work will be to look into the role of the physician in ending a patient’s life through the act of euthanasia. Although necessary but not a central point of this work to merely develop arguments for and against the justification of euthanasia and a physician’s involvement in the act, but to critically view the role played by physicians in ending the life of patients through euthanasia in contrast with their medical obligation. The issue of euthanasia raises ethical questions for physicians. Is it morally right or wrong for a physician to end the life of his or her patient? And this therefore will be the focus of this work.

**Keyword**

Euthanasia, Physician-Assisted Suicide, Morality, Principles of Nonmaleficence and Beneficence.
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DEDICATION

This work is dedicated to my parents, Chief, Sir Isaac N. Madu and
Lolo Clementina N. Madu
And
To my brothers and sisters and their children, for their loving
care and support to me. God bless you all abundantly.
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As a being that exists not in isolation, the success of this work owes much thanks and
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In a very special way, I am highly indebted to the fingers that feed me, my parents and all my
brothers and sisters, I will ever remain grateful.
And to all others who in one way or the other were positive instruments to the realized
success of this work, I cannot but say, thank you, and thank you all for being there.

Madu Benedict Chinweze.

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ABSTRACT.

Sometimes relatives have taken me on one side and told me they cannot bear it any more: "Isn't there something you can do to end it all?" More often requests for euthanasia have come from those who are ill. I remember visiting a man with lung cancer. He asked his wife to leave the room. As she closed the door he leaned over and grabbed my arm. "I want to die", he said. "Please can you give me something." He felt a burden on his wife and wanted euthanasia for himself.

Often in their duty, physicians are faced with euthanasia requests of this kind. Death is the inevitable fate of all humans but how we die is an issue of great concern for many of us. Fear of pain, loss of control and being a burden to our loved ones are common issues surrounding dying and death of patients. This has led to varying circumstances of patients’ death, and of a significant remark, the involvement of physicians in bringing about these deaths through an act of euthanasia. Euthanasia involves the intentional killing of a patient by the direct intervention of a physician (or another party) ostensibly for the good of the patient, and the most common form that this comes is through lethal injection. The ethics of euthanasia and of a physicians’ involvement have been a contentious issue from the beginnings of medicine. This for the most part is as a result that the ethical code of physicians has long been based in part on the Hippocratic Oath, which requires physicians to “do no harm”. Thus, the focus of this work will be to look into the role of the physician in ending a patient’s life through the act of euthanasia. Although necessary but not a central point of this work to merely develop arguments for and against the justification of euthanasia and a physician’s involvement in the act, but to critically view the role played by physicians in ending the life of patients through euthanasia in contrast with their medical obligation. The issue of euthanasia raises ethical questions for physicians. Is it morally right or wrong for a physician to end the life of his or her patient? And this therefore will be the focus of this work.

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1 Dixon, P., in: www.globalchange.com/euthandt.htm

iii
# TABLE OF CONTENTS

## CHAPTER ONE

1.0 GENERAL INTRODUCTION .................................................................6.
1.1 EXPLICATION OF TERMS .................................................................8.
1.2 WHAT IS EUTHANASIA? .................................................................8.
1.3 WHAT IS PHYSICIAN-ASSISTED SUICIDE? ......................................10.
1.4 DIFFERENT KINDS OF EUTHANASIA .............................................11.
   1.4.1 VOLUNTARY AND NON-VOLUNTARY EUTHANASIA .................12.
   1.4.2 INVOLUNTARY EUTHANASIA ...............................................13.
   1.4.3 ACTIVE AND PASSIVE EUTHANASIA ..................................13.

## CHAPTER TWO

2.0 HISTORICAL OVERVIEW OF EUTHANASIA ......................................19.
2.1 VARIOUS ARGUMENTS IN THE DEBATE OF EUTHANASIA AND PHYSICIANS’ INVOLVEMENT .................................................................21.
2.2 ARGUMENTS IN FAVOUR OF EUTHANASIA ......................................21.
   2.2.1 PHYSICIANS RESPECT FOR THE PATIENT’S AUTONOMY, RIGHT, AND SELF DETERMINATION .................................................................21.
   2.2.2 RELIEF FROM PAIN AND SUFFERING ...................................23.
   2.2.3 EUTHANASIA IS IN LINE WITH MEDICAL PRACTICE ..................24.
   2.2.4 CRITIQUE OF THE ARGUMENTS FOR .....................................24.
2.3 ARGUMENTS AGAINST EUTHANASIA ...............................................27.
   2.3.1 ARGUMENT FROM NATURE ..................................................28.
   2.3.2 RELIGIOUS ARGUMENT .....................................................29.
   2.3.3 PHYSICIANS RESPECT FOR THE PATIENT’S SELF-INTEREST .........30.
   2.3.4 ARGUMENT FROM PRACTICAL EFFECTS ................................31.
   2.3.5 ARGUMENT FROM THE VALUE AND SANCTITY OF LIFE ..........34.
   2.3.6 EUTHANASIA CAN BECOME A MEANS OF HEALTH CARE CONTAINMENT .................................................................37.
CHAPTER THREE.
3.0 EXAMINING THE PHYSICIAN’S ROLE IN EUTHANASIA .......................45.
3.1 A BACKGROUND CASE IN EUTHANASIA – THE NETHERLANDS ...........47.
3.2 THE PHYSICIAN AND THE HIPPOCRATIC OATH ...............................53.
3.3 THE PRINCIPLES OF NONMALEFICENCE, BENEFICENCE, AND THE
STANDARD OF DUE CARE ...............................................................56.
3.4 OPINION OF PHYSICIANS/SURGEONS ON EUTHANASIA AND OF ITS
PRACTICE BY A PHYSICIAN .........................................................61.
3.5 WORLD MEDICAL ASSOCIATION STAND ON EUTHANASIA ............63.
3.6 LEGAL VIEW OF EUTHANASIA ......................................................65.
3.7 RELIGIOUS VIEW OF EUTHANASIA ...............................................68.

CHAPTER FOUR.
4.0 EVALUATION .................................................................................72.
4.1 CONCLUSION .................................................................................78.

BIBLIOGRAPHY .................................................................................80 – 84.
CHAPTER ONE.

1.0 GENERAL INTRODUCTION.

The rule against killing patients or aiding patients to end their lives by physicians is a strong and an enduring prohibition in medicine. This is testified by the frequently quoted portion of the Hippocratic Oath “I will give no deadly medicine to any one if asked, nor suggest any such counsel…” Central in this oath is the norm that physicians are neither on their own, to cause, nor to help in bringing about the death of their patients. Euthanasia is a major issue in medicine and health care ethics for two reasons. First, those seeking to end their lives are patients, usually terminally ill patients and, second, those who give or prescribe the lethal drugs used to end life are physicians. In recent centuries most people, including physicians, were unalterably opposed to physicians killing or ending the lives of their patients or even helping them kill themselves. This opposition was so strong that euthanasia and suicide were not considered issues of serious moral discussion. However, owing to a change in the trend of events, euthanasia is now a subject of serious debate. As Bernard Gert et al. observe, patients with terminal illness which are accompanied by considerable pain and suffering often do not wish their disease to be treated aggressively. All want the pain and suffering to be minimized, but many, at some stage, do not want their life prolonged. In fact, many actually want their life shortened; they want to die sooner than they would if they simply waited for the disease to run its natural course. Consequent upon this, many terminally ill patients therefore seek an aid in dying by a physician. This is in contrast to the physician whose culture, tradition, and instincts are devoted to the prolonging of life, and not to the shortening of it. More so, physicians also consider their profession to be devoted to the relieving of pain and suffering. These two goals in the past, were not usually seen as conflicting with each other, treatments that relieved pain and suffering were also generally life preserving. However, conflict between these two acknowledged goals of medicine, prolonging life and relieving pain and suffering has increased. Central in the face of this conflict, is the fact that physicians kill or at least assist patients to kill themselves. Many arguments in current literatures of Medical Ethics are opposed to euthanasia and the physician’s involvement in deliberately bringing about the death of patients. Ethically, some people however, accept euthanasia and a physician’s assistance in bringing an end to life in

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extenuating circumstances. Hence, various words and phrases have been employed here: “Death with dignity”, “allowing to die”, “euthanasia”, “assisted suicide”, and “mercy killing”. Euthanasia has become outstanding amongst these terms. Euthanasia is an extremely sensitive and emotionally laden topic. Rarely does an issue spark such intense and complex discussions based on ethics and morality. It is now a subject of significant professional debate amongst Ethicists and Lawyers in many Western Countries because of the involvement of physicians who engage in the role of ending, or helping to end the life of their patients. As proponents of euthanasia argue, if a competent patient requests for euthanasia, or when incompetent, the request is now made by a surrogate, a physician acting in honour of such request is morally justified. It is in view of this that Jeff McMahan rightly describes euthanasia as “team killing”, in which case, the death of the patient is as a result of a joint decision of the patient/or a surrogate and the physician. For instance, as Richard Miniter observes, in a 1997 study published in the Lancet, a British medical journal, some 8% of all infants who die in the Netherlands are killed by their doctors. The study reports the case of Dr. Henk Prins, who killed—with her parents' consent—a three-day old girl with spina bifida and an open wound at the base of her spine. In line with McMahan, euthanasia therefore is team killing because, both the patient/or the surrogate and the physician are deeply involved in bringing about the death, and hence both are moral agents. Thus, the applied ethical issues in the debate as will be addressed in this work will include the following:

- Is it ethically permissible for a physician, to end, or to aid in ending the life of a patient?
- If euthanasia is justified by the patient’s right to life, can this right require physicians to prescribe barbiturates and/or administer lethal injections to aid the patient’s death?
- Does the respect for the patient’s autonomy, right, and self-determination call for the physicians’ total adherence to the request for euthanasia?
- What are the goals of medicine and the role of physicians as medical professionals?

These questions will form the focus of this work which will basically be an ‘exposé’ and analysis, particularly exploring some prevalent conceptions and recurring arguments in the debate on euthanasia with regard to any possible role the physician might have in terminating

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a life, and whether the physician should have a role per se in terminating a life. This work is therefore divided into four chapters.

Chapter one bears the General Introduction of the work, the explication of the terms Euthanasia and Assisted-Suicide and some relevant distinctions, and also the explication of the various kinds of euthanasia and some necessary distinctions amongst the various kinds of euthanasia.

Chapter two will focus on the Historical Overview of Euthanasia, then the various Arguments in Favour of, and also the Arguments against Euthanasia and Physicians involvement. Chapter three will be basically taking a critical view of the Physicians’ Role in general and particularly in euthanasia. This will be followed by the Netherlands experience in euthanasia as a background case, then comes a look into the Physician’s role in the face of the Hippocratic Oath, the Physician vis-à-vis the Principles of Nonmaleficence and Beneficence and the Standard of Due Care, then opinions of some Physicians/Surgeons on Euthanasia, the World Medical Association stand on Euthanasia, and finally a Legal View and Religious View on Euthanasia. Chapter four will be an evaluation of the whole analysis, and finally comes some conclusions.

1.1 EXPLICATION OF TERMS.

Euthanasia is one of the perennial ethical problems in medicine and health care and is as well an issue that involves law and public policy. The issue of euthanasia has become a subject of significant professional interest on the part of the physicians, biomedical ethicists and health-law attorneys. Consequent upon some misuse of ideas and terminologies that are employed in the discussion about euthanasia, there has often been some conceptual confusion in the distinctions between the various forms of euthanasia, and other ethical and health care/medical issues related to euthanasia such as, physician assisted suicide PAS. Hence, for conceptual clarity, it will be necessary to give the meaning of euthanasia and physician assisted suicide, the different forms of euthanasia, and as well draw some distinctions.

1.2 WHAT IS EUTHANASIA?

The word “euthanasia” stems from two Greek words – “eu, meaning well or good” and
“thanatos, meaning death.” Literally therefore, euthanasia means “a good death.” However, in current debates, euthanasia is generally understood to mean the bringing about of a good death – mercy killing, where one person, A, ends the life of another person, B, for the sake of B. Euthanasia often is defined as the act of bringing about the death of a hopeless ill and suffering person in a relatively quick and painless way for reasons of mercy. An essential aspect of euthanasia is that it involves taking a human life, either one’s own or that of another who in most cases is believed to be suffering from some disease or injury from which recovery cannot reasonably be expected. Finally, the action must be deliberate and intentional. Thus, Gay-Williams maintains that euthanasia is intentionally taking the life of a presumably hopeless person. Whether the life is one’s own or that of another, the taking of it is still euthanasia. Thus, Georgios Anagnostopoulos states: At the most basic level, euthanasia is the termination of a life by an act that interferes in some way or other with the natural or normal course of events as far as life is concerned. Various features characterize the concept of Euthanasia:

(i) Euthanasia concerns the agent and the subject, i.e., it concerns the Physician and the patient.
(ii) Intention of the agent. The intention of the agent is taken to be for the best interest of the subject (often relief of pain and suffering for the hopelessly ill), and the outcome is often the death of the subject.
(iii) Causal proximity, which concerns what, the agent does or chooses not to do that, ends in the death of the patient.

The implication of these features inherent in Euthanasia is that the physician plays both the active role as well as the passive role in the death of the patient. The physician is seen as a passive agent in euthanasia by killing or "letting die" of a dying, seriously ill or suffering person in accordance with their own express or assumed wishes or interests. As an active agent, the physician engages in the intentional and active acceleration or bringing about of death. Here the doctor suggests, brings the means and carries out the action. Hence Euthanasia can be seen or defined as death that results from the intention of one person to kill another person, using the most gentle and easy means possible, that is motivated solely for

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the best interest of the person who dies. Thus, mercy killing or euthanasia according to Austin Fagothey is the giving of an easy, painless death to one suffering from an incurable or agonizing ailment. As Fagothey notes, its advocates argue that the person will die anyway, that the purpose is not to invade the person’s right to life but only to substitute a painless for a painful death, that the shortening of the person’s life merely deprives him or her of a bit of existence that is not only useless but unbearable, that the person can do no more good for anyone, himself or herself included.

This understanding of euthanasia Peter Singer observes emphasizes two important features of acts of euthanasia. First, that euthanasia involves the deliberate taking of a person’s life; and, second, that life is taken for the sake of the person whose life it is – typically because he or she is suffering from an incurable or terminal disease. Hence, human euthanasia as Anagnostopoulos points out has some common features with suicide and raises all the familiar problems associated with actions that aim to end the life of a human being. Human euthanasia however, in its paradigmatic cases as he states, is the termination of the life of some person by another person or persons.

1.3 WHAT IS PHYSICIAN-ASSISTED SUICIDE?
Assisted suicide refers to the provision of a causative agent (usually a medication) to a patient, with the intention that the patient will use the agent to commit suicide. Physician-assisted suicide PAS, thus, specifically refers to cases where a doctor provides the means for the patient to kill his or herself, usually medication. Hence, Raymond J. Devettere remarks that physician-assisted suicide is the killing of a patient – a patient killing herself with a physician’s help. However, as he points out, there seems to be a very clear and sharp distinction between euthanasia and assisted suicide, most notable because the physician does the killing in euthanasia and the patient does it in suicide. However, he asserts:

In both cases, the physician plays an important role in the killing. In euthanasia the physician alone causes the death, and in physician-assisted
suicide both the physician and the patient cause the death. By providing
the lethal overdose and the proper instructions for suicide, the physician
is very much an active participant in the killing that occurs in the
physician-assisted suicide\textsuperscript{12}.

One way to distinguish euthanasia and physician-assisted suicide is to look at the last act –
the act without which death would not occur. Using this distinction, if a third party performs
the last act that intentionally causes a patient’s death, euthanasia has occurred. For example,
giving a patient a lethal injection or putting a plastic bag over her head to suffocate her would
be considered euthanasia. On the other hand, if the person who dies performs the last act,
assisted suicide has taken place. Thus, it would be physician-assisted suicide if a person
swallows an overdose of drugs that has been provided by a doctor for the purpose of causing
death. It would also be physician-assisted suicide if a patient pushes a switch to trigger a fatal
injection after the doctor has inserted an intravenous needle into the patient’s vein.

Euthanasia and physician-assisted suicide however, are similar in a crucial way. As Devettere
remarks: In both, the physician is a moral agent deeply involved in causing the death of a
patient. In the case of suicide, of course, there is a second moral agent active in causing
death, the patient, but the physician is still playing a major causal role\textsuperscript{13}. Furthermore, he
maintains that teaching a person how to kill someone, whether that someone is the person to
be killed or another, and providing them with the poison to do it, is simply not that different
from actually injecting the lethal dose. The similarity between euthanasia and physician-
assisted suicide he notes is so strong that they stand or fall together. In euthanasia, the
physician does the killing; while in physician-assisted suicide, the physician and the patient
form a team to do the killing. This by implication therefore reveals the fact that the whole act
of killing rests on the physician in matters of Euthanasia.

1.4 DIFFERENT KINDS OF EUTHANASIA.
Several terms have been coined to describe different types of euthanasia. Active and passive
euthanasia, voluntary and non-voluntary euthanasia, and Involuntary Euthanasia. In all,

\textsuperscript{12} Devettere, R. J., 1995, p.365.
\textsuperscript{13} Ibid, p.366.
however, intentional killing is involved, and the different forms of euthanasia are based on a common ground – a judgement about the value of life of an individual.

1.4.1 VOLUNTARY AND NON-VOLUNTARY EUTHANASIA.
Voluntary euthanasia refers to mercy killing that takes place with the explicit and voluntary consent of the patient, either verbally or in written document such as a living will. Raymond Devettere therefore notes:

> It presupposes all the requirements for informed consent are met. These include: (1) the patient has the capacity to understand, reason, and communicate; (2) the patient has sufficient information about diagnosis, prognosis, treatment options, etc.; and (3) the patient is not coerced or manipulated into giving consent. If these requirements are met and the patient wants to be killed, then it is a matter of voluntary euthanasia. Thus, when someone (in most cases physician) out of passion, carries out an action aimed at ending the life of another (a terminally ill or suffering patient) at his or her request, this is termed voluntary euthanasia\(^\text{14}\).

Non-voluntary euthanasia occurs when any of these requirements is missing. This, therefore, implies that there is no specific consent (in the present or in the past) given by the person who is killed. The patient may never have had the capacity to make such a decision or, if she had the capacity, never have made the decision. This therefore refers to the mercy killing of a patient, supposedly in that person’s own interests, but where the person is otherwise unable to explicitly make his intentions known. This may happen to people who the doctors or relatives think may have “lives worse than death” for example, babies born with terrible abnormalities, or adults who are hopelessly ill. As Jeff McMahan rightly observes, there are two types of cases in which the question of non-voluntary euthanasia might arise: first, cases involving individuals that have never been self-conscious and thus have never been able to have or to express a rational preference between death and continued life; and, second, cases involving individuals who were ones person’s (that is self-conscious and minimally rational) but have irreversibly lost the capacity to deliberate competently

\(^\text{14}\) Ibid, p.367.
about whether it would be better for them to die or to continue to live. McMahan maintains that an individual who has lost the capacity to deliberate about life and death and whose life now seems, to third parties, to have ceased to be worth living, may formerly, when competent have been opposed to being euthanized in these circumstances. Or he may have expressed a desire to be euthanized. Or, finally, he may have had or expressed no view at all. If he was formerly set against being euthanized, that, McMahan rightly notes, seems to constitute a decisive reason not to kill him.

1.4.2 INVOLUNTARY EUTHANASIA.
Involuntary euthanasia occurs when any person especially a medical personnel, kills a suffering patient who would have been able to give or withhold consent to his or her death who did not give any consent either because no one consulted him/her, or when asked, he/she refused to consent because he/she wanted to live. It is the act of causing the death of an individual without their consent. A husband’s withdrawing a life-support system from his unconscious wife, causing her immediate death, is an example of involuntary euthanasia because the wife is unaware that her life is being ended. Thus, involuntary euthanasia refers to euthanasia in cases when the patient either did not request death at all, when he or she was in a position to make such request, or when the patient had specifically rejected euthanasia. This therefore means the killing of a person, supposedly in that person’s own interests, in disregard of that person’s own view, thus, the person has the capacity to express wishes, but those wishes are overridden. Mason and S. McCall as Justin Ekennia writes, maintain that: the motive of bringing relief to the suffering patient in involuntary euthanasia may be the same in voluntary euthanasia, but its only justification lies in a paternalistic decision as to what is best for the victim of disease.

1.4.3 ACTIVE AND PASSIVE EUTHANASIA.
As has been defined, euthanasia – mercy killing, is where A brings about the death of B, for the sake of B. There are, however, two different ways in which A can bring about B’s death: A can kill B by, say administering a lethal injection; or A can allow B to die by withholding

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or withdrawing life-sustaining treatment. Cases of the first kind are typically referred to as ‘active’ or ‘positive’ euthanasia, whereas cases of the second kind are often referred to as ‘passive’ or ‘negative’ euthanasia. Thus, the three forms of euthanasia (voluntary, non-voluntary and involuntary euthanasia) could either take the form of active or passive euthanasia. Active euthanasia occurs when a person actually takes the life of a suffering or dying individual instead of allowing them to die from natural causes. Active euthanasia, therefore, implies a direct action that results to death which is often through giving a lethal injection. And passive euthanasia on the other hand implies an indirect act of killing. Here something is not done and whose absence results to death of the patient, and this often takes the form of withdrawing life-sustaining treatments. This distinction between active and passive euthanasia is an all crucial distinction in medical ethics. There has been tremendous controversy and debate over whether ethical distinctions exist between passive and active euthanasia. Some ethics experts contend that it is ethically irrelevant whether a doctor withdraws treatment or gives a lethal injection to end a patient’s life because in either case the doctor’s intention is to terminate that life. Therefore, they argue that if it is morally permissible to withdraw treatment to terminate a life, then it should be equally acceptable to inject a patient with a lethal dose to accomplish the same objective. As Tom Beauchamp however expressed,

The justification for assistance in bringing about death in medicine is an extension of the justification for letting patients die. Letting a patient die by accepting a valid refusal to continue in life is directly analogous to helping a patient die by accepting a valid request for help.

In his article in The New England Journal of Medicine, 1975, James Rachels however, attacks the distinction between active and passive euthanasia, and the doctrine apparently accepted by the American Medical Association that taking direct action to kill a patient (active euthanasia) is wrong, but withholding treatment and allowing a patient to die (passive euthanasia) is allowable. Rachels argues: To begin with a familiar type of situation, a patient who is dying of incurable cancer of the throat is in terrible pain, which can no longer

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18 Ethics of Euthanasia eNotes, www.enotes.com/ethics-euthanasia
19 Lane, B., in: www.members.shaw.ca/rdlane/euthanas.htm
be satisfactorily alleviated. He is certain to die within a few days, even if present treatment is
continued, but he does not want to go on living for those days since the pain is unbearable.
So he asks the doctor for an end to it, and his family joins in this request. Suppose the doctor
agrees to withhold treatment ... The justification for his doing so is that the patient is in
terrible agony, and since he is going to die anyway, it would be wrong to prolong his
suffering needlessly. But now notice this. If one simply withholds treatment, it may take the
patient longer to die, and so he may suffer more than he would if more direct action were
taken and a lethal injection given. This fact provides strong reason for thinking that, once the
initial decision not to prolong his agony has been made, active euthanasia is actually
preferable to passive euthanasia, rather than the reverse. Rachels asks, is killing someone
worse than letting them die? Consider these two cases: In the first Smith will gain a large
inheritance if anything should happen to his young cousin. One evening while the youngster
is taking a bath, Smith sneaks into the bathroom and drowns the child, and then arranges
things so it will look like an accident. In the second parallel case, Jones will gain a large
inheritance and plans to drown his cousin, but as he enters the bathroom Jones sees the child
slip and hit his head and fall face down in the water. Jones watches and does nothing. Now,
Smith killed the child while Jones "merely" let the child die. Rachels’ question, did either
man behave better, from a moral point of view? If the difference between killing and letting
die were in itself a morally important matter, one should say that Jones's behaviour was less
reprehensible than Smith's. But does one really want to say that? He then states that if the
crucial issue in the euthanasia debate is the intentional termination of the life of one human
being by another, then how can it be consistent to forbid mercy killing and yet deny that the
cessation of treatment is the intentional termination of a life? What is the cessation of
treatment if it is not the "intentional termination of the life of one human being by another"?
The so-called distinction between active and passive does not provide a useful moral
distinction20.

This view for the most part is deontological in contrast to a utilitarian or consequentialist
view. Clearly however, Rachels argument is that there is no moral difference between
actively killing a patient and passively allowing the patient to die. Thus, it is less cruel for
physicians to use active procedures of mercy killing, and he maintains that from a strictly

20 Lane, B., in: www.members.shaw.ca/rdlane/euthanas.htm
moral standpoint, there is no difference between passive and active euthanasia. Against the American Medical doctrine, Rachels makes three criticisms. First, it results in unnecessary suffering for patients who die slowly and painfully rather than quickly and painlessly. Second, the doctrine leads to moral decisions based on irrelevant considerations. Third, the distinction between killing and letting die assumed by the doctrine is of no moral significance. Rachel therefore maintains: If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. Thus, whether a patient is killed through a direct action or through an indirect act such as withholding treatment according to Rachels is wrong, they do not differ since both have the same outcome: the death of the patient on humanitarian grounds.

There is a widespread agreement that omissions as well as actions can constitute euthanasia. For example, in the Catholic Church’s position as expressed in the Sacred Congregation for the Doctrine of the Faith – Declaration on Euthanasia, euthanasia is defined as an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. However, philosophical, and ethical disagreement does arise over which actions and omissions amount to euthanasia. Arguably, some people are of the view that a physician practices euthanasia by refraining for instance, from resuscitating a severely brain damaged patient, or a patient in vegetative state, or that a physician engages in euthanasia, when she administers increasingly large doses of a painkilling drug that she knows will eventually result in the patient’s death. Others hold that whenever a physician deliberately and knowingly engages in an action or an omission that results in the patient’s foreseen death, the physician has performed active or passive euthanasia. One may then ask, Must all available life-sustaining means always be used, or are there certain ‘extraordinary’ or ‘disproportionate’ means that need not employed? In essence, if physicians must always do everything possible to try to save life, must active treatment be instigated with regard to terminally ill patients like patients in persistent vegetative state or severely brain damaged patients?

The traditional distinction between ‘ordinary’ and ‘extraordinary’ life-sustaining means are today often expressed as ‘proportionate’ and ‘disproportionate’ means of treatment. As

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expressed in the Roman Catholic Church’s document, the Sacred Congregation for the Doctrine of the Faith – Declaration on Euthanasia, a means is ‘proportionate’ if it offers a reasonable hope of benefit to the patient; it is ‘disproportionate’ if it does not. There is a shared view, even by those who regard euthanasia or the intentional termination of life as always wrong, that there are times when life-sustaining treatment should be withheld. The Roman Catholic Church for instance in her declaration thus states:

When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help the person in danger.23

Following this principle, a physician therefore is bound to use ordinary means of caring for the sick in ordinary medial care setting, ordinary would thus be those which offer reasonable hope of benefit and are not unduly burdensome to either the patient or the family. As Thomas Sullivan also argues, no intentional mercy killing (active or passive) is morally permissible. However, extraordinary means of prolonging life may be discontinued even though the patient's death may be foreseen. Sullivan further argues that most reflective people will agree with Rachels that there is no moral distinction between killing someone and allowing someone to die. According to Sullivan, Rachels's biggest mistake is that he misunderstands the position of the American medical Association AMA, pointing out that AMA maintains that all intentional mercy killing is wrong, either active or passive. Although extraordinary procedures for prolonging life may be discontinued for terminally ill patients, these procedures are ones that are both inconvenient and ineffective for the patient. If death occurs more quickly by discontinuing extraordinary procedures, it is only then a by-product. In short, to aim at death (either actively or passively) is always wrong, but it is not wrong to merely foresee death when discontinuing extraordinary procedures.24 Most other critics of

24 *ABC Online Forum: www2b.abc.net.au/science/k2/stn/archives/archive6/newposts/47/topic47223.shtm*
Rachel focus their arguments on the actual cause of death in the two forms of killing. Thus, if a patient is allowed to die, isn’t that patient killed by the disease? But if someone acts directly to bring about the death of the patient, isn’t that person the cause of the patient’s death? In this case then he takes the responsibility of the death. Further in his reply to Rachels, Tom L. Beauchamp argues that one may, of course, be entirely responsible and culpable for another’s death either by killing him or by letting him die. In such cases, there is no morally significant difference between killing and letting die precisely because whatever one does, omits, or refrains from doing does not absolve one of responsibility. But not all cases of killing and letting die, he points out fall under this same moral principle. One is sometimes culpable of killing, because morally responsible as the agent for death, as when one pulls the plug on a respirator sustaining a recovering patient (a murder). But one is sometimes not culpable for letting die because one is not morally responsible as agent, as when one pulls the plug on a respirator sustaining an irreversibly comatose and unrecoverable patient (a routine procedure, where one is merely causally responsible)\textsuperscript{25}.

2.0 HISTORICAL OVERVIEW OF EUTHANASIA.

Debate over euthanasia is not a modern phenomenon. It is for the most part, an ancient one traceable to the Greek and Roman times. In the Western tradition, euthanasia in the classical world of Greece and Rome was thought by many as morally acceptable in appropriate/extenuating circumstances. For instance, Aristotle thought it ethical to end the life of defective infants. Plato approved of it in cases of terminal illness. Epicurus encouraged hedonism, and made seeking pleasure and avoiding pain the norm of living. Thus most ancient Greek and Romans believed in the maxim that “an unexamined life is not worth living” and placed priority not on living alone but on living well. G. Gruman maintains that prior to this epoch, in prehistoric times, measures had been taken to hasten death. For him the Graeco-Roman antiquity was characterized by a generally recognised “freedom to live” that permitted the sick and despondent to terminate their lives, sometimes without side helps.26 As Devettere notes, stoicism, the philosophy that dominated the Greek and Roman classical worlds for centuries after 300 B.C.E, also advocates living “according to nature,” and many stoics did not hesitate to kill themselves when the struggle to live became an unreasonable effort to prevent death. For them, death was natural, and so helping it come at the end was reasonable and virtuous.27 The Hebrew culture, he notes, was more conservative than the Stoics, which stems from the Biblical belief that human life was created by Yahweh or God, a belief which implies that we should be careful about destroying God’s creature. In medieval times, Christian, Jewish, and Muslim philosophers opposed active euthanasia. Notably however, the Pythagoreans in general and the Hippocratic medical tradition in particular, were opposed to euthanasia. This as Devettere notes is consequent upon the Pythagorean religious beliefs which included two important doctrines – the kinship of all life and the transmigration of souls. Thus, with the rise of Christianity and Judaism, human life underwent a change and was seen as having sanctity and must not be taken deliberately. Hence, taking an innocent human life is in these traditions, to usurp the right of God to give and take life and therefore a violation of natural law. Pythagoras believed that life was somehow a single reality shared by all living things; there was no such thing as “my” life or “your” life, but simple life. Our souls recycle through life in different forms many times over

until they finally attain some form purified reincarnation\textsuperscript{28}. The Pythagoreans thought great care must be taken not to disrupt or destroy this cycle of life. Hence, deliberately bringing about any death, even the death of animals, was considered wrong. Hippocrates, the originator of the famous Hippocratic Oath was a physician in the Pythagorean tradition whose Oath is still being appealed to for moral guidance in medicine.

In the modern period, this religious view, remained unchallenged until the sixteenth century, when the English humanist, Sir Thomas More (1478 – 1535) published his Utopia, portraying in the work, euthanasia for the desperately ill as one of the important institution of an imaginary community. Subsequently, British philosophers like David Hume, Jeremy Bentham, and John Stuart Mill challenged the religious basis of morality and the absolute prohibition of suicide, euthanasia and infanticide. On the other hand, Immanuel Kant, the great eighteenth-century German philosopher, whilst believing that moral truths were founded on reason rather than religion, nonetheless thought that ‘man cannot have the power to dispose of his life’\textsuperscript{29}. Arguably and parallel to this is that physicians too are not to help or even directly dispose of a patients life. During the Renaissance, in New Atlantis (1627), British philosopher Francis Bacon (1561-1626) writes that physicians are not only to restore the health, but to mitigate pain and dolours; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage\textsuperscript{30}.

Today in our contemporary epoch, the issue of euthanasia has remained controversial. Consequent upon this, some people accept some forms of euthanasia while some others reject euthanasia. Thus, many contemporary philosophers have agreed that euthanasia and equally its practice by a physician is morally defensible although official religious opposition, (for example, the Catholic Church) does, however, remain unchanged, and euthanasia has remained illegal in every other nation aside the Netherlands and Belgium where physicians are allowed to practice euthanasia under the conditions that, the decision to die must be a voluntary and considered decision of an informed patient; there is no other reasonable (i.e. acceptable to the patient) solution to improve the situation; the doctor must consult another senior professional.

\textsuperscript{28} Ibid, p.360.
\textsuperscript{30} www2b.abc.net.au/science/k2/stn/archives/archive6/newposts/47/topic47223.shtml
However, the acceptance of euthanasia is contrary to the fundamental tradition of the physician in medicine, one devoted to the ethical formation as well as the widely spread and acceptance of the Hippocratic Oath. From the above overview, we can see almost unanimous long-standing religious and philosophical positions against euthanasia and other forms of killing.

2.1 VARIOUS ARGUMENTS IN THE DEBATE OF EUTHANASIA AND PHYSICIANS’ INVOLVEMENT.
The debate on euthanasia and of the involvement of physicians in euthanasia has led to barbell of voices either in view of acceptance, or in its rejection. Euthanasia literally defined as mercy killing, involves taking of one’s life or with the aid of a physician and intentionally, hence, is it morally and ethically justifiable to take one’s life or for a physician to end a patient’s life? This brings us then to the various arguments in the debate. First, will be a look into the arguments advanced by proponents of euthanasia and of physicians involvement, then some criticisms of these arguments, and secondly the various arguments advanced by opponents of euthanasia and of the physicians involvement, and also some criticisms of these arguments.

2.2 ARGUMENTS IN FAVOUR OF EUTHANASIA AND ITS PRACTICE BY A PHYSICIAN.
Proponents of euthanasia are of the view that euthanasia is ethically acceptable, hence, a justification of a physician performing euthanasia. In defence of this position, various arguments have been advanced, thus, following are some of the arguments favouring euthanasia and a physician’s involvement in euthanasia.

2.2.1 PHYSICIANS RESPECT FOR A PATIENT’S AUTONOMY, RIGHT, AND SELF DETERMINATION.
Central in most arguments favouring euthanasia is the idea that people should decide for themselves how to live and die. In view of this, proponents of euthanasia have captured words like autonomy, choice, rights, privacy and self-determination. Their intent is for
individuals to have the right to choose how, why, when and where to die and to receive physicians assistance in dying. According to the Encyclopedia of Applied Ethics, this is perhaps the strongest argument by proponents in favour of permitting euthanasia. It asserts that if there one thing over which we should be able to exert absolute control, it is over our own lives. If an individual decides that death is preferable to the life she currently has, that she should be free to end that life. If she is not in the position to end her without help, it is not wrong for her to ask others for assistance to do so and it is not, therefore, wrong for them to give that assistance. Hitherto, proponents of euthanasia argue that patients are enabled as a result of their possession of autonomy, right, and self-determination, to kill themselves, akin to this right they argue is also that patients should have physicians kill them or at least help them to kill themselves. Each person therefore, has the right to control his or her body and life and so should be able to determine at what time, in what way and by whose hand he or she will die. Human beings therefore should be as free as possible and that unnecessary restraints on human rights are wrong. Human beings are thus seen as independent biological entities, with the right to take and carry out decisions about themselves. The notion of absolute autonomy, that is, the unfettered right to decide all things, is a radical departure from the traditional moral order. Nevertheless, if autonomy, right, and self determination are accepted as fundamental moral principles or moral values, then voluntary requests for assistance in euthanasia and subsequently a physician’s involvement will therefore become morally justified. If autonomy (which gives one the right to make choices freely) is understood as a principle whereby whatever I choose is thereby morally right, then it can be argued that my choice to end my life through euthanasia is moral and that I can ask my physician, whose act in helping me bring about this is also moral.

However, James Rachels maintains that in the connection between the acceptability of an autonomous decision to end one’s life and euthanasia, it must be shown that one can engage the help of another (example, a physician) to die, maintaining that it is not just clear that because one is permitted to do something, then she is also entitled to expect help to carry out such. He says, a man may have the right to sleep with his wife, without having the right to delegate that privilege. Rachels further sums up this connection saying that: If it is permissible for a person … to do, or bring about a certain situation, then it is permissible for

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32 Rachels, J., 1986, p.86.
that person … to enlist the freely given aid of someone else in so doing the act or bringing about the situation, provided this does not violate the rights of any third party\textsuperscript{33}. Thus, it is then permissible for physicians to act on the wishes of patients to give euthanasia.

2.2.2 RELIEF FROM PAIN AND SUFFERING.

Amongst the major arguments in favour of euthanasia is that the person involved is in great pain. Euthanasia advocates stress the cases of unbearable pain and suffering as reasons for euthanasia, arguing that the pain of dying is sometimes uncontrollable and that a quick merciful death through the aid of a physician is morally justified in such circumstance. As Dan Brock argues in his view regarding the permissibility of euthanasia for patients who’s dying is filled with severe and unrelievable suffering: \ldots euthanasia may be the only release from their otherwise prolonged suffering and agony\textsuperscript{34}. Thus, proponents of euthanasia in the light of this argument are of the view that a physician euthanizing a patient who is suffering unbearable pain, carries out a moral duty, hence, what justifies his act arguably then is the relief of pain and suffering. This is a consequentialist view as opposed to deontologist view. Nevertheless, opponents of euthanasia are of the view that most suffering could be controlled by medication, and in those rare cases where it can not be eliminated, it can still be reduced significantly through the provision of proper treatment by a physician. Euthanasia advocates on the other hand argue that if dying people are suffering terrible intractable pain and want to die, they say it is more humane for physicians to honour requests for euthanasia than to induce somnolence by drugs while awaiting inevitable death. The relief from suffering argument Raymond Devettere notes is based on two of the noblest human feelings: compassion and mercy in the face of another’s suffering. The relief of suffering has long been one of the primary goals of medicine. Thus, proponents of euthanasia maintain that consequent upon this, physicians should respond to pleas from patients for euthanasia. They also argue that suffering need not be physical, it could also be psychological. The fear of loosing control or dignity at the end as a result of diseases can cause great distress, hence, a reason for euthanasia.

\textsuperscript{33} Ibid.

\textsuperscript{34} Brock, D.W., in: Beauchamp, T.L., Walters, L., (4\textsuperscript{th} ed.), 1994, p.494.
2.2.3 EUTHANASIA IS IN LINE WITH MEDICAL PRACTICE.
Hitherto, the argument by advocates of medical aid in euthanasia is rooted in the claim that these actions are no more than a normal evolution in modern medicine. Through research and better modern medical diagnosis, it is argued that physicians now know more about the inexorable and painful degeneration of certain diseases. The certainty of what will be a painful dying therefore suggests that out of mercy for suffering patients, physicians are to make the inevitable death easier for the patients. This practice as advocates of euthanasia argue is in line with medical practice. And since this state of degeneration is accompanied by suffering and misery, needless therefore a suffering patient enduring a miserable end, hence, euthanasia. They argue therefore that for this reason, it is ethically and morally permissible for a physician to perform euthanasia. Arguments in favour of euthanasia have variously been criticised. Following are some of the criticism of the arguments.

2.3.4 CRITIQUE OF THE ARGUMENTS IN FAVOUR OF EUTHANASIA AND ITS PRACTICE BY A PHYSICIAN.

(i) CRITIQUE OF THE PHYSICIAN’S RESPECT OF A PATIENT’S AUTONOMY, RIGHT AND SELF-DETERMINATION ARGUMENT.
Arguments based on the physicians respect of the patient’s self-determination, or the right to choose contains a major limitation, they cannot by themselves establish what is morally right or wrong. As R. J. Devettere remarks, saying something is morally right simply because it is autonomously and freely chosen is missing the whole point of ethics. The task of ethics is to determine that what is freely chosen is morally good; that is, that it will truly contribute to the agent’s good. Certainly patients should be responsible for their lives and make the important choices, but no choice becomes morally justified simply because it is chosen. It is worthy of note that even if the argument from autonomy, right and self-determination is acceptable, it would justify euthanasia only for those who have the capacity to request for it. What then becomes of people who are unconscious or comatose who are incapable of taking decisions? Furthermore, it is important to point out that people who request euthanasia are not always in the best frame of mind. In view of this, Aristotle rightly points out the difficulty

36 Ibid, p.373.
of making a rational decision while in the grip of pain and suffering, even for those considered objective and detached observers of matters of life and death – the physicians themselves:

Doctors themselves call in others doctors to treat them when they are sick, and trainers call in other trainers when they are exercising, their assumption being that they are unable to judge truly because they are judging about their own cases, and while in pain.

Although proponents of autonomy, right, and self-determination try to circumvent this, it however shows that autonomy, right, and self-determination cannot be a necessary condition or a sufficient reason justifying euthanasia or of a physician’s practice of such, for the most part, it rules out the possibility of determining the wishes of incompetent patients. Religiously, the right to decide when a person dies belongs to God. In secular sphere, opponents argue that whatever rights we have are limited by our obligations, and in the same vein, a physician is limited by his obligation to perform euthanasia. The decision to die by euthanasia will affect other people – our family, friends, and even the physician – thus, the need to balance the consequences for them (guilt, grief, anger) against our rights. We should also take account of our obligations to society, and balance our individual right to die against any bad consequences that it might have for the community in general. These bad consequences might be practical - such as making involuntary euthanasia easier and so putting vulnerable people at risk. There is also a political and philosophical objection that says that our individual right to autonomy against the state must be balanced against the need to make the sanctity of life an important, intrinsic, abstract value of the state. Secular philosophers put forward a number of technical arguments mostly based on the duty to preserve life because it has value in itself, or the importance of regarding all human beings as ends rather than means.

(ii) CRITIQUE OF THE ARGUMENT BASED ON RELIEF OF SUFFERING.

Relief of suffering has always been the goal of physicians and of medicine itself. The

38 www.bbc.co.uk/religion/ethics/euthanasia/euth_rights.shtml
argument claims that physicians should, in cases where the suffering is intractable and death inevitable, respond in a spirit of mercy and compassion to the patient’s desire for euthanasia. Stated this way, the arguments prompted by mercy and compassion are clearly a limited one because suffering can almost always be relieved without killing the person. Suffering is frequently associated with the experience of aversive physical symptoms (e.g., pain); Secondly, suffering due to advanced disease does not appear to be limited to the affected patient. Family members also suffer, which may, in turn, exacerbate the patient's suffering. However, relief of these sources of suffering by physicians can be achieved through a vigorous approach to patient care in which physicians should increase their treatment effort. Thus, addressing the psychosocial aspects as well as the medical aspects of palliative care can further reduce the suffering experienced by patients with terminal illnesses. Furthermore, euthanasia is only a moral option only when patients are experiencing, or expect to experience, severe intractable suffering that cannot otherwise be controlled. The argument for euthanasia based on relief of suffering was much stronger prior to anaesthesia and pain medication became so effective. Knowing a heavy dose of pain medication might in fact kill a person does not make it an action akin to euthanasia because the intention is radically different. Therefore Devettere writes:

The intention – and intentions are important in ethics – in giving medication for pain is fundamentally different from the intention in giving a lethal injection. It is one kind of normal action to give drugs in order to mask pain; it is quite another kind of normal action to give drugs in order to kill.

Therefore, if a physician can relieve pain and suffering with medication, then no matter how unsatisfactory the situation, it is at least arguable that this route is less bad than killing them. Given a cultural tradition against killing, then only where euthanasia would be justified by the relief of suffering argument, then, is a situation where the suffering can be relieved by no other way than by killing the patient. There may be such situations (on the battle field, for example), but they are almost inconceivable in a normal health care setting.

39 www.psyperplexus.com/excl/death_2.html
40 Devettere, R.J., 1995 p.375.
(iii) CRITIQUE OF THE ARGUMENT THAT EUTHANASIA IS IN LINE WITH MEDICAL PRACTICE.

Responding to the desire to be killed through euthanasia is not all that clear as being truly a part of medical practice. The decision of a person to be killed as Raymond Devettere observes is much more than a medical decision, it is a fundamental decision about a person’s whole life and how it should end. It is not a clinical decision involving treatment of disease or pain, but an existential decision involving the destruction of human life. He therefore asserts:

Physicians and nurses have no special training or expertise whereby they can join in decisions about ending someone’s life. This is not a professional or clinical decision. Killing people, and helping them kill themselves, is a social issue of immense consequence.\(^{41}\)

Devettere therefore maintains that, killing innocent people has never been, and is not now, in line with medical practice for any segment of our society.

2.3 ARGUMENTS AGAINST EUTHANASIA AND ITS PRACTICE BY A PHYSICIAN.

The idea and practice of euthanasia by physicians, is slowly gaining acceptance in our society. Cynics might attribute this to an increasing tendency to devalue human life. However, today, observation shows that the acceptance is much more as a result of unthinking sympathy and benevolence. For instance, a well publicized, tragic story like that of Karen Quinlan elicit from us deep feelings and compassion, thus we may think, ‘she and her family would be better off if she were dead.’ In 1975, after a drug overdose, Quinlan had fallen into what her doctors judged to be an irreversible coma and was kept alive by a life-support system. Her parents’ request that she be disconnected from the life-support system and allowed to die was denied, forcing them to pursue legal channels. The court decided in favour of Quinlan’s parents and created a legal precedent for passive euthanasia. It is an easy step from this very human response to the view that if someone (and others) would be better off dead, then it must be all right to kill that person.\(^{42}\) Good as the compassion that leads to this conclusion are, however, the conclusion, per sé, is wrong. Since there is a cultural

\(^{41}\) Ibid, p.376.

presupposition against killing people, even when they request it, criticisms of the arguments favouring euthanasia constitute a good reason for the rejection of euthanasia by physicians.

Moreover, opponents of euthanasia have also offered more positive arguments designed to show that euthanasia and a physician’s involvement in it is immoral. In line with Gay-Williams observation, it is worthy of note that what is at stake in euthanasia is taking human life, which is either one’s life or that of another. Also the person whose life is taken must be someone who is believed to be suffering from some disease or injury from which recovery cannot reasonably be expected. And the action must be deliberate and intentional. Whether the life is one’s own or that of another, the taking of it is still euthanasia. It is important to be clear about the “deliberate” and “intentional” aspect of the killing. If a hopeless person is mistakenly given an injection of the wrong drug, and consequent upon this, the person dies, this is termed “wrongful killing” and not euthanasia. Furthermore, if a person is given an injection of a drug believed to be necessary to treat his disease or better his conditions and the person dies as a result of this, this is then neither wrongful killing nor euthanasia. The intention was to make the patient well, and not kill him. What follows thus, are some of the arguments advanced against euthanasia.

2.3.1 ARGUMENT FROM NATURE.
According to this argument, killing ourselves is immoral, and in the same vein, killing by a physician is immoral because it runs counter to the natural impulse for self-preservation and is thus against human nature. Every human being as Gay-Williams argues has a natural inclination to continue living. This is manifest in the exercise of care and caution necessary to protect ourselves in our daily lives. Our reflexes and responses fit us to fight attackers, flee wild animals and dodge out of the way of trucks. Also, our bodies are structured for survival right down to the molecular level. When we are cut, our capillaries seal shut, our blood clots, and fibrogen is produced to start the process of healing the wound. When we are invaded by bacteria, antibodies are produced to fight against the alien organisms, and their remains are swept out of the body by special cells designed for clean-up working. Hence killing our self, or a physician killing us, violates this natural goal of survival, and is therefore literally acting

against nature because all the processes of nature are bent towards the end of bodily survival. It is worthy of note that the organisation of human body and our patterns of behavioural responses make the continuation of life a natural goal. Thus, reason makes it clear that euthanasia sets us against our own nature and therefore makes it wrong for us to kill ourselves or be killed by a physician. Hence, St. Thomas Aquinas states:

It is altogether unlawful to kill oneself, for three reasons. First, because everything naturally loves itself, the result being that everything naturally keeps itself in being, and resists corruption so far as it can. Wherefore suicide is contrary to the inclination of nature, and to charity whereby every man should love himself^{44}.

Thus, unlike animals, we are conscious through reason of our nature and our ends. Euthanasia especially by a physician, involves acting as if this dual nature – inclination towards survival and awareness of this as an end – did not exist. Thus, euthanasia denies our basic human character and requires that we regard ourselves or that physicians regard patients as something less than fully human.

2.3.2 RELIGIOUS ARGUMENT.

God, in the light of this argument is the creator of the world and everything therein, and His creative involvement has continued till this day. Religiously, God is the giver of life, that is, He gives life as a gift and remains Lord of it. For instance, as the Biblical book of Deuteronomy 32:39 says, “Learn that I, I alone, am God, and there is no God besides me. It is I who brings both death and life.” Thus, as William Blackstone captures it, … the law on England wisely and religiously considers, that no man hath a power to destroy life, but by commission from God, the author of it …^{45} Therefore, when man who is just a trustee of his body, takes his own life or is helped by another (e.g. a physician) to achieve this, acts against God and His biblical injunction “Thou shall not kill” which is the basis of natural law. By so doing, man therefore, rejects the gift of life and of God’s sovereignty over it. By killing,

^{44} Aquinas, T., Summa Theologica, 11, 11, Q.64, Art.5.
^{45} Blackstone, W., (1765-9), BK. IV.
people assume a power over life and death that belongs not to them but to God. Despite the references indicating that the Bible sanctions various killings including the killing of the enemy’s women and children, there is yet a consensus that the Bible takes a strong stand against most intentional killing of innocent people, hence, the foundation for the prohibition, “doctors must not kill.”

The religious argument has great appeal not only for Christians and theologians, but for many. As Immanuel Kant argues, morality is an affair of reason, not religious revelation; he employed a religious argument against killing. As R. J. Devettere captures it, Kant believed we were placed by God in the world for specific purposes, and that people committing suicide desert their posts and are rebelling against God. John Locke, a major architect of the theory of natural rights which include amongst others the rights to life and liberty also argued against one killing his or herself emphasizing that God sent us into the world to be about His business, and thus we are bound to preserve ourselves and not quit our station wilfully. This by implication therefore indicates that no one has the right to decide when to end any life, and as such, it is arguable then that a physician should altogether abstain from the practice of euthanasia and work for the preservation of life.

2.3.3 PHYSICIANS RESPECT FOR THE PATIENTS SELF-INTEREST.
When judged by standards other than reason, there are reasons to show that euthanasia is wrong and a physician carrying out euthanasia is equally wrong. Death is final and irreversible, it is therefore set forth in the light of this argument that, euthanasia contains within it the possibility that we will work against our own interest when we practice or allow a physician to practice it on us. Contemporary medicine as Gay-Williams rightly pointed out, has high standards of excellence and a proven record of accomplishment, but does not possess perfect and complete knowledge. A mistaken diagnosis is possible, and so a mistaken prognosis. Consequently we may believe we are dying of a disease when, as a matter of fact we may not be. We may think we have no hope of recovery when, as a matter of fact, our chances are quite good. In such circumstances, if euthanasia were permitted, we would die

needlessly. Death is final and the chance of error too great to approve the practice of euthanasia.\(^4^8\)

Furthermore, it is always possible for an experimental procedure or an untried technique to yield a positive result. However, euthanasia closes off this option, which as a matter of fact, should be open. Also, in many cases, spontaneous remission takes place. There have been cases of patients recovering when death is apparent to those around him including his or her physician. Thus, ending such life by a physician would only guarantee their position leaving no room for the “miraculous” healing that frequently occur. More so, a knowledge that we are free to take our lives or do so through the aid of a physician might well incline us to give up too easily. We all have a strong will to live, but this can be weakened by factors as suffering, pain and feelings of hopelessness, and more so by an inclination that we can end our lives through physicians. Recovery form any illness requires that we fight for it, hence that which weakens our determination in achieving this is ultimately against our interest. Again, owing to our concern for others, we may be inclined towards euthanasia. For instance, seeing our suffering and sickness as an emotional and financial burden on our family, we may feel that to take away our life or to carry out this with the help of a physician is to make life on the other hand easier for them. The very presence of the possibility of euthanasia may keep us from surviving when we might. However, as a result of self interest, some people especially terminally ill people might want euthanasia in which case, owing to their suffering, they would opt to end their lives or have a physician end their lives. Nevertheless, euthanasia as a result of this is wrong in the light of the above argument.

2.3.4 ARGUMENT FROM PRACTICAL EFFECTS.
Doctors and nurses are, the most part, totally committed to saving lives. A life lost is, for them, almost a personal failure, an insult to their skills and knowledge of the profession. Euthanasia as a practice might as well alter this. This could have a corrupt influence that in a severe case physicians might not try hard enough to save patients. They might simply decide that the patient would be “better off dead” and take the steps necessary to bring about this. This attitude might well be carried over to patients who are less seriously ill. The

resultant effect will then be an overall decline in the quality of medical care. However, as have been argued, proper palliative care makes euthanasia unnecessary. Palliative care is physical, emotional and spiritual care for a dying person even when it is believed that cure is not possible. It includes support from family, friends and even the physician. Complete palliative care may well be enough to prevent a person feeling any need to contemplate euthanasia. As Bobby Webster captures Dame Cicely Saunders, founder of the Modern Hospice Movement: You matter because you are you. You matter to the last moment of your life and we will do all we can to help you die peacefully, but also to live until you die\textsuperscript{49}. The key to successful palliative care Bobby Webster maintains is to treat the patient as a person, not as a set of symptoms, or medical problems. In actual practice as Bernard Gert et al. maintain, far too many physicians do not provide sufficient relief for the pain and suffering of those who are suffering from chronic diseases or are terminally ill. Inadequate palliative care is one of the significant causes of patients seeking to die. Hence, they expressed: We think that if such care were universally provided, the question of euthanasia would be a far less pressing problem\textsuperscript{50}. The World Health Organisation states that palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- will enhance quality of life, and may also positively influence the course of illness\textsuperscript{51}.

In effect, good palliative care is the alternative to euthanasia. This made available to every patient would reduce the desire for a hastened death to be brought about sooner. More so, euthanasia if accepted as a policy, would lead to a slippery slope. Thus, a person who is apparently hopelessly ill may now take his own life, or if incompetent may have a physician help end his/her life. The ruling factor then becomes the judgement of others. Since others now act on behalf of the patient as they deem fit, euthanasia now becomes involuntary.

\textsuperscript{49} Webster, B., in: http://bmj.bmjjournals.com/cgi/content/full/326/7402/1335
\textsuperscript{50} Gert, B; Culver, C.M; Clouser, K.D., 1997, p.280.
\textsuperscript{51} www.who.int/cancer/palliative/definition/en/
This act may well then be extended to others who have not authorized them to exercise judgement. As Gay-Williams captures it, this is only a short step, then, from voluntary euthanasia (self-inflicted or authorized), to directed euthanasia administered to a patient who has given no authorization, to involuntary euthanasia conducted as part of a social policy. In view of this, the American Medical Association (AMA) thus remarks:

> The AMA has watched, with great interest, doctor-assisted suicide in The Netherlands expand to include euthanasia even without a patient's knowledge or consent. Doctors in The Netherlands often resort to euthanasia when it appears that their efforts to cure the patient have been unsuccessful … Holland has shown that once the doctor has accepted the fact that he can end life, no amount of rules or regulations will protect the public.

In the same vein, a University of Michigan Professor of law, Yale Kamisar, articulates these attacks that utilize the slippery slope argument, the risk of abuse, and the risk of mistake. Thus, he argues that, once society accepts that life can be terminated because of its diminished quality, there is no rational way to limit euthanasia and prevent its abuse. Accordingly therefore, voluntary euthanasia is just the thin edge of a wedge that, once in place, will be driven deeply into our society. Euthanasia if embedded in a social policy would give the society or its representatives the authority to eliminate all those who might be considered too ill to function normally any longer. There is anecdotal evidence of physicians falsifying data to justify euthanasia, making egregious mistakes in diagnosis, and prognosis, or entering into collusion with families, ordering involuntary euthanasia, etc. Hence he states:

> These anecdotal impressions and further study of the Dutch experience is therefore crucial for any society contemplating euthanasia as public policy. Present evidence indicates that the “slippery slope” – conceptual and actual – is no ethical myth but a reality in Holland.

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53 AMA, in: [www.pregnantpause.org/euth/amagomez.htm](http://www.pregnantpause.org/euth/amagomez.htm)
Jeff McMahan commenting on the issue of euthanasia therefore remarks that fears in the acceptance of euthanasia most especially non-voluntary euthanasia, is that this would result in the fact that mistakes are bound to come in, abuses would occur, and the acceptance of killing in these cases would erode our sensitivity to the value of life and engender an increasingly callous and promiscuous attitude toward killing. However, doubtless as McMahan acknowledges, some mistakes would occur: occasionally someone would be killed who was misdiagnosed or would have been among the tiny majority who recover against the odds or for whom cure is unexpectedly found. Moreover, even if mistakes are statistically certain, the costs of permitting euthanasia have to be weighed against the equally certain and probably much greater costs of denying people a release from great suffering.

2.3.5 ARGUMENT FROM THE VALUE AND SANCTITY OF LIFE.

Each human being is valuable simply because each is human. In the light of this argument, euthanasia is bad because of the value attached to human life and the regard that human life is sacred. A physician who therefore practices euthanasia in view of this argument acts contrary to the goals of preserving a life that is sacred and has a valuable worth. In her 1984 Declaration on IVF, The World Federation of Doctors Who Respect Human Life, - States that each human life is sacred, is unique and of infinite value from fertilisation to natural death and that one may never end the life of a patient no matter his/her age or illness.

According to Immanuel Kant, rational human beings should be treated as an end in themselves and not just as a means to something else. Our inherent value is absolute, and does not depend on anything else. We exist, so we have value. Life, or human life, has a special value that is independent of the value that it has either for the individual whose life it is or for others. Therefore, this forms a value that is present in a life even when a continuation of the life is bad both for its possessor and others. The inherent value of life thus asserts that it is not the quality or quantity of life that gives it value, but the fact that life is the vehicle for all experience, both good and bad, that gives it its value. As Thomas Nagal argues:

> There are elements which, if added to one’s experience, make life better; there are other elements which if added to one’s experience make life worse. But what remains when these are set aside is not merely neutral: it

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is emphatically positive. Therefore life is worth living even when the bad elements of experience are plentiful, and the good ones too meagre to outweigh the bad ones on their own. The additional positive element is supplied by experience itself, rather than by any of its contents.\(^\text{56}\)

Accordingly as Jeff McMahan notes, when in 1990 the Supreme Court ruled on the Cruzan case, in which the State of Missouri claimed the right to keep the body of a young woman in PVS alive against the wishes of her parents, Chief Justice William Rehnquist, writing for the majority, and Justice Antonin Scalia, in a concurring opinion, both appealed to the idea that the state has an interest in protecting the value of human life even when that is contrary to the interests of the individual whose life it is. Dworkin as McMahan rightly captures it paraphrased Scalia’s view who holds that, a state has the constitutional power to prohibit suicide in any circumstance … even for someone dying in terrible pain who would plainly be better off dead, because it has the power to protect human life for its own sake.\(^\text{57}\). Similarly John Finnis according to McMahan, is of the view that those who accept the legitimacy of euthanasia or suicide erroneously suppose that human life in certain conditions or circumstances retains no intrinsic value …\(^\text{58}\). He then argues that human life always has intrinsic value, and that respect for this value requires that human life must never be intentionally terminated, no matter how wretched it may be for the person condemned to live it and irrespective of whether that person autonomously desires to die. Invariably then, physicians are not to even on request carry out euthanasia.

According to Immanuel Kant and Velleman J. David as McMahan writes:

to kill a person, or for a person to kill himself, in order to spare him a future that would be worth not living, is to violate the worth of that person. It is to assume that the value of worth of the person is commensurable with and outweighed by what is good for him. But these values are not commensurable, the value of what’s good for a person is only a shadow of the value inhering in the person, and cannot overshadow or be overshadowed by it.\(^\text{59}\).

\(^{56}\) Nagal, T., 1979, p.2.
\(^{58}\) Ibid.
\(^{59}\) Ibid, p.474.
Therefore to kill a person out of a concern for the person’s own good, even if the person is oneself, is to make the mistake of giving the person’s good priority over the worth of the person himself. It is to sacrifice the person for the sake of his good, thereby treating the person as a means rather than an end-in-himself.

As Velleman David observes, the worth makes different demands from those made by other sorts of value. Velleman as McMahan notes, contend that insofar as we regard rational nature as something for us to promote, preserve or facilitate, we regard it no differently from happiness, and our motive toward it is no different from desire. Thus, he maintains that:

When considering the motivational force for respect, (Kant) says that its object “must … be conceived only negatively – that is, as an end against which we should never act, and consequently as one which in all our willing we must never rate merely as a means.” In other words, respect can motivate us, if not by impelling us to produce its object, then by deterring us from violating it; and the violation from which we are thus deterred can be conceived as that of using the object as a mere means to other ends.\(^{60}\)

Thus, euthanasia and subsequently its practice by a physician in this view is wrong not because they destroy a person’s rational nature, but because they sacrifice the person’s rational nature for the sake of his good, thereby treating the person’s rational nature as if it were an instrument of the person’s good rather than as an end-in-itself. Therefore, euthanasia on the ground that one’s life has ceased to be worth living is as Derek Parfit describes it, to trade one’s person in exchange for … relief from harm, and this is incompatible with respect for one’s worth as a person.\(^{61}\) Furthermore, accepting euthanasia and its practice by physicians is to accept the fact that some lives (especially those of the disabled and the seriously ill) are worth less than others. This sends the message, “it is better to be dead than to be sick or disabled”. The subtext is that some lives are not worth living. Not only does this put the disabled or seriously ill people at risk, it also downgrades their status as human beings while they are alive.

\(^{60}\) Ibid, p.478.
\(^{61}\) Ibid, p.478.
2.3.6 EUTHANASIA CAN BECOME A MEANS OF HEALTH CARE CONTAINMENT. Here, it is argued, that if euthanasia becomes widespread, it could become a profit-enhancing avenue for physicians. Drugs used in euthanasia may well be very cheap in comparison to what it will cost to treat a patient properly and to save them from want of the choice of euthanasia. Perhaps one of the most important developments in recent years is the increasing emphasis placed on health care providers to contain costs. In such a climate, euthanasia certainly could become a means of cost containment. Relating this to the Dutch euthanasia, Richard Miniter remarks that the path to the death culture began when doctors learned to think like accountants. As the cost of socialized medicine in the Netherlands grew, doctors were lectured about the importance of keeping expenses down. In many hospitals, signs were posted indicating how much old-age treatments cost taxpayers. The result was a growing "social pressure" from doctors and others. As contained in the report of the International Task Force on Euthanasia and Assisted Suicide, in the United States alone, millions of people have no medical insurance and studies have shown that the elderly, the poor and minorities are often denied access to needed treatment or pain control. Doctors are being pressured by big HMOs to reduce care; "futile care guidelines" are being instituted, enabling health facilities to deny necessary and wanted interventions; and health care providers are often likely to benefit financially from providing less, rather than more, care for their patients. With greater and greater emphasis being placed on managed care, many doctors are at financial risk when they provide treatment and proper palliative care for their patients. Euthanasia therefore raises the potential for a profoundly dangerous situation in which doctors could find themselves far better off financially if a seriously ill or disabled person chooses to die rather than receive long-term care. Savings to the government may also become a consideration. This could take place if governments cut back on paying for treatment and care and replace them with mercy killing. For example, immediately after the passage of Measure 16, Oregon's law permitting assisted suicide, Jean Thorne, the state's Medical Director, announced that physician-assisted suicide would be paid for as "comfort care" under the Oregon Health Plan which provides medical coverage for about 345,000 poor Oregonians. Within eighteen months of Measure 16's passage, the State of Oregon announced plans to cut back on health care coverage for poor state residents. In Canada, hospital stays are being shortened while, at the same time, funds have not been made available for home

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63 International Task Force on Euthanasia and Assisted Suicide, www.internationltaskforce.org/
care for the sick and elderly. Registered nurses are being replaced with less expensive practical nurses. Patients are forced to endure long waits for many types of needed surgery\textsuperscript{64}. The choice and acceptance of euthanasia raises the potential for a profoundly dangerous situation in which the choice of euthanasia is the only affordable option for some people. Arguments against euthanasia and the involvement of physicians in the practice have also been criticised. Here are some of the criticisms.

2.3.7 CRITIQUE OF THE ARGUMENTS AGAINST EUTHANASIA AND ITS PRACTICE BY A PHYSICIAN.

(i) CRITIQUE OF THE ARGUMENT FROM NATURE.
As has been argued by opponents of euthanasia, euthanasia or mercy killing and its practice by a physician is wrong and is against nature because human beings have a natural instinct to survive, to continue living. Thus, it is absurd and is a contradiction, killing ourselves or a physician killing or helping us to kill ourselves since all living things naturally preserve themselves. However, opponents of this view are of the opinion that there are many circumstances under which life ought to be sacrificed, especially a life which as they argue, with diminished quality. To live, they argue, is not a necessity; but to live honourably while life lasts is a necessity.

(ii) CRITIQUE OF RELIGIOUS ARGUMENTS.
According to religious tradition, euthanasia and the physician’s involvement in euthanasia violates the natural law that God (Allah) has created to govern the natural world and human existence. This natural law according to Pabst Battin can be conceived of in terms of (a) natural causal laws, such that suicide violates this causal order, (b) teleological laws, according to which all natural beings seek to preserve themselves, or (c) the laws governing human nature, from which it follows that euthanasia or suicide is ‘unnatural’.

These natural law arguments Battin further notes are no longer the main focus of philosophical discussion, as they have been subjected to strenuous criticism by Hume and

\textsuperscript{64} Arguments Against Euthanasia, www.euthanasia.com/argumentsagainsteuthanasia.html
others. These criticisms include that the natural law arguments cannot be disentangled from a highly speculative theistic metaphysics; that these claims are not confirmed by observations of human nature (e.g., the existence of self-destructive human behaviors casts doubt on the claim that we naturally preserve ourselves); and that other acts (e.g., religious martyrdom) which God is assumed not to condemn, also violate these natural laws, making the prohibition on euthanasia or suicide appear arbitrary. The second general category of religious arguments rest on analogies concerning the relationship between God and humanity. For the most part, these arguments aim to establish that God, and not human individuals, have the proper moral authority to determine the circumstances of their deaths. In line with this, Aquinas and Locke suggest and maintain that we are God’s property and so suicide is a wrong to God akin to theft or destruction of property. As captured in Stanford Encyclopedia of philosophy, this analogy seems weak on several fronts: First, if we are God's property, we are an odd sort of property, in that God apparently bestowed upon us free will that permits acting in ways that are inconsistent with God's wishes or intentions. Second, the argument appears to rest on the assumption that God does not wish his property destroyed. Yet given the traditional theistic conception of God as not lacking in any way, how could the destruction of something God owns (a human life) be a harm to God or to his interests? Third, it is difficult to reconcile this argument with the claim that God is all-loving. If a person's life is sufficiently bad, an all-loving God might permit his property to be ended. However, some have questioned the extent of the duties imposed by God's property right in us by arguing that the destruction of property might be morally justified in order to prevent significant harm to oneself. Thus:

If the only available means to saving myself from a ticking bomb is to stash it in the trunk of the nearest car to dampen the blast, and the nearest car belongs to my neighbor, then destroying his property appears justified in order to avoid serious harm to myself. Likewise, if only by killing can I avoid a serious future harm to myself, I appear justified in destroying God’s property (my life).

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Thus, a physician who ends the life of a patient through euthanasia to avert a continued pain and suffering of that patient therefore has performed a morally justified act. Also, religious arguments assert that God (Allah) bestows life upon us as a gift, and it would be a mark of ingratitude or neglect to reject that gift by taking our lives. The obvious weakness with this gift argument is that a gift, genuinely given, does not come with conditions such as that suggested by the argument, i.e., once given, a gift becomes the property of its recipient and its giver no longer has any claim on what the recipient does with this gift. It may perhaps be imprudent to waste an especially valuable gift, but it does not appear to be unjust to a gift giver to do so. As Kluge puts it, a gift we cannot reject is not a gift.67

(iii) CRITIQUE OF THE PHYSICIANS RESPECT FOR THE PATIENTS SELF-INTEREST ARGUMENT.

Opponents of euthanasia worry that a moral requirement to euthanasia either by oneself or through the help of a physician raises the sinister and totalitarian prospect that individuals may be obliged to commit suicide against their wishes, hence, a physician who practices euthanasia on a patient, carries out a duty which is in contrast to the patient’s self-interest. This worry may reflect an implicit acceptance of a variation of the sanctity of life view or may reflect concerns about infringements upon individual's autonomy and self determination. However, utilitarians as Dick Marty observes have given particular attention to the question of end-of-life euthanasia, suggesting that at the very least, those with painful terminal illnesses have a right to even voluntary euthanasia. Marty states that, utilitarian views hold that we have a moral duty to maximize happiness, from which it follows that when an act of suicide or euthanasia will produce more happiness than will remaining alive, then that suicide or euthanasia, is not only morally permitted, but morally required68. By implication therefore a patient ending his/her life or bringing about an end to life through a physicians intervention as an alternative to any unbearable suffering, or in a situation where such an act will produce a reverse of hopeless state, it is arguably seen as a better reflection of a patient’s, or of anyone’s self-interest, and is morally acceptable.

(iv) CRITIQUE OF THE ARGUMENT FROM PRACTICAL EFFECTS.

It is often said that if society allows the practice of euthanasia, we will have set foot on a

68 www.assembly.coe.int/Documents/WorkingDocs/Doc03/EDOC9898.htm
slippery slope that will lead us inevitably to support other forms of euthanasia, especially non-voluntary euthanasia. Proponents of euthanasia have refuted the argument from practical effect and subsequently the slippery slope resultant effect of the practice of euthanasia in a variety of ways. As Garn LeBaron captures it, they contend that the current mechanisms used by the courts could easily prevent any slide toward involuntary euthanasia against the fear of opponents of euthanasia, that the current practice of passive euthanasia proves that the slope isn't all that slippery since we haven't witnessed any massive killing programs, and that the example of how forced sterilization in the U.S. has diminished rather than increased, provides a more appropriate example to rely on. Callahan, a vocal opponent of active euthanasia in the USA, he notes, admits that, lives are not being shortened. They are steadily being lengthened, and particularly for those who are the most powerless: sick children and the very old, the mentally and mentally retarded, the disabled and the demented. Newman also attacks the concept of the slippery slope itself, arguing that just pointing out that one type of action could conceivably lead to another constitutes a very unpersuasive argument and that for the premise to hold true, it must be shown that pressure to allow further steps will be so strong that these steps will actually occur.

Furthermore, 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 euthanasia, especially voluntary euthanasia is unnecessary. However, there are several flaws in this counter-argument according to Stanford Encyclopedia of Philosophy. 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 it maintains, 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

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70 Ibid.
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.

The prohibition of killing is an attempt to promote a solid basis for trust in the role of caring for patients and protecting them from harm. This prohibition is both instrumentally and symbolically important, and its removal would weaken a set of practices and restraints that we cannot easily replace. Thus, opponents of euthanasia maintain that physicians practicing euthanasia will reduce the public's trust in doctors and in the health care system. According to Garn LeBaron, Michael Levy warns of the erosion of trust that the health care delivery system will do everything possible to relieve suffering prior to terminating life. Also, Dr. Alan Stone he further states, claims that 'it is destructive to the public good to make people worry that when they go to a hospital the doctor is thinking about whether to allow them to live or die. However, Newman goes on to present some convincing arguments against this position, stating that the public already views the medical profession with distrust and that this distrust is likely to grow since doctors frequently have poor communication skills, and spend little time with individual patients. As over reliance on technology increases and as hospitals and nursing homes continue to increase already exorbitant fees, this distrust is likely to increase. Newman even contends that a caring program of active euthanasia and physician assisted suicide might actually serve to increase public trust in the medical profession and serve to reduce some of the impression that doctors and health care institutions only care about the bottom line.

CRITIQUE OF THE ARGUMENT OF THE VALUE AND SANCTITY OF LIFE.

As the sanctity of life proponents argue, lives have sanctity regardless of the degree or kind of suffering, deterioration, dependency, or development they manifest, and regardless of the imminence of death, the burden on others, and the wishes of the subject to live or die.

Therefore, the sanctity of life position as Peter Suber notes is opposed to any position that allows the value of a life to vary with its condition or circumstances. The assertion he maintains is meant to be distinguished from the view that the value of a life may depend on its quality, condition, or circumstances. To the sanctity of life proponents, lives have sanctity regardless of the degree or kind of suffering, deterioration, dependency, or development they manifest, and regardless of the imminence of death, the burden on others, and the wishes of the subject to live or die. The sanctity position values life independently of its quality or condition. It invests with ultimate value just life ‘qua’ vital signs or life ‘qua’ bio-electrical activity, and nothing more grandiose, because this is the only life left when quality and condition are disregarded. Several objections arise from this essential core of the position.

Against the sanctity of life position, Suber therefore raises two basic objections. First, the sanctity position as described is not capable of making distinctions of value among lives. From one angle this is the “raison d'être” of the position: it is designed to value the very young and very old, the immature and the degenerating, the retarded and the competent, and wealthy and the indigent, all equally and all ultimately. What is often overlooked, however, is that the premise that justifies this uniform valuation also justifies, even requires, that we value plants, non-human animals, and human beings all equally and all ultimately. Because plants and animals share life ‘qua’ life, life ‘qua’ bio-electricity, sanctity must therefore be ascribed to lives regardless of their zoological or botanical species. If life ‘qua’ life independent of its quality is the locus of value, then we must value not just foetuses, but frogs and fungus, as much as we value mature and healthy human beings. Secondly, if life is the ultimate value, then we must promote it before all lesser values. This requires not only that we preserve the lives in being, and prolong them as much as possible, but also that we make more lives. If making life is within our power (if we are fertile), then all other uses of our time, energy, and resources would be pre-empted by a duty to bring about more life. Again, the sanctity of life position cannot help us choose among lives when scarce resources make it necessary to do so. Its equality condition paralyzes choice; all the contenders must be valued.

Suber, P., in: www.earlham.edu/~peters/writing/sanctity.htm

43
equally, even when some are otherwise fit and happy and others are unborn, vegetative, suicidal, or brain-dead.

(vi) CRITIQUE OF THE ARGUMENT OF EUTHANASIA AS A MEANS HEALTH CARE CONTAINMENT.

It is argued by opponents of euthanasia that the ever increasing costs of health care, especially for the terminally ill and those on life support systems, might also serve to influence some toward a decision for an early death. Thus, the growing incentives for physicians, hospitals, families, and insurance companies to control the cost of health care will bring additional pressures to bear on patients. However, these views have been criticised by proponents of euthanasia who contend that carefully drawn laws and the use of balancing tests already in place can effectively eliminate such concerns.

More so, providing palliative care by physicians is absolutely essential in attempting to ease the pain of the terminally ill and the dying alternatively to eliminating the patient in a bid to save cost, unfortunately some patients find it inadequate as opponents of this view point out. Palliative care they maintain, cannot in all circumstances take away unbearable pain and suffering. In any case the issue goes beyond the alleviation of pain: the degree of patients’ suffering, including mental anguish and loss of dignity, is something that only they can assess. Therefore, individuals suffering in the same situation may take different end-of-life decisions, but each human being’s choice is deserving of respect. Depression should not come into it, to the extent that the doctor treating the patient has got to know the case, and the request for euthanasia has been persistently expressed. Euthanasia on this ground is thus a justified act by a physician.
CHAPTER THREE.

3.0 EXAMINING THE PHYSICIAN’S ROLE IN EUTHANASIA.

The record of human activity, including the archaeologic, shows beyond much doubt that the role of the healer of disease and injury is a necessary one even in the most primitive societies. It is a role as Carleton Chapman notes, that must be played, and the player is usually an individual who possesses, or is thought to possess, appropriate talents and qualification. Hence, ethical standards require the best performance the individual can by virtue of training and natural endowment, deliver. Thomas Gisborne as Chapman captures it discusses rules of etiquette and of gracious doctor-to-doctor conduct, truth-telling in the clinical setting and other matters. Setting out his main theme, he says:

Diligent and early attention … and an honest exertion of his best abilities are the primary duties which the physician owes to his patient. The performance of them is virtually promised, for he knows that it is universally expected when he undertakes the case of the sick man; and consequently, if he neglects to fulfil them, he is guilty of a direct breach of his agreement.\(^74\)

The physician is therefore always expected to give the best of his/her attention to patients. Also, John Gregory describes the profession as a liberal one, whose object is the life and health of the human species to be exercised by gentlemen of honour and ingenious manners\(^75\). In his first Medical Ethics article, Percival Thomas observes that:

Physicians should study, also, in their department so to unite tenderness with steadiness and condescension with authority, as to inspire the minds of their patients with gratitude, respect and confidence\(^76\)

Judged in this context therefore, this is a well-intentioned rule of etiquette and practical consel to the physician at the bedside, and strongly reflects the tradition of authority of the

\(^{74}\) Chapman, C.B., 1984, p.81.
\(^{75}\) Ibid, p.83.
\(^{76}\) Ibid, p.84.
medical profession rather than primary concern for the patient’s interests. Physicians in their duties are thus, to treat their patients with diligence and to do all in their power to cure them. Adopted by the 2nd World Medical Assembly (WMA) General Assembly, Geneva, Switzerland, September 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th WMA General Assembly, Stockholm, Sweden, September 1994, a physician at the time of being admitted as a member of the medical profession takes this oath:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity; …

THE HEALTH OF MY PATIENT will be my first consideration; …

I WILL MAINTAIN the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity; …

I MAKE THESE PROMISES solemnly, freely and upon my honour77.

Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949, amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968, and the 35th World Medical Assembly, Venice, Italy, October 1983, it is stated that in general: … A physician shall, in all types of medical practice, be dedicated to providing competent medical service in full technical and moral independence, with compassion and respect for human dignity … And in his duty to the sick, a physician shall always bear in mind the obligation of preserving human life78. These solemn and free oaths which physicians take, then calls for an absolute commitment of preserving life. It is understandable, though tragic, that some patients in extreme duress – such as those suffering from a terminal, painful, debilitating illness – may come to decide that death is preferable to life, however, permitting physicians to engage in euthanasia on this ground and the like is contrary to the oath which the physician takes, and would ultimately cause more harm than good. Euthanasia of which the practice is fundamentally incompatible with the physician’s role as healer, would therefore become difficult or impossible to control, and would pose serious societal risks. As the American Medical Association (AMA) remarks in a report issued in June 1994, the involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient’s life. AMA therefore stated that:

77 World Medical Association Declaration of Geneva, in: www.wma.net/e/policy/c8.htm
78 Ibid.
Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. This therefore reiterates the call for total commitment of the physician to the alleviation of pain and suffering of patient rather than a thought toward euthanasia as an alternative. For a better appreciation and examination of the physicians’ role in euthanasia, this work will now take a look at the practice of euthanasia in the Netherlands as a background case.

3.1 A BACKGROUND CASE IN EUTHANASIA – THE NETHERLANDS.

For more than 15 years, the Dutch government has permitted assisted suicide as well as euthanasia by lethal injection. On 10 April 2001, the Dutch parliament passed a new Act on euthanasia, the Termination of Life on request and Assisted Suicide (Review Procedures) Act, and on 1 April 2002 this came into effect. An aspect of the Act stipulates that doctors who comply with a request for euthanasia are now exempt from prosecution if they fulfil the statutory criteria of due care and report to the authorities. The Act lays down rules for assessing whether or not doctors have met the criteria. Under the rules established by The Royal Dutch Medical Association (KNMG) and the Dutch courts, euthanasia and physician assisted suicide is permitted when each of the following conditions is fulfilled:

- the patient’s decision must be freely made, well-considered and persistent;
- the patient’s suffering is unbearable with no prospect of improvement;
- the doctor has prior to the act consulted a colleague;
- the patient has to be at least 12 years old; patients between 12 and 16 years of age require consent of their parents.

The doctor must also report the cause of death to the municipal coronor in accordance with the relevant provisions of the Burial and Cremation Act. A regional review committee

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accesses whether a case of termination of life on request or assisted suicide complies with the due care criteria. Depending on its findings, the case will be closed or brought to the attention of the Public Prosecutor. Finally, the legislation offers an explicit recognition of the validity of a written declaration of will of the patient regarding euthanasia (a “euthanasia directive”). Such declarations can be used when a patient is in coma or otherwise unable to state whether he/she wants euthanasia or not. There are no official guidelines for ending the lives of those who are unable to make their own decision, such as in the case of a baby, but Groningen Academic Hospital as captured by CNN Health report, has conducted such procedures under its own, internal guidelines. Dr. Eduard Verhagen, clinical director of the hospital's paediatric clinic, says in an interview that the babies who had been euthanized were born with incurable conditions that were so serious, (we) felt that the most humane course would be to allow the child to die and even actively assist them with their death. Cases of such extreme suffering he remarks are rare. And in these cases, the diagnosis was extreme spina bifida. The disorder is marked by incomplete development of the brain, spinal cord and/or their protective coverings. Because the procedure was not legal, Verhagen said, the hospital preferred that cases be assessed by a committee of experts.

However, Carrie Gordon Earll re-echoing the views of Carlos Gomez in his article Dutch (Holland/Netherlands) Euthanasia: The Dutch Disaster of September 22, 2003, rightly points out that euthanasia advocates argue that strict guidelines will protect the dependent, disabled and elderly from family members or medical professionals who deem their lives are no longer worth living. These “right to die” supporters point to Holland, where physicians have practiced physician-assisted suicide and euthanasia for more than two decades. While euthanasia and assisted suicide remain illegal in Holland, doctors are free to engage in such practices without prosecution if they follow specific guidelines. Among others, these parameters require that the patient be competent, voluntarily repeating the request for death and experiencing unbearable suffering from an irreversible illness. However, he continues, (prior to the legalisation of euthanasia), two Dutch studies, conducted in 1990 and 1995 found that doctors in the Netherlands practiced euthanasia apart from these guidelines. As Richard Miniter rightly notes in his article “The Dutch Way of Death,” of the 130,000 Dutchmen who died in 1990, some 11,800 were killed or helped to die by their doctors.

80 CNN, in: www.cnn.com/2004/HEALTH/12/01/netherlands.mercykill/
81 Earll, C.G., in: www.family.org/cforum/fosi/bioethics/euthanasia/a0027997.cfm
according to a 1991 report by the attorney general of the High Council of the Netherlands. However, an estimated 5,981 people – an average of 16 per day – were killed by their doctors without their consent, according to the Dutch government report. And these numbers do not measure several other groups that are put to death involuntarily: disabled infants, terminally ill children and mental patients. Also Kenneth J. Simcic, M.D. in his article “Lessons from the Netherlands” writes that in a survey carried out in 1990, closer inspection of the statistics reveals that an additional 1,000 patients had their lives terminated without specifically requesting the termination. Also, 8,000 terminal patients were intentionally given lethal overdoses of pain medication. Fewer than half of the overdosed patients had requested euthanasia. Perhaps the most disturbing finding of the study was that more than 60 percent of the doctors surveyed admitted to falsifying the cause of death on death certificates after performing euthanasia. This implies that the study grossly underestimated the true incidence of doctor-assisted death in Holland. These studies prior to the legalisation of euthanasia substantiate the suspicion that granting physicians the legal liberty to intentionally bring about the death of a patient could result in people being killed who did not ask to die. The studies make a distinction between two forms of euthanasia: euthanasia – the intentional killing of a patient by the direct intervention of a physician at the patient’s explicit request, and ending life without the explicit request of the patient – the intentional killing of a patient by the direct intervention of a physician without the patient’s explicit request. An analysis of deaths in both categories reveals that 31 percent of cases in 1990, and 22.5 percent in 1995 involved patients who did not give their explicit consent to be killed.

Dutch physicians also extended the practice of euthanasia to include comatose patients, handicapped infants and healthy but depressed adults. A Dutch psychiatrist in 1991 gave a lethal dose of barbiturates to a severely depressed 50-year-old woman at her request. The woman had recently suffered a bitter divorce and the deaths of her two children, one from cancer, the other from suicide. The Dutch Supreme Court found the doctor guilty, but exempted him from any penalty. The court ruled that there was no distinction between physical and emotional suffering in euthanasia. A Dutch court in 1996, found a physician guilty of euthanizing a comatose patient at the request of the patient’s family. Although the

83 Simcic, K.J., in: www.leaderu.com/orgs/tul/ott-euthanasia.html#lessons
84 Earll, C.G., in: www.family.org/cforum/fosi/bioethics/euthanasia/a0028008.cfm
85 Simcic, K.J., in: www.leaderu.com/orgs/tul/ott-euthanasia.html#lessons
court determined the patient was not suffering and did not ask to die, the doctor was not punished. Also, in April 1995, Dutch physician Henk Prins was convicted of giving a lethal injection to Rianne Quirine Kunst, a baby born with a partly formed brain and spina bifida. The court refused to punish Prins. Likewise, though psychiatrist Boudewijn Chabot was found guilty in 1994 of prescribing a fatal dose of sleeping pills for Hilly Bosscher, who was suffering from depression, Chabot was not penalized.

In a British Medical Journal report of (2001; 322:509 (3 March) by Tony Sheldon Utrecht, a Dutch GP, found guilty of murdering a dying 84 year old patient, was not penalised for his action. The Amsterdam court that tried him as Sheldon reports, said that Dr Wilfred van Oijen had made an "error of judgment" but had acted "honourably and according to his conscience," showing compassion, in what he considered the interests of his patient. Van Oijen, who featured in the 1994 euthanasia television documentary, Death on Request (BMJ 1994; 309:1107), argued that he chose to let his patient die in the most ethical manner. The Royal Dutch Medical Association (KNMG) defended his action as having "complete integrity," claiming a "huge emotional gulf" between it and the offence of murder. Johan Legemaate, Professor of health law at Rotterdam's Erasmus University, commenting on the case, said that the court recognised that the doctor had crossed a border between what is an entirely acceptable medical practice of relieving pain and what is legally defined as murder. As Sheldon thus puts it, Johan Legemaate wrestled with that and finally decided that from a legal point of view this is murder, although entirely different from the normal criminal intention to kill. Furthermore, in the face of law, Wikipedia, the free encyclopaedia statistical report shows that, in the Netherlands in 2003, 1626 cases were reported of euthanasia in the sense of a physician causing death (1.2 % of all deaths). Usually the sedative sodium thiopental is intravenously administered to induce a coma, and after making sure the patient is in deep coma, typically after some minutes, a muscle relaxant is administered to stop the breathing and cause death. Holland's most recent development involves a 38-year-old Dutch nurse who gave a lethal injection at the request of a friend suffering from AIDS. Dutch law requires that a physician perform euthanasia, and the nurse was found guilty of violating this law. However, she was given only a two-month suspended sentence, and she is appealing the

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86 Earll, C.G., in: www.family.org/cforum/fosi/bioethics/euthanasia/a0028008.cfm
87 Sheldon, T.U., in: www.bmj.bmjjournals.com/cgi/content/full/322/7285/509/a
88 Euthanasia, www.encyclopedia-online.info/Euthanasia
89 Simcic, K.J., in: www.leaderu.com/orgs/tul/ott-euthanasia.html#lessons

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decision. With these rulings, the liberal Dutch courts have now nearly eliminated any formal legal restriction on any doctor (or nurse) killing any patient for any reason. In what he calls “the continuing collapse of medical ethics in the Netherlands,” Wesley J. Smith asserts:

FIRST, Dutch euthanasia advocates said that patient killing will be limited to the competent, terminally ill who ask for it. Then, when doctors began euthanizing patients who clearly were not terminally ill, sweat not, they soothed: medicalized killing will be limited to competent people with incurable illnesses or disabilities. Then, when doctors began killing patients who were depressed but not physically ill, not to worry, they told us: only competent depressed people whose desire to commit suicide is "rational" will have their deaths facilitated. Then, when doctors began killing incompetent people, such as those with Alzheimer's, it's all under control, they crooned: non-voluntary killing will be limited to patients who would have asked for it if they were competent.

This in effect reveals the gradual decline and neglect of the role of medical ethics by physicians in the Netherlands. Conrad W. Baars, well captures the reaction of some Dutch Physicians, as the “World Federation of Doctors Who Respect Human Life” write: ...We discontinued our membership in the Dutch Medical Society ... to express our conviction that the function of the physician is born of his own high moral and spiritual norms and ... should be free from political control … The Physician is the undisputed protector of two holy and precious values; the respect of life, and charity towards the sick human being. From time immemorial the vocation of the physician has been a vocation of confidence ... a priestly vocation. The physician ... realises the smallness of his knowledge in the face of the magnitude of the mystery of life, suffering and death ... We do not deny that social hygienic measures constitute part of the task of the physician; we can recognise the duty only insofar as it proceeds from and is not in conflict with the first and holiest precept of the physician ... the respect for life and for the physical well-being of the individual...

As the Dutch experience thus demonstrates prior to and even after legalisation, euthanasia does not remain limited to competent, terminally ill adults who choose to end their own lives.

90 Smith. W.J., in: www.weeklystandard.com/Content/Public/Articles/000/004/616jszlg.asp
Furthermore, guidelines have proven to be no protection for Holland’s disabled, depressed or elderly citizens. In a similar development from Brussels, Andrew Osborn in his October 9, 2002 article in “The Guardian” reports a bitter row that flared up over the first official case less than a month after mercy killing was legalised in Belgium with the country's professional medical organisation saying that despite the new legislation the patient was not legally entitled to die. Following this, the Belgian government thus launched an investigation into the case of Mario Verstraete, 39, who suffered from multiple sclerosis and who died by lethal injection on September 30, exactly a week after a law legalising euthanasia came into force. As Osborn reports, under the law, at least one month must elapse between a written request to die and the mercy killing itself, the idea being to give the patient a chance to change his or her mind. But Mr Verstraete was dead within seven days of the law taking force. The fact that he was not in the final stages of a terminal illness (although suffering considerably) has also angered sceptics.

It is worthy of note that involuntary euthanasia has become so prevalent that many Dutch citizens carry “Life Passports,” cards that state they do not want so-called “physician aid-in-dying” if they are hospitalized. Richard Miniter commenting on this notes that many old people now fear Dutch hospitals. More than 10% of senior citizens who responded to a recent survey, which did not mention euthanasia he says, volunteered that they feared being killed by their doctors without their consent.

As has been reiterated especially by opponents of euthanasia, physicians’ practice of this, is incompatible with their fundamental moral and professional commitment as healers who care for patients and who protect lives. Moreover, if euthanasia by physicians become common, patients would come to fear that a medication was intended not to treat or care, but instead to kill, and would thus loose trust in their physicians. This position was forcefully stated in a paper by Willard Gaylin et al. as Dan W. Brock captures it:

The very soul of medicine is on trial … This issue touches medicine at its moral center; if this moral center collapses, if physicians become killers

scerosis.org/news/Oct2002/PwMSEuthanasiaBelgium.html+Andrew+Osborn:+a+bitter+row+that+flared+up+o
ver+the+first+official+case+less+than+a+month+after+mercy+killing+was+legalised+in+Belgium+with+the+c
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or are even licensed to kill, the profession – and, therewith, each physician – will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty.  

This clearly points out the wide hiatus that the practice of euthanasia would create between physicians and patients, as is even evident in the Netherlands where many citizens are now afraid of being euthanized. While Willard et al. oppose permitting anyone to perform euthanasia, their special concern is with physicians doing so. This implies therefore that euthanasia undermines the trust of physicians by patients and the very ‘moral center’ of medicine, and suggests in essence that physicians should not be involved in the practice of course they voluntarily swore not to.

3.2 THE PHYSICIAN AND THE HIPPOCRATIC OATH.
Born in the island of Cos between 470 and 460 B.C., Hippocrates, the celebrated Greek physician, belonged to the family that claimed descent from the mythical AESculapius, son of Apollo. There was already a long medical tradition in Greece before his day, and this he is supposed to have inherited chiefly through his predecessor Herodotus. The works attributed to Hippocrates are the earliest extant Greek medical writings, and among these is the famous "Oath." This interesting document shows that in his time physicians were already organized into a corporation or guild, with regulations for the training of disciples, and with an esprit de corps and a professional ideal which, with slight exceptions, can hardly yet be regarded as out of date. One saying occurring in the words of Hippocrates has achieved universal currency, it is the first of his Aphorisms, that refers to the art of the physician, “Life is short, and the Art long; the occasion fleeting; experience fallacious, and judgment difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate.” Dramatically, medicine has changed from the classical era to the present in terms of the contents of both its theoretical and practical components. Nonetheless, the Hippocratic Oath continues to be the medical oath. The substance of the oath is concerned with the goals of medical discipline or art or with some broader ethical conceptions that perhaps are at the foundation of the goals the medical profession. The Hippocratic Oath quite explicitly enjoins against any act of euthanasia performed by a physician or even any act by a

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physician that consists of providing the means by which a person could terminate his own or another’s life. However, many current prevalent views on euthanasia may not be consistent with those embodied in the oath. As contained in the Harvard Classics of 1909-14, the Hippocratic Oath reads thus:

I SWEAR by Apollo the physician and Æsculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation—to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this Art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the Art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot.94

This is a solemn voluntary promise which physicians take not to be involved in bringing about an end to life either on request by one whose life it is, or as life deemed unfit for continued existence. Primarily in medical ethics, the Hippocratic Oath is not a set of laws

94 The oath and Law of Hippocrates, in: www.bartleby.com/38/1/1.html
enforced upon a physician by an authority but rather a guide which he accepts of his own free will. Far from being a legal document too, the Hippocratic Oath is a solemn promise given by the conscience of the physician who swears to it. In view of the Hippocratic tradition in medicine, Paul Ramsey remarks as Davis and Aroskar rightly note that no profession comes close to medicine in its concern to inculcate, transmit, and keep in constant repair its standards governing the conduct of its members. Hence, the strengths of the Hippocratic tradition, a vital center of responsible medicine today, emphasize the importance of covenant fidelity between physician and patient. Medicine as a social contract, functions on the basis of this covenant. Furthermore, Ramsey states that:

Justice, fairness, righteousness, faithfulness, canons of loyalty, the sanctity of life, hesed, agape or charity are some of the names given to the moral quality of attitudes and of actions owed by any individual who steps into a covenant with another.

In essence, a physician who solemnly and willingly takes the Hippocratic Oath should as a matter of having entered into a contract with the patient, faithfully keep to the oath.

Medicine’s ancient charge is “Above all, do no harm.” For centuries, physicians pledge to this oath. In modern times, Hippocratic principles were expressed in the 1948 World Medical Association Declaration of Geneva in reaction to the violation of the Hippocratic Oath by physicians and those medical personnel complicit in the crimes against humanity: I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity. In contrast, it is widely argued by proponents that euthanasia is perfectly compatible with the aims of medicine. However, a physician who participates in euthanasia already abuses medicine. As Beauchamp and Walters rightly pointed out, the great temptation of modern medicine, not always resisted, is to move beyond the promotion and preservation of health into the boundless realm of general human happiness and well-being. The root problem of illness and mortality the duo note is both medical and philosophical or religious. “Why must I die?” can

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96 Ibid.
97 www.wma.net/e/policy/c8.htm
be asked as a technical, biological question or as a question about the meaning of life. When medicine tries to respond to the later, which it is always under pressure to do, it moves beyond its proper role. Thus they assert:

It is not medicine’s place to lift from us the burden of that suffering which turns on the meaning we assign to the decay of the body and its eventual death. It is not medicine’s place to determine when lives are not worth living or when the burden of life is too great to be borne. Doctors have no conceivable way of evaluating such claims on the part of patients, and they should have no right to act in response to them⁹⁸.

This arguably clearly implies that physicians should not partake in the practice of euthanasia. Beauchamp and Walters therefore maintain that medicine’s aim is to relief those suffering brought on by illness and dying as biological phenomena, not that suffering which comes from anguish or despair at the human condition. A physician’s utmost priority and duty therefore is to ensure at to the best of his/her ability, the relief of pain and suffering of the patient since he is obliged not to inflict harm intentionally but to benefit the patient.

3.3 THE PRINCIPLES OF NONMALEFICENCE, BENEFICENCE, AND THE STANDARD OF DUE CARE.

The principle of nonmaleficence asserts an obligation not to inflict harm intentionally. This principle, has been closely associated in medical ethics with the maxim ‘primum non nocere,’ which is often translated as “Above all [or first] do no harm.” This maxim is frequently invoked by physicians. An obligation of the principles of nonmaleficence and its corollary, the principle of beneficence, are both expressed in the Hippocratic Oath: “I will use treatment to help the sick according to my ability and judgement, but I will never use it to injure or wrong them.” However, as Tom Beauchamp and James Childress rightly note, conceptually, the two principles are distinguished as follows

Nonmaleficence
1. One ought not to inflict evil or harm.

Beneficence

2. One ought to prevent evil or harm.
3. One ought to remove evil or harm.
4. One ought to do or promote good.

Each of these three forms of beneficence they maintain, require taking action by helping in preventing harm and promoting good – whereas nonmaleficence only requires intentionally refraining from actions that cause harm. Rules of nonmaleficence they assert, therefore take the form “Do not do X.” The moral principle of nonmaleficence espouses the belief of not inflicting harm on any person. The Hippocratic Oath, which is the source of this principle, states, that into whatsoever house the physician shall enter, it shall be for the good of the sick to the utmost of the physician’s power. That the physician will exercise his or her art solely for the cure of patients. The principle of nonmaleficence is also based on a portion of the Epidemics which states: Declare the past, diagnose the present, foretell the future, practice these acts. As to diseases, make a habit of two things--to help or at least to do no harm. The principle of nonmaleficence requires of physicians not to intentionally create a needless harm or injury to the patient, either through acts of commission or omission. However, as David San Filippo remarks, euthanasia can be morally supported by the principle of nonmaleficence. The moral principle of nonmaleficence espouses the belief of not inflicting harm on any person. He therefore maintains that if however a person is suffering, is terminally ill, and or the quality of life is poor, then the use of euthanasia could be considered acceptable. The act of euthanasia he states ends the harm of intractable situation. Hence, physicians should be free to practice euthanasia if requested by their patient. Assisting a chronically suffering person to die should not be seen as a breach of the Hippocratic Oath, rather, by practicing euthanasia a physician does “good of the sick”. The physician is relieving the person of the intractable pain and suffering of life, and thus seen, euthanasia is not inflicting harm but an act of nonmaleficence towards the human being. It is an act of love.

In practice, it is nevertheless considered negligence if a physician imposes an unreasonable risk of harm upon a patient. Providing a proper standard of care that avoids or minimizes the risk of harm is supported not only by medical commonly held moral convictions, but by the laws of society as well. In their professional model of care, a physician may be morally and

99 www.fincher.org/History/RandomThoughts.shtml
legally blameworthy if he or she fails to meet the standards of due care. The following as Beauchamp and Childress note, are essential elements in a professional model of due care:

1. The professional must have a duty to the affected party.
2. The professional must breach that duty.
3. The affected party must experience harm.
4. The harm must be caused by the breach of duty.\(^\text{101}\)

This principle affirms the need for medical competence. It is clear that medical mistakes occur, however, this principle articulates a fundamental commitment on the part of health care professionals to protect their patients from harm. This therefore brings the principle of nonmaleficence in conflict with the practice of euthanasia by physicians. However, legal and moral standards of due care include proper training, skills, and diligence. Physicians accept the responsibility to observe these standards in rendering health care services. Hence, a fall below these standards in their conduct renders their act negligent. As Beauchamp and Childress observe, malpractice occurs if and only if professional standards of due care are not met. Giving an instance as the duo rightly note, the Supreme Court of Indiana in Adkins v. Ropp, considered a patient’s claim that a physician had been negligent in removing foreign matter from the patients eye and that, as a result the eye became infected and blinded. The court therefore held as follows:

When a physician and surgeon assumes to treat and care for a patient, in the absence of a special agreement, he is held in law to have impliedly contracted that he possesses the reasonable and ordinary qualifications of his profession and that he will exercise at least reasonable skill, care and diligence in his treatment of him. This implied contract on the part of the physician does not include a promise to effect a cure and negligence cannot be imputed because a cure is not effected, but he does impliedly promise that he will use due diligence and ordinary skill in his treatment of the patient so that a cure may follow such care and skill, and this degree of care and skill is required of him, not only in performing an operation or administering first treatments, but he is held to the like degree of care and skill in the necessary subsequent treatments …\(^\text{102}\).

\(^{102}\) Ibid.
Thus, a physician’s call demands the full employment of his/her skill in healing and helping the sick to be healed. Furthermore, physicians are required morally, not only to treat others autonomously and refrain from harming them, but also that they contribute to their welfare. Such beneficial actions fall under the heading of beneficence. The term beneficence in ordinary English term connotes acts of mercy, kindness, and charity. Altruism, love, and humanity are also sometimes considered forms of beneficence. Thus, beneficent action broadly understood, includes all forms of action intended to benefit other persons. This therefore refers to an action done for the benefit of others; benevolence refers to the character trait or virtue of being disposed to act for the benefit of others; and the principle of beneficence refers to a moral obligation to act for the benefit of others. The ordinary meaning of this principle is the duty of physicians and other health care providers to be beneficial to their patient, as well as to take positive steps to prevent and to remove harm from their patients. However, as have been argued by proponents of euthanasia, where there is no other means of reducing suffering, euthanasia may be justified as the only remaining benevolent option. The imperative to act benevolently is considered to be one of the most important ethical principles, along with nonmalevolence, governing medical practice. Appeals to the principle of beneficence are reinforced by utilitarianism. Utilitarians such as Peter Singer, John Harris, James Rachels and Jonathan Glover as captured by the Encyclopedia of Applied ethics, have asserted that the goodness of any action – even that of causing death – must be assessed solely in terms of the consequences that flow from it. Killing a patient may conflict with a previously held taboo, but it is not wrong if it prevents suffering and achieves a desirable end. a peaceful death. Nevertheless, beneficence requires a physician to act in ways that best promote the welfare of his patients. These duties are viewed as self-evident and are widely accepted as the proper goals of medicine. These goals are applied both to individual patients, and to the good of society as a whole. For example, the good health of a particular patient is an appropriate goal of medicine, and the prevention of disease through research and the employment of vaccines is the same goal expanded to the population at large. Thus, the principle of beneficence asserts the duty to help others.

105 Ibid.
The most famous example of beneficence is found in the New Testament parable of the Good Samaritan. In this parable, a man travelling from Jerusalem to Jericho was beaten by robbers, leaving him “half-dead.” After two other travellers passed by the injured man without rendering help, a Samaritan who saw him “had compassion and went to him and bound up his wounds, … took him to an inn, and took care of him.” In having compassion and showing mercy, the Good Samaritan therefore expressed an attitude of caring for the injured man and also took care of him. Both his motives and his actions were beneficent as Beauchamp and Childress remark. However, the parable they pointed out, suggests that positive beneficence is more an ideal than an obligation, because the Samaritan’s act seems to exceed ordinary morality. Moreover, suppose the injured man, when encountered by the Samaritan, had pulled out an advanced directive indicating that he wanted to die if wounded on the dangerous road from Jerusalem to Jericho. Then the Samaritan would have faced a dilemma: to respect the injured man’s wishes or to take care of him against his wishes. Our beneficence, then, notes Beauchamp and Childress, is sometimes an admirable ideal of action that exceeds obligations, and at other times it is appropriately limited by other moral obligations. Hence, one may well then question whether we are obliged to act beneficently. According to Beauchamp and Childress, acts of beneficence play a vital role in the moral life quite apart from a principle of obligatory beneficence. Undeniably, many beneficent acts, such as the donation of kidney to a stranger, are morally praiseworthy and not obligatory. Similarly, virtually everyone agrees that the common morality does not contain a principle of beneficence that requires severe sacrifice and extreme altruism in the moral life, for example, giving both of one’s kidneys for transplantation. Only ideals of beneficence incorporate such extreme generosity. Nonetheless, several rules of obligatory beneficence the duo note, form an important part of morality. Because of the range of types of benefit, the principle of positive beneficence supports an array of more specific moral rules. Examples of such rules of beneficence are:

1. Protect and defend the rights of others.
2. Prevent harm from occurring to others.
3. Remove conditions that will cause harm to others.
5. Rescue persons in danger.\textsuperscript{106}

\textsuperscript{106}Beauchamp, T.L., Childress, J.F., 1994, p.262.
In the medical context, failure by physicians to benefit patients violates the professional relationship that is institutionally established between the physicians and the patients. Euthanasia in the light of the principle of nonmaleficence and beneficence, and judged with the standard of due care, is in contrast with the profession of physicians and the chief aim of medicine.

3.4 OPINION OF PHYSICIANS/SURGEONS ON EUTHANASIA AND OF ITS PRACTICE BY A PHYSICIAN.

The issue of euthanasia, and subsequently its practice by a physician has led to varying views either in support or in rejection by physicians/surgeons. In his opinion regarding this, C. Everett Koop, the former Surgeon General of the United States says: "... we must be wary of those who are too willing to end the lives of the elderly and the ill. If we ever decide that a poor quality of life justifies ending that life, we have taken a step down a slippery slope that places all of us in danger. There is a difference between allowing nature to take its course and actively assisting death. The call for euthanasia surfaces in our society periodically, as it is doing now under the guise of "death with dignity" or assisted suicide. Euthanasia is a concept, it seems to me, that is in direct conflict with a religious and ethical tradition in which the human race is presented with “a blessing and a curse, life and death," and we are instructed '...therefore, to choose life." I believe 'euthanasia' lies outside the commonly held life-centered values of the West and cannot be allowed without incurring great social and personal tragedy. This is not merely an intellectual conundrum. This issue involves actual human beings at risk…"107 Continuing, Koop maintains that for two millennia the Hippocratic tradition has stood for the 'sanctity' of human life. He then points out that physicians can alleviate the unbearable pain in life better than ever before. He asserts: We can do that and not eliminate life itself. As I have said many times, medicine cannot be both our healer and our killer108. In the same vein, Dr Peter Ravenscroft, a Medical Professor in Palliative Care at a hospital in New South Wales, Australia is against euthanasia. In 1996 the government of Australia's Northern Territory passed a law allowing voluntary euthanasia. Peter Ravenscroft suggests that this law was passed because very little care is available for terminally ill patients in the Northern Territory. Dr Ravenscroft believes that euthanasia is

107 Koop, C.E., in: www.euthanasia.com/koop.html
108 Ibid.
wrong. He believes that when people have an incurable illness, they should be given palliative care. That means care that lessens their pain and suffering, and helps them to feel less afraid. He says that: palliative care tries to improve the quality of a person's life, even the very last part of their life, without bringing death … I value sitting with dying patients or holding their hands. It reminds me that life is a great mystery and we all share the characteristics of being human. We take part in all of life, including dying, but we are not masters of it.

However, for some physicians, euthanasia is acceptable in certain circumstances. They argue that if a person who wishes to die expresses the desire for euthanasia, it must be considered whether or not his desire is "authentic", i.e. whether he genuinely wants to die, or whether this wish could be fulfilled in some other way. Here, too, various points of view have been put forward. It is often pointed out that dying persons experience various stages of the dying process which can be accompanied by major mood swings. If a dying person requests euthanasia in such a situation, that may not be the expression of a genuine wish to die but rather a "natural" and transient accompanying phenomenon of the dying process. Opponents of these theories state that although personal comfort and pain-relief treatment and, in the case of mentally ill patients, psychotherapy, can often lead to a reversal of the wish to die, there are also patients whose severe physical and/or psychological suffering cannot be relieved by such measures. That, they argue, is the reason why - if only in exceptional cases - there may in fact be no alternative to euthanasia.

Thus, some physicians in their views have expressed acceptance of euthanasia in certain circumstances. In a statement to a group of Dutch Senators, a physician J.J.M Van Delden as Cheryl Eckstein captures it says: No physician, in my opinion, performs euthanasia with the sole intent to kill his patient. His intention can always be described as trying to relieve the suffering of his or her patient. Notable as one of the most outspoken proponents of euthanasia, Peter Singer, argues from a utilitarian philosophical point of view. Consistent with his general ethical theory, Singer holds that the right to physical integrity is grounded in a being's ability to suffer, and the right to life is grounded in the ability to plan and anticipate one's future. Since the unborn, infants and severely disabled people lack the latter (but not the

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109 Ravenscroft, P., in: www2.gol.com/users/bobkeim/right_to_die/againstmd.html
former) ability, he states that abortion, painless infanticide and euthanasia can be justified in certain special circumstances, for instance in the case of severely disabled infants whose life would cause suffering both to themselves and to their parents\textsuperscript{111}. This justification then carries along with it the justification by any physician performing the euthanasia. Also, Joseph Fletcher, the founder of "situational ethics," in his 1973 discussion of death with dignity gives this argument for euthanasia: It is ridiculous to give ethical approval to the positive ending of sub-human life in utero as we do in therapeutic abortions for reasons of mercy and compassion but refuse to approve of positively ending a sub-human life in extremis. If we are morally obliged to put an end to a pregnancy when an amniocentesis reveals a terrible defective fetus, we are equally obliged to put an end to a patient's hopeless misery when a brain scan reveals that a patient with cancer has advanced brain metastases\textsuperscript{112}.

3.5 WORLD MEDICAL ASSOCIATION ON EUTHANASIA.

1). The World Medical Association's Declaration on Euthanasia, adopted by the 38th World Medical Assembly, Madrid, Spain, October 1987, states:
"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness."

2). The WMA Statement on Physician-Assisted Suicide, adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 likewise states:
"Physicians-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient."

3). The World Medical Association has noted that the practice of active euthanasia with

\textsuperscript{111} Singer, P., 1993.
\textsuperscript{112} The Slippery Slope, in: www.jeremiahproject.com/culture/life3.html
physician assistance, has been adopted into law in some countries.

4). BE IT RESOLVED that:

1). The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and

2). The World Medical Association strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions\textsuperscript{113}.

In the same vein, the American Medical Association (AMA) has long opposed the issue of euthanasia and of a physician’s involvement. Its formal policy maintains that euthanasia or physician assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. In November 2001, the AMA endorsed Attorney General John Ashcroft’s ruling that euthanasia and assisting suicide are not “legitimate medical practices,” with the consequence that under federal law federally controlled narcotics and other dangerous drugs may not be used to assist suicide. Physicians have a fundamental obligation to ‘do no harm,’ and the AMA has consistently held that euthanasia and physician-assisted suicide falls outside the realm of legitimate medical practice, Dr. Yank Coble, then AMA President-Elect, said: We see nothing in this decision to concern physicians committed to aggressive pain treatment at the end of life\textsuperscript{114}. The American Medical Association House of Delegates, at its June 2003 annual meeting in Chicago, failed to adopt a resolution proposed by the Wisconsin Medical Association that would have effectively reversed its longstanding position that assisting suicide is not a legitimate medical practice. Instead, the committee to which the resolution was referred offered a substitute resolution focusing on protecting physicians who appropriately prescribe pain management, without any mention of policy on assisting suicide – and the House of Delegates adopted the substitute resolution. The AMA is keenly aware that doctors perform a crucial act of healing and saving life. Accepting a dual role of taking life, while at the same time protecting life, would undermine their credibility and the sacred trust that exists between a patient and doctor.

\textsuperscript{113} The World Medical Association Resolution on Euthanasia, www.wma.net/e/policy/e13b.htm

\textsuperscript{114} Coble, Y., in: www.nrlc.org/euthanasia/AMARetainsOppAS.doc
3.6 LEGAL VIEW OF EUTHANASIA.

Euthanasia has been accepted both legally and morally in various forms by various groups or various societies in history. In ancient Greece and Rome, helping others to die or putting them to death was considered permissible in some situations. For example, the Greek writer Plutarch mentioned that in Sparta infanticide was practised on children who lacked health and vigour. Both Socrates and Plato sanctioned forms of euthanasia in certain cases. Voluntary euthanasia for the elderly was an approved custom in several ancient societies. With the rise of organized religion, euthanasia became morally and ethically abhorrent. Christianity, Judaism, and Islam all hold human life sacred and condemn euthanasia in any form.

Following traditional religious principles, Western laws have generally considered the act of helping someone to die a form of punishable homicide (unlawful killing) subject to legal sanctions. Even a passive withholding of help to prevent death has frequently been severely punished. Euthanasia, however, is thought to occur secretly in all societies, including those in which it is held to be immoral and illegal. However, in modern times laws have become more secular, and many contemporary philosophers have argued that euthanasia is morally defensible. Official religious opposition, for example, the Roman Catholic Church, does, however, remain unchanged, and active euthanasia remains a crime in every nation other than the Netherlands and in Belgium. Those who wish to legalize euthanasia, like the Netherlands, have argued that, under principles of individual liberty, that individuals have a legal right to die as they choose. As laws have evolved from their traditional religious underpinnings, certain forms of euthanasia have been legally accepted. In general, laws attempt to draw a line between passive euthanasia (generally associated with allowing a person to die) and active euthanasia (generally associated with killing a person). While laws commonly permit passive euthanasia, active euthanasia is typically prohibited except in few countries for example the Netherlands as the first country to legalize euthanasia in 1 April 2002, and the parliament of Belgium taking the second lead to legalize active euthanasia in 23 September 2002 under limited conditions. Under the Dutch law, euthanasia is justified (not legally punishable) if the physician strictly follows the guidelines. Like the Dutch law, the Belgian law allows physicians to perform euthanasia only for patients who are suffering unbearably with no hope of improvement. The patient must make a voluntary, well-considered, and repeated request to die, and the request must be put in writing. Other physicians must be

115 http://uk.encarta.msn.com/encyclopedia_761562836/Euthanasia.html
consulted to confirm the patient’s condition. Additionally, each act of euthanasia must be reported to a government commission for review.\textsuperscript{116}

Laws in the United States and Canada maintain the distinction between passive and active euthanasia. While active euthanasia is prohibited, courts in both countries have ruled that physicians should not be legally punished if they withhold or withdraw a life-sustaining treatment at the request of a patient or the patient’s authorized representative.\textsuperscript{117} These decisions are based on increasing acceptance of the doctrine that patients possess a right to refuse treatment. Until the late 1970s, whether or not patients possessed a legal right of refusal was highly disputed. One factor that may have contributed to growing acceptance of this right is the ability to keep individuals alive for long periods of time—even when they are permanently unconscious or severely brain-damaged. Proponents of euthanasia believe that prolonging life through the use of modern technological advances, such as respirators and kidney machines, may cause unwarranted suffering to the patient and the family. As technology has advanced, the legal rights of the patient to forgo such technological intervention have expanded. For instance, states in the USA have adopted laws that authorize legally competent individuals to make advanced directives, often referred to as living wills. Such documents allow individuals to control some features of the time and manner of their deaths. In particular, these directives empower and instruct doctors to withhold life-support systems if the individuals become terminally ill. Furthermore, the federal Patient Self-Determination Act, which became effective in 1991, requires federally certified health-care facilities to notify competent adult patients of their right to accept or refuse medical treatment. The facilities must also inform such patients of their rights under the applicable state law to formulate an advanced directive. Patients in Canada have similar rights to refuse life-sustaining treatments and formulate advanced directives. However, only one U.S. state, Oregon, has enacted a law allowing physicians to actively assist patients who wish to end their lives. However, Oregon’s law concerns assisted suicide rather than active euthanasia. It authorizes physicians to prescribe lethal amounts of medication that patients then administer themselves.\textsuperscript{118} In response to modern medical technology, physicians and lawmakers are slowly developing new professional and legal definitions of death. Additionally, experts are

\begin{footnotesize}
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\item \textsuperscript{116} http://encarta.msn.com/encyclopedia_761562836_2/Euthanasia.html
\item \textsuperscript{117} http://encarta.msn.com/encyclopedia_761562836/Euthanasia.html#endads
\item \textsuperscript{118} Ibid.
\end{itemize}
\end{footnotesize}
formulating rules to implement these definitions in clinical situations—for example, when procuring organs for transplantation. The majority of states have accepted a definition of brain death—the point when certain parts of the brain cease to function—as the time when it is legal to turn off a patient’s life-support system, with permission from the family.

In 1995 the Northern Territory of Australia became the first jurisdiction to explicitly legalize voluntary active euthanasia. However, the federal parliament of Australia overturned the law in 1997. In 2001 The Netherlands became the first country to legalize active euthanasia and assisted suicide, formalizing medical practices that the government had tolerated for years. Officials estimate that about 2 percent of all deaths in The Netherlands each year occur as a result of euthanasia.

Although euthanasia is not a contentious issue in Africa, there are however strong positions against the destruction or termination of life. In The African Chatter on Human and Peoples’ Rights signed by African Leaders in 1963 which came into full force in 1986, its article 4 stipulates that, human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right. Also article 20 (1) of the same document states that, All peoples shall have right to existence. They shall have the unquestionable and inalienable right to self-determination. They shall freely determine their political status and shall pursue their economic and social development according to the policy they have freely chosen.

The issue of euthanasia however, raises ethical questions for physicians and other health-care providers. The ethical code of physicians has long been based in part on the Hippocratic Oath, which requires physicians to do no harm. However, medical ethics are refined over time as definitions of harm change. Prior to the 1970s, the right of patients to refuse life-sustaining treatment (passive euthanasia) was controversial. As a result of various court cases, this right is nearly universally acknowledged today, even among conservative bioethicists. The controversy over active euthanasia remains intense, in part because of opposition from religious groups and many members of the legal and medical professions. Opponents of

119 http://encarta.msn.com/text_761562836__1/Euthanasia.html
120 http://www.diplomacy.edu/AfricanCharter/acharter_intro.asp
121 Ibid.
voluntary active euthanasia emphasize that physicians and other health-care providers have professional obligations that prohibit killing. These opponents maintain that active euthanasia is inconsistent with the roles of nursing, care-giving, and healing of which the physician assumes. Opponents also argue that permitting physicians to engage in active euthanasia creates intolerable risks of abuse and misuse of the power over life and death. Supporters of voluntary active euthanasia however, maintain that, in certain cases, relief from suffering (rather than preserving life) should be the primary objective of physicians. They argue that society is obligated to acknowledge the rights of patients and to respect the decisions of those who elect euthanasia. Supporters of active euthanasia contend that if society acknowledges a patient’s right to passive euthanasia (for example, by legally recognizing refusal of life-sustaining treatment), active euthanasia and subsequently its practice by a physician should similarly be permitted. When arguing on behalf of legalizing active euthanasia, proponents emphasize circumstances in which a condition has become overwhelmingly burdensome for a patient, pain management for the patient is inadequate, and only a physician seems capable of bringing relief. They also point out that almost any individual freedom involves some risk of abuse and argue that such risks can be kept to a minimum by using proper legal safeguards.

3.7 RELIGIOUS VIEW OF EUTHANASIA.
Other than promoting abuse and giving doctors the right to murder, Euthanasia also contradicts religious beliefs and is considered to be gravely sinful. For instance, in the Roman Catholic Church’s opinion on Euthanasia as contained in the Vatican's 1980 Declaration on Euthanasia, no one can make an attempt on the life of an innocent person without opposing God's love for that person, without violating a fundamental right, and therefore without committing a crime of the utmost sin. It also says that intentionally causing one's own death, or suicide is therefore equally wrong as murder, such an action on the part of a person is to be considered as a rejection of God's sovereignty and loving plan. Karl Barth as Göran Collste rightly captures, dissociates himself from all kinds of euthanasia. Against involuntary euthanasia, Barth condemns all the killing of persons whose lives by some authorities are considered to be a burden and maintains that God knows the value of such a person’s life.
Thus, he regards this kind of killing as being the same as murder and an act in disobedience of God’s command\textsuperscript{122}. Arguing against voluntary active euthanasia which is the active killing of an ill or dying person in accordance with his or her will, Barth says:

This kind of active euthanasia can very well be performed from good intentions and sympathy, but it cannot be defended from a christian point of view … against … passive euthanasia … it is from a Christian point of view not even permitted to refrain from using life-sustaining methods such as a respirator. When a physician takes a decision not to use this kind of life-support, he or she intentionally lets a patient die and takes a decision which he/she should leave to God\textsuperscript{123}.

However, foreseeing a development in medicine when it will be possible to keep severely ill and dying patients alive for a long period of time, Barth rightly notes therefore that in such cases, the doctor may hesitate to prolong the dying, hence, he asserts as Collste captures and translates:

\begin{quote}
Nicht um ein willkürliche ‘Euthanasia’ würde es sich dann handeln, sondern um denjenigen Respekt, den auch das sterbende Leben als solches in Anspruch nehmenden darf. /Then it would not be a question of conditional euthanasia, but of a respect that also the dying life as such can count on\textsuperscript{124}.
\end{quote}

However, a Jewish Rabbi Immanuel Jakobovits warns that a patient must not shrink from spiritual distress by refusing ritually forbidden services or foods if necessary for healing; how much less he may refuse treatment to escape from physical suffering. As there is no possibility of repentance or self-destruction, Judaism according to Derek Humphry and Wicket Ann as Mahjabeen Hassan rightly observes, considers suicide a sin worse than murder. Therefore, euthanasia, voluntary or involuntary is forbidden\textsuperscript{125}. Islam too finds euthanasia to be immoral and against God's teachings. There is absolutely no justification of taking life to escape suffering in Islam. Patience and endurance are highly regarded and

\begin{itemize}
\item \textsuperscript{122} Collste, G., 2002, p.82.
\item \textsuperscript{123} Ibid.
\item \textsuperscript{124} Ibid, p.83.
\item \textsuperscript{125} The Quran, in: www.quran.ca/modules.php?name=FAQ&
\end{itemize}
rewarded values in Islam. Some verses from the Holy Quran say: “Those who patiently persevere will truly receive a reward without measure” (Quran 39:10) “And bear in patience whatever (ill) may befall you: this, behold, is something to set one's heart upon” (Quran 31:17). The Holy Prophet Mohammad taught “When the believer is afflicted with pain, even that of a prick of a thorn or more, God forgives his sins, and his wrong doings are discarded as a tree sheds off its leaves.” When means of preventing or alleviating pain fall short, this spiritual dimension can be very effectively called upon to support the patient who believes that accepting and standing unavoidable pain will be to his/her credit in the hereafter, the real and enduring life. Thus, euthanasia, the practice of terminating someone's life to end their perceived suffering, is not permissible in Islam. Muslims believe that all things are ultimately according to God's decree, and pain and suffering must be dealt with through prayer and repentance. Moreover, only God determines the time and manner of one's death, and to "pre-empt" God is seen as a rejection of God's divine Wisdom and plan. Invariably therefore, neither the physician nor even the patient has the right to bring an end to any life.

Hindus believe in the reincarnation of the soul (or atman) through many lives. Thus, the ultimate aim of life is to achieve moksha or liberation from the cycle of death and rebirth. For most Hindus, a physician should not accept a patient's request for euthanasia since this will cause the soul and body to be separated at an unnatural time. The result will damage the ‘karma’ of both doctor and patient. Other Hindus believe that euthanasia cannot be allowed because it breaches the teaching of ‘ahimsa’ (doing no harm). There are however, two Hindu views on euthanasia:

By helping to end a painful life a person is performing a good deed and so fulfilling their moral obligations

By helping to end a life, even one filled with suffering, a person is disturbing the timing of the cycle of death and rebirth. This is a bad thing to do, and those involved in the euthanasia will take on the remaining karma of the patient.

The same argument suggests that keeping a person artificially alive on a life-support machines would also be a bad thing to do. However the use of a life-support machine as part of a temporary attempt at healing would not be a bad thing.

126 Euthanasia and Islam, in: www.geocities.com/Heartland/Fields/2704/article20.html
127 The Quran, in: www.quran.ca/modules.php?name=FAQ&
128 Euthanasia and Suicide – The Hindu View, in: www.bbc.co.uk/religion/ethics/euthanasia/indian.shtml

70
The various religious views and beliefs show that all forms of euthanasia and its practice by a physician are almost unequivocally wrong and are certainly baloney to those who believe in God and the sanctity of life. Euthanasia is seen by no means as a solution to human suffering and therefore an unacceptable practice by physicians who by virtue of their profession are called to be healers of disease. Though euthanasia is a controversial subject, it is evident that it only disrupts the normal pattern of life and leads toward creating a more violent and abusive society. Life is a gift and not a choice and the practice euthanasia, more so by a physician violates this vital concept of human society.
4.0 EVALUATION.

This work has critically analysed the concept of euthanasia with regard to any possible role the physician can play in ending a patient’s life by addressing some recurring problems and questions that are always associated with physicians’ role in euthanasia. Is the physician’s ending or aid in ending the patient’s life ethically permissible? If the patient’s right to life justifies euthanasia, does this right extend to the right of the physician to end or aid the patient end his/her life? Does the determination of the patient to have euthanasia imply that the physician should carry out euthanasia request by the patient? What are the goals of medicine and the role of physicians as medical professionals? These problems have been dwelt on in this work, via an analysis of the physician’s role in euthanasia.

This work as I stated in the introductory part, followed systematic stages and approach in analysing these problems. For the purpose of clarity, I tried in chapter one, to give the meaning of, and some distinctions between the terms euthanasia and physician-assisted suicide as a result that both are often viewed to mean the same. As I pointed out, their distinction lies in the last act – the act without which death would not occur. Nevertheless, they are similar, in that, both the physician and the patient are moral agents deeply involved in the act. Furthermore, I gave the various distinctions in the various forms of euthanasia. Voluntary euthanasia has to do with the explicit voluntary request and consent of the patient, and non-voluntary euthanasia implies that there is no specific consent of the patient killed. Involuntary euthanasia is euthanasia carried out without the patient giving consent often in the case of an incompetent patient and supposedly in the person’s best interest. In distinguishing between the two forms of euthanasia, active and passive euthanasia, I discovered contrasting opinions and arguments. On the one hand, some arguments see no difference in both forms of euthanasia, while on the other hand, some argue and maintain that they differ. For example, James Rachels argues that there is no moral difference between actively killing a patient and passively allowing the patient to die. In view of these divergent opinions, I maintain therefore that literally some differences exist between the two forms of killing. Though some people might agree that from a moral standpoint, there exist no distinction because the action and omission involved in both forms of killing are geared toward an end, the death of the patient, the application of morality in this case I feel,
importantly is situational, it depends on the very condition on ground. Chapter two of this work has dealt with the history of euthanasia and the debate over euthanasia traceable to the Greek and Roman times where the conception of life and death and the formulation of the Hippocratic Oath is a clear indication of the existence of the problem of a physician’s involvement in euthanasia. This gave a link to long – standing, though prevalent religious, philosophical arguments for and against euthanasia and the physicians involvement in the issue of euthanasia giving also some criticisms of both sides of arguments. As argued by defenders of euthanasia, the action of a physician who carries out euthanasia request by a patient is justified based on the idea of the patient’s rights and self-determination, and that liberty and the right to choose is basically a fundamental right, hence, one has the right to freely end his/her life or even request the aid of the physician in doing so. However, my opinion here is in line with Lord Acton’s conception that liberty cannot be based on the satisfaction of individual appetite. In his article, “The Kingdom of Man in America: Economic Freedom and Prosperity in Moral and Theological Perspectives”, Calo R. Zachary rightly captures Acton that the benefit and privileges that freedom creates are wholly dependent on meeting the obligations and sacrifices that freedom requires. He asserts:

This perspective is captured in Acton’s statement that “liberty is not the power of doing what we like, but the right of being able to do what we ought.” … Alan Keyes recently articulated a similar position when he stated, “freedom is not another kind of empty licentiousness.” Freedom in other words does not grant people the right to do what is wrong”129.

The third chapter of this work bears what I may regard as the heart of this work. Here I examined the role of the physician in euthanasia with the Netherlands experience in euthanasia as a background case, and then taking a look at the physician’s involvement in euthanasia, which is contrary to the oath he swore and the principles of nonmaleficence and beneficence, which asserts an obligation not to harm and to benefit others respectively. Also looked into here is the opinion of some physicians on euthanasia, the World Medical Association and the American Medical Association stand on euthanasia, legal view of euthanasia, and religious view of euthanasia. In all these as I variously pointed out and argued, euthanasia is in contrast with the role of the physician as a healer of disease, although

some people nevertheless accept euthanasia and a physician carrying out this in extenuating circumstances. Over and above all, the background case studies on the issue of euthanasia in the Netherlands and even its counterpart country Belgium where physicians legally practice euthanasia clearly shows abuses and malpractices by physicians regardless of the law guiding the practice. As I indicated, there are reports of physicians’ euthanizing patients who have not requested euthanasia. This therefore as I argued, sends a danger signal even for any country contemplating legalizing euthanasia.

Thus far and from analysis of the various arguments and positions as have been presented in this work, I therefore maintain that euthanasia, most especially voluntary-active euthanasia, and a physician's practice of euthanasia is incompatible with the fundamental human right to life and the concept of human dignity from which it stems. More so, it is contrary to the physicians medical ethics and the principles, including the Roman axiom which has been closely associated with the principle of nonmaleficence, “primum non nocere” (“first of all do not harm”) and the Hippocratic Oath, and therefore wrong. However, I feel that it is important to limit the term euthanasia to situations in which one person acts solely and intentionally to cause the death of another and distinguish it from letting die. Acts of discontinuing treatment with the realization (i.e. proofs) that patients will die of their disease in my opinion do not constitute euthanasia and a physician acting in view of this incurs no moral blame. It was in view of this that the World Medical Association in her position adopted by its 39th World Medical Assembly Madrid, Spain, October 1987 stated that:

> Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.¹³⁰

When discontinuation is done with the intention of ending life of someone who is not already unavoidably in a dying process, it is morally objectionable for many of the same reasons that euthanasia is objectionable, but euthanasia should be distinguished from the stopping of

¹³⁰ The World Medical Association Resolution on Euthanasia, www.wma.net/e/policy/e13b.htm
extraordinary means of health care or other aggressive medical treatment. Withholding treatment when there is no likely benefit from using it is just letting nature take its course. The patient or guardian in the case of an unconscious patient, has the right to reject outright or to discontinue those procedures which are extraordinary, no longer correspond to the real situation of the patient, do not offer a proportionate good, do not offer reasonable hope of benefit, impose excessive burdens on the patient and his family, or are simply "heroic." Such a decision is most appropriate when death is clearly imminent and inevitable. Here a person may refuse forms of treatment which at best provide a precarious and burdensome prolonging of life, but the physician however, has to maintain the ordinary means of health care. Since discontinuation is morally acceptable (when death is inevitable and without the intention of bringing about death), in such circumstance therefore, discontinuation should not be regarded as euthanasia. As J.N. Ekennia summarily captures it:

The euthanasia debate is concerned with intentional action and omission- that is, with deaths that are deliberately and knowingly brought about in a situation where the agent could have done otherwise.¹³¹

Performing our duty can some times be difficult. Reason demands that we do what is right, but our desire can interfere with what we ought to do. This kind of conflict between moral reasoning and desire obviously does not occur at all times in the care of patients. Many times we find that our desire to overcome challenges and our duty are congruent and it is easy to do our duty. Kant however places duty at the center of a moral life and cautions us that:

We should not be fooled by an occasional coincidence of inclination and duty into thinking that warm feelings for others bestow moral worth on our actions. Nor is it enough to act in accordance with duty, from whatever motive, or order for our behaviour to have moral worth. Helping our neighbour is required by duty, but helping our neighbour has no moral worth if done out of an inclination to help others. Moral worth is achieved only if we act from duty, that is to say, only if we act out of our appreciation of the fact that the act is our duty.¹³²

¹³² Papadimos, T.J., in: www.biomedcentral.com/1472-6939/5/3
Therefore, in order for a physician’s good will to have moral worth it must spring forth from duty. We frequently feel sorry for our patients. Yet this motivation does not spring from duty. As Arrington, R.L remarks, there are two reasons as to why sympathy cannot bestow moral worth on a deed:

First, the physician may have sympathy for someone who does not deserve it, but in turn not exhibit sympathy for someone who deserves it. Sympathy is an inclination and all inclinations are unreliable as vectors for moral actions. In the second case, sympathy lacks moral content. If you treat a patient out of sympathy you are satisfying an internal need rather than an external good, and not doing something that is of moral value. Therefore, only the motive of duty bestows moral worth on an action.\(^{133}\)

This therefore emphasizes the need for a physician to hold to his duty in all circumstances. As Arrington further notes, evidence of moral worth in doing our duty is most clear when physicians and other health care professionals are not inclined to do their duty because it costs them time or money, but do so nevertheless. Taking care of sick people, especially terminally or seriously ill patients he observes, is something many physicians and institutions do not like, or even do, however, in doing so they provide society with an example of beneficent action having moral worth.

The relief of suffering is an essential part of the physician’s role as healer, and some patients seek euthanasia because they are suffering greatly. In view of this, Beauchamp and Walters assert: Doctors ought to relieve those forms of suffering that medically accompany serious illness and the treat of death. They should relieve pain, do what they can to allay anxiety and uncertainty, and be a comforting presence.\(^{134}\) Continuing, the duo maintain that doctors as sensitive human beings, should be prepared to respond to patients who ask why they must die, or die in pain. However, as they pointed out, the patient and the doctor here are at the same level. Hence, the doctor may have no better an answer to those old questions than any one else; and certainly no special insight from his

\(^{133}\) Ibid.

training as a physician. However, Beauchamp and Walters maintain that, it would be terrible for physicians to forget this, and to think that in a swift, lethal injection, medicine has found its own answer to the riddle of life. They therefore state:

It would be a false answer, given by the wrong people. It would be no less a false answer for patients. They should neither ask medicine to put its own vocation at risk to serve their private interests, nor think that the answer to suffering is to be killed by another\textsuperscript{135}.

And in line with these views, Frederick Nietzsche rightly maintains that there is a universal conception of how a physician should respond to a patient (one who suffers). Hurt no one; rather help all as much as you can is the basic moral premise with which many moral philosophers agree\textsuperscript{136}. Suffering is a complex process that may exist in one or several forms, including pain, loss of self-control and independence, a sense of futility, loss of dignity and fear of dying. It is incumbent upon physicians to discuss and identify the elements contributing to the patient’s suffering and address each appropriately. The patient and family members as well, should participate with the physician to ensure that measures to provide comfort will be given the patient in a timely fashion.

The first priority of physicians in the care of patients facing severe pain as a result of terminal illness or chronic condition should be the relief of the pain rather than euthanasia. Fear of addiction to pain medications should not be a barrier to the adequate relief of pain. In view of this, The American Medical Association Council on Ethical and Judicial Affairs, remarks:

Indeed, it is well accepted both ethically and legally that pain medications may be administered in whatever dose necessary to relieve the patient’s suffering, even if the medication has the side effect of causing addiction or of causing death through respiratory depression\textsuperscript{137}.

\textsuperscript{135} Ibid.
\textsuperscript{136} Papadimos, T.J., in: www.biomedcentral.com/1472-6939/5/3
\textsuperscript{137} Council on Ethical and Judicial Affairs, American Medical Association, 1992, 267: 2229-2233.
This then employs the principle of double effect which states that when an unwanted outcome (death) is the result of actions taken for the good of the patient (relief of pain), the intent was not to cause death and the action is therefore defensible. Relieving the patient’s psychological and other suffering is as important as relieving the patient’s pain. When the treatment goals for patients shift from curative efforts to comfort care, the level of physician involvement in the patient’s care should in no way decrease.

It is pertinent to mention that the physician's role is to make a diagnosis, and sound judgments about medical treatment, not whether the patient's life is worth living. They have an obligation to perform sufficient care. When physicians are involved in the euthanasia process, the implied weakening of the categorical prohibition of killing has significant impacts on the patient-physician relationship. Traditionally, the physician's role vis-à-vis the patient is that of a healer, and helper. However, by practising euthanasia, the physician becomes an active agent in the achievement of death. This, as has been argued, is in fundamental conflict with the basic principles of the profession and is accordingly viewed with scepticism and even rejected by most medical communities world over. And as oppositions have rightly pointed out, modern medical advances and palliative care render euthanasia and all other forms of physician-assisted death unnecessary.

4.1 CONCLUSION.

Medicine is a healing relationship. Its long term range goal is restoration or cultivation of health; its more proximate goal is healing and helping a particular patient in a particular clinical situation achieved through the physician. Medicine restores health when this is possible, and enables the patient to cope with disability and death when cure is not possible. The aims of medicine are positive, even when death is inevitable. Healing can occur even when cure is impossible. Hence, Edmund D Pellegrino states: The patient can become whole again if the physician helps him to live with a disability, to face dying, and to live as human a life as circumstances will allow. Furthermore, Edmund Pellegrino maintains that:

Medicine is also incredibly grounded in trust. The physician invokes trust when she offers to help. The patient is forced to trust because he or she is vulnerable and lacks the power to cure himself without help. The patient is dependent
upon the physician’s good will and character. The physician to be faithful to the trust built into the relationship built with the patient, must seek to heal, not to remove the need for healing by killing the patient.\footnote{Pellegrino, E.D., in: Beauchamp, T. L. and Walters, L. (eds.), 1995, p.483.}

However, when euthanasia is a possible option, this trust relationship is seriously distorted. Healing now includes killing. When the proscription against killing is eroded, trust in the physician cannot survive. This is already apparent in Holland where observation shows that, older and handicapped people are fearful of entering Dutch hospitals and nursing homes. In accord with Beauchamp and Walter’s observation, I maintain that the problem is precisely that, too often in human history, killing has seemed the quick, efficient way to put aside that which burdens us. It rarely helps, and too often simply adds to the one evil still another. That is what euthanasia would accomplish.

Conclusively, it is worthy of note that suffering is surely a terrible thing and we have a clear duty to comfort those in need and to ease their suffering when we can. But suffering is also a natural part of life with values for the individual and for others that we should not overlook. We may legitimately seek for others and for ourselves an easeful death. However, in line with Gay-Williams’ rightful remarks, euthanasia, is not just an easeful death. It is wrong death. Euthanasia is not just dying. It is killing. The practice of medicine is a privilege which carries important responsibilities. Physicians should observe the core values of the profession which centre on the duty to help sick people and to avoid harm.
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