Voluntary Euthanasia and Physician Assisted Suicide. 
(A Critical Ethical Comparative Analysis)

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Abstract
The two most controversial ends of life decisions are those in which physicians help patients take their lives and when the physician deliberately and directly intervenes to end the patients’ life upon his request. These are often referred to as voluntary euthanasia and physician assisted suicide. Voluntary euthanasia and physician assisted suicide have continued to be controversial public issues. This controversy has agitated the minds of great thinkers including ethicists, physicians, psychologists, moralists, philosophers even the patient himself. Hence the physician, patient, the public and policy makers have recently had to face several difficult questions. Is it morally right to end the life of the patients? Is there any moral difference at all between Voluntary euthanasia and Physician assisted suicide? Should a terminally ill patient be allowed to take his life and should the medical profession have the option of helping the patient die? Should voluntary euthanasia and physician assisted suicide be legalised at all? And what actually will be the legal and moral implications if they are allowed. In a bid to find a lasting solution to these moral problems and questions has led to two different strong positions viz opponents and proponents of voluntary euthanasia and physician assisted suicide. The centre of my argument in this work is not to develop new general arguments for or against voluntary euthanasia and physician assisted suicide but to make a critical ethical comparative analysis of voluntary euthanasia and physician assisted suicide. This is the focus of my work. The sole aim of this work is neither to solely condemn nor to support voluntary euthanasia and physician assisted suicide but to critically analyze the two since we live in a world of pluralism.

Keyword
Voluntary euthanasia, Physician assisted suicide (PAS), Morality, Physician, Patient.
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DEDICATION

This work is dedicated to God, St. Anthony my wonder worker

And

To my lovely parents Nze Ezeji Simeon Chilaka Opara. Nze birikwe o!
Oga adiri gi mma. (Traditional Prime Minister) and my Mum Lolo Dorathy N. Opara.
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ABSTRACT.

The two most controversial ends of life decisions are those in which physicians help patients take their lives and when the physician deliberately and directly intervenes to end the patients’ life upon his request. These are often referred to as voluntary euthanasia and physician assisted suicide. Voluntary euthanasia and physician assisted suicide have continued to be controversial public issues. This controversy has agitated the minds of great thinkers including ethicists, physicians, psychologists, moralists, philosophers even the patient himself. Hence the physician, patient, the public and policy makers have recently had to face several difficult questions.

Is it morally right to end the life of the patients? Is there any moral difference at all between Voluntary euthanasia and physician assisted suicide? Should a terminally ill patient be allowed to take his life and should the medical profession have the option of helping the patient die. Should voluntary euthanasia and physician assisted suicide be legalised at all? And what actually will be the legal and moral implications if they are allowed.

In a bid to find a lasting solution to these moral problems and questions has led to two different strong positions viz opponents and proponents of voluntary euthanasia and physician assisted suicide. The centre of my argument in this work is not to develop new general arguments for or against voluntary euthanasia and physician assisted suicide but to make a critical ethical comparative analysis of voluntary euthanasia and physician assisted suicide. This is the focus of my work. The sole aim of this work is neither to solely condemn nor to support voluntary euthanasia and physician assisted suicide but to critically analyze the two since we live in a world of pluralism.

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CHAPTER ONE

1. GENERAL INTRODUCTION.

One night, a gynecology resident was called in a large private hospital to look at a woman who was having trouble getting rest. Upon entering the patient’s room, he found a thin woman sitting upright in bed, breathing heavily and rapidly, and looking a lot older than the 20 year old that her medical charts indicated. Doctors were only able to offer Debbie palliative care due to her non-responsiveness to chemotherapy for ovarian cancer. Her profuse vomiting and severe air hunger made it hard for her to sleep and eat for two days. In her suffering, she whispered to the resident to “let’s get it over with.” He decided that he could not give her health, but can certainly give her rest by injecting morphine. Before inserting the needle, he informed the patient and an anonymous woman next to her that the drug would let her rest and say goodbye. Upon hearing this, the patient voluntarily lowered her head on her pillow and looked around the room as if to get the last of the world. Soon, her breathing began to slow as the drug took effect and her features began to soften. The woman at her side watched with relief as Debbie slowly drifted off to sleep and peacefully entered death.

Quill gained respect and admiration for Diane over the many years as she overcame many difficult obstacles in alcoholism and depression with individualistic strength. Therefore, it did not come as a surprise to Dr. Quill when she refused treatment after diagnosed with acute myelomonocytic leukemia. Following the medical prognosis of 25% success rate for a long-term cure, she decided that it was too slim to go through a painful chemotherapy procedure in the absence of a closely matched bone marrow donor. With each meeting and consultation, Quill and other doctors find that she had remarkable understanding of the situation and her options in treatment. Despite their multiple efforts, she didn’t want any part in lingering relative comfort. After they arranged for home hospice care, she indicated her wish to ensure her death, or would have to attempt a violent process to end her life in order for her to effectively enjoy the time remaining. With this decision, both doctor and family believed that they should respect her choice to commit suicide. Therefore, the doctor directed her to find the necessary information from Hemlock Society. Throughout the time between her suicide and obtaining the drug, he had multiple consultations with her again to make sure that it was her ultimate choice and that she knew how to use the drugs properly. In the next few months, even though there minor occasions when Diane was admitted to the hospital to receive transfusions
as an outpatient, Diane was able to spend more time with her husband, bond with her son who stayed home from college, and meet with her closet friends. Despite two weeks of relative calm, the terminal symptoms of the illness were emerging, making it difficult to minimize her suffering and promote comfort. Finally, two days before she died, she met with Dr. Quill one last time to express her regrets for leaving, but a greater fear in the suffering to come if she lived. Then, after saying goodbyes to her family, she wrapped herself in her favorite shawl and died peacefully on her couch alone. The doctor reported to the medical examiner that an acute leukemia hospice patient has died without mentioning suicide.¹

The above two stories are typical illustrations of the theme of my work, voluntary euthanasia and physician assisted suicide (PAS). Our world is in fact experiencing a lot of ethical problems today such as voluntary Euthanasia and Physicians assisted suicide which have become major issues in Heath care and especially in the more advanced countries. Voluntary euthanasia occurs when a patient voluntary asks to be killed while Physician assisted suicide occurs when a physician assists and provides a patients with lethal overdose and proper instruction to take his or herself. In our world today there seems to be a one-dimensional movement towards unethical practices in the opposite direction. Euthanasia and physician assisted suicide are ethical problems which have pre-occupied many minds including moralists, psychologists, ethicists, theologians, physicians, patients, even the ordinary man in the society. These ethical problems have raised a lot of ethical questions, debates and conferences in our world. These stem from the fact that human life is involved and it is a truism that majority of people cherish life even those who want to be against it. One of the major reasons why it is becoming an issue is because those seeking to die are patients’ usually ill patients. Another is that persons giving the lethal injections or prescribing the lethal drugs are physicians. Thus both euthanasia and physicisian assisted suicide are really issues in the ethics of patient-physician relationship.²

Furthermore, the issues have become the focus of public debates and controversies. Early in the 70s, the debate was if physicians could ever withdraw life sustaining treatments especially respirators. In the 80s, it was whether physicians could ever remove medical hydration and nutrition.³

¹ Was it Euthanasia, Physician Assisted Suicide Or Murder? in http://home.uchicago.edu/~khytam22/Intro%20to%20Medical%20Ethics/PAS%20vs.%20Euthanasia.doc
³ Ibid.
Nowadays, the debate is whether physicians can at all help patients to commit suicide or even put them to death. In an effort to put a lasting solution to these ethical problems, some questions need to be answered concerning the practice of voluntary euthanasia and physician assisted suicide.

In fact, all these ethical questions that need answers makes the subject of voluntary euthanasia and physician assisted a very hot debate in our contemporary epoch.

The purpose of this work then is to make a critical comparism between voluntary euthanasia and physician assisted suicide. I will limit and always use the term voluntary euthanasia. So I will limit myself only to voluntary euthanasia for clarity and distinctiveness. For brevity and unless explicitly indicated otherwise, I shall use PAS to refer to physician assisted suicide and sometimes euthanasia to refer to voluntary euthanasia. The purpose of my work is not to make or develop new arguments for the practice or rejection of voluntary euthanasia and physician assisted suicide, but to make a critical comparative analysis of the two thereby pointing out different opinions in this ethical debate and taking a critical look on the various arguments on voluntary euthanasia and PAS.

It is important here to establish three major situations that should not be considered as euthanasia. In the first place, stopping or deciding not to initiate a medically useless treatment is not euthanasia. A medically useless treatment is in fact one where the suffering it causes would outweigh any benefits.

Again, giving treatments aimed at relieving pain and other symptoms when the treatment may also carry some risk should not be considered as euthanasia, this is in fact double effect. Also a situation whereby a patient refuses treatment and dies as a consequence of it is not euthanasia because the doctor cannot force him to have treatment against his will.

So in this work, chapter one will be the general introduction to the whole work. I shall treat and explain the history of euthanasia and some explications of terms will be made.

Chapter two will be the explanation of what euthanasia and physician assisted suicide are all about. In chapter three, I shall dwell in some arguments that favour and that are against voluntary euthanasia and physician assisted suicide. In this chapter also I shall touch on the Religions argument on voluntary euthanasia and assisted suicide.

Again in chapter four I shall dwell in the main theme of this work which is the ethical comparative analysis of voluntary euthanasia and physician assisted suicide. Here I will try to

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4 Maughan,T, Euthanasia in http://www.cmf.org.uk/literature/content.asp?context=article&id=151
distinguish between the two. The similarities and differences shall be discussed. I shall look at the ethical implications of voluntary euthanasia and physician assisted suicide. Lastly in this chapter I will try to bring an argument in favour of physician assisted suicide if at all it must be legalised. I will always use the word euthanasia and PAS to mean physician assisted suicide in this work and the reader should not misunderstand me with the theme of my work which is specifically on voluntary euthanasia. Finally, I shall make a critical evaluation and conclusion.

1.2 AIM OF THE THESIS.

The aim of my thesis is to make some necessary distinctions and explications of some terms in voluntary euthanasia and physician assisted suicide. Discussing some relevant themes like the principle of autonomy and decision making connected with voluntary euthanasia and PAS. Pointing out the various arguments for and against voluntary euthanasia and physician assisted suicide. Critically pointing out the main differences and similarities between voluntary euthanasia and physician assisted suicide. Finally making a critical ethical comparative analysis between the two and making some possible suggestions.

1.3 ANALYTICAL QUESTIONS.

In my analytical question, the following questions shall be addressed; what actually is voluntary euthanasia and PAS? Is there actually any relevant distinction between voluntary euthanasia and PAS? Can any moral difference exist between voluntary euthanasia and PAS? What are the various arguments opposing and defending voluntary euthanasia and PAS? When and what role does the physician play in cases of voluntary euthanasia and physician assisted suicide? What will be the effect if voluntary euthanasia and PAS is legalised and what actually will be the ethical implication of the practice of euthanasia? Is their any general law at all that allows the termination of life in the case of the terminally ill.? Is it not going against the ‘Hippocratic oath’ which says ‘I will give no deadly medicine to anyone if asked, nor suggest such counsel’ if a physician terminates a human life.

1.4 METHOD OF THE WORK

The methodology of my work will be based on research method. My approach will be the identification, exposition and a comparative analysis of voluntary euthanasia and physician assisted suicide. Books, journals, and the internet are my sources for the actualization of this work.
1.5 HISTORY OF EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.

The ethical debate on euthanasia and physician assisted suicide have been in practice since the classical world of Greece and Rome (500BC-350CE.)\(^5\) Many notably thought that in some appropriate circumstances they are morally acceptable. The Pythagoreans which Hippocrates was a member developed a strong tradition in medicine which was mainly devoted to ethical formation and medication of their physicians. This is in fact the origin of Hippocratic Oath which some people still appeal today for moral guidance in medicine.\(^6\) The Pythagoreans and the Hippocratic medical tradition were really opposed to euthanasia. In their doctrine, the Pythagoreans believe in the kingship of all life and the transmigration of the soul. They believe that life was somehow a single reality shared by all living things. For them there was no such thing as my life or your life but simply life. Our Souls recycle through life in different forms many times over until they finally attain some form of purified reincarnation. In fact the Pythagoreans believe that appropriate care must be taken not to terminate or disrupt life. Intentional taken of life even that of animals was considered to be morally wrong.

In the classical period also, people like Aristotle, and the epicureans on the other hand advocated for suicide. Epicureans for instance encouraged hedonism\(^7\). They avoided anything that could bring pain to them; hence they believe that it is good for one to take his life than to live in pain. Their philosophy is that of pleasure. Aristotle saw it wise and ethical to take the life of defective infants. His view however on suicide was somewhat complex. He argued against suicide whenever it violated any of the virtues. For him, a person committing suicide to escape from the troubles and sufferings of life acts cowardly and hence fails the virtue of courage. He argues that if a suicide did not conflict with any virtues, there would be no reason to consider it immoral. It might be an act of courage and love, as would be a suicide for the sake of saving the lives of others.\(^8\)

Others in line with the Epicureans were the Stoics who strongly believe that death is natural. They believe that it is best to take ones life when the struggle to live becomes unreasonable. Suicide becomes the best answer whenever poverty, illness or pain overwhelms a person that living virtuously is no longer possibly.

\(^5\) Devettere, R. J, p.359.
\(^6\) Ibid, p.359.
\(^7\) Hedonism, the doctrine that moral value can be defined in terms of pleasure; it is the pursuit of pleasure as a matter of principle.
\(^8\) Devettere, R.J, Ibid. p. 359.
Another ancient tradition that condemned euthanasia was the Hebrew tradition. The Hebrew believes in the sacred word of the old treatment not to destroy human life. They believe strongly in the biblical injunction not to kill or destroy what was created by God.\(^9\) In fact the bible out rightly forbid all intentional taking of life. This is embedded in the sixth commandment ‘thou shall not kill’. Most religious faiths regard intentional ending of life as morally wrong. A fundamental Christian principle is that human beings are made in the image of God and therefore worthy of the utmost respect, protection and empathy.\(^10\) The killing of the first born child in every Egyptian family during the night of the original Passover is seen as immoral. (Exodus 11.) Stories of suicide abound in the scripture. We read about the story of Saul in the bible. Saul killed himself. Badly wounded in the war, he had asked his armour bearer to kill him, but the man refused, so Saul took his life by himself. David gave a lamentation of his death as an honourable and illustrious son. (1 Samuel 31) However it is good to observe here that it is unwise to use biblical texts as arguments for or against killing, even killing the innocent. In fact biblical arguments are not good argument for or against euthanasia and killing of the innocent.

The texts in the scripture are not consistent, thus not conclusive. A point I want to make here is that the people in the biblical tradition as time went on, tended to kill less and that this tendency to avoid killing is a major factor behind our culture’s traditional stand against euthanasia and suicide.

Another strong cultural factor against euthanasia and suicide is Christianity. Christians were deeply moved by the example of their founder Christ, who refused to allow the use of weapon to defend his life, who accepted his rigged trial and execution without a struggle. Christians took a strong stand against killing and most of them considered infanticides, capital punishment and suicide as immoral.\(^11\)

Furthermore, Christians at that time accepted the morality of Capital Punishment. the Empire had to be protected against criminals and death penalty was seen as a powerful deterrent to criminals’ activity. Although the list of crimes subject to the death penalty varied from time to time and place to place.

\(^9\) Ibid, p. 360.
\(^10\) http://www.cmf.org.uk/literature/content.asp?context=article&id=151
The Romans at the end of the fourth century forced the Christians to reconsider their earlier doctrines of non-violence. They began to allow exceptions to their prohibition against killing. The defended their empire from the barbarians coming down from northern Europe. In fact Christians set forth what became as the ‘just war’ doctrine which was developed in great detail by st. Augustine. (354-431ad)

However, all the killings that the Christians considered exceptions to the prohibition against killing shared a common theme; the person killed was somehow not innocent. In the just war theory, the enemy was not justified in attacking, which means that the enemy solders are not innocent. All these people that are not innocent are guilty of serious crimes and can be killed if necessary.

In fact what began for Christians as a universal prohibition against all killing became in time a more narrow prohibition; do not deliberately kill innocent people. This in fact remains a central Christian’s position today. However, few Christians continue to reject the exceptions to the original prohibition against killing and remain convinced that any killing is contrary to Christian’s morality. This people are known as pacifists. They oppose all capital punishment and killing in self defence and adopt a pacifist stance on questions of war.

In fact the religious prohibition against killing the innocent has received strong philosophical support in the past few centuries. In the seventeenth century when the political theories which cantered on natural right blossomed, the primary right to life which was a move to protect every human being against being killed was maintained. This provided a strong basis for protecting the lives of the innocent which was a development in political and moral and philosophy. However, ironically the rights movements that originally protected human life is now used to justify destroying it. And this is understand in two ways, 1) if I have rights other than the right to life, and the right to die is one of them, then I should be able to kill myself or have someone kill me, 2) if life is understood as a right of mine, it can be argued then that I should be able to waive that right and kill myself or ask someone to kill me.

These rights–based arguments are now used to defend physician assisted suicide and euthanasia.

In the modern epoch, Kant moral philosophy remains influential in our world today. According to him, suicide is a horrible violation of our duty. For him nothing more terrible can be

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12 Pacifism. The belief that violence of any kind is unjustifiable and that one should not participate in war.
imagined and horrified at the sight of suicide. Moral philosophers should show and condemn suicide as abominable.¹⁴ Euthanasia and physician assisted suicide took another dimension in our contemporary period. Several debates have been going on in some countries on the morality of euthanasia and assisted suicide. In the 1970s and 1980s, series of court injunctions in the Netherlands culminated in the agreement being reached to ensure that no physician would be prosecuted for assisting a patient to take his or her life, as far as the physician adheres to the stipulated rules guiding the act. In November 2000, a bill was passed to legalise the practice of euthanasia which passed all the parliamentary stages and became a law in 2001.¹⁵ According to Egbert Schuurman the Dutch senate passed legislation to legalise euthanasia, the new legislation states that doctors must be convinced that the patient’s request is voluntary and well considered and that the patient is facing unremitting and unbearable suffering. Doctors must inform patients of their situation and reach an agreement that there is no reasonable alternative solution. Additionally, the doctor must consult at least one other independent physician. Nowadays advocacy for euthanasia has increased on political and legal fronts as well. An instance is Holland where euthanasia is being practiced without legal intervention. Although it is not allowed by statute, the law accepts a standard defence from doctors who have adhered to official guidelines. Reports say that there are between 3000 and 4000 cases of euthanasia in the Netherlands each year. According to the 1996 Dutch report in the New England journal of Medicine, there were 3253 cases of euthanasia and 271 cases of physician assisted suicide. In addition, there were 948 patients who had a life terminating act performed without explicit request, plus 3883 deaths related to treatment of pain and symptoms and 18071 deaths related to withholding or withdrawing treatment. The real number of cases of euthanasia in the Netherlands is actually over 26000 persons per year. It is reported that more than 10,000 people in Holland have started carrying anti euthanasia passport because they are frightened of being killed prematurely by over enthusiastic doctors if they fall ill.¹⁶

¹⁴ Devettere, R.J., p.363.
¹⁵ The Netherlands Department of Justice , press releases , http://www.minjust.nl
A report commissioned by the Dutch government showed that for 2001 and in around 900 of the estimated 3,500 cases of euthanasia, the doctor had ended a person’s life without there being any evidence that the person had made an explicit request.17

A former British Journalist, Dr Derek Humphrey Founded the hemlock society in the United States. This was to help people with terminal ill patients to die without pain and with dignity. In 1990, the first legislative approval for voluntary euthanasia was achieved with the passage of bill in the Australia’s Northern Territory parliament.

In Oregon in the United States of America, legislation was introduced in 1997 to permit physician –assisted suicide when a second referendum clearly endorsed the proposed legislation. Later in 1997 the supreme court of the United States ruled that there is no constitutional right to physician assisted suicide. However the court did not preclude individual states from legislating in favour of physician –assisted suicide. The Oregon legislation has, in consequence, remained operative and has been successfully utilised by a number of people.18

1.6 VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE AROUND THE WORLD.

Sweden has no law specifically proscribing assisted suicide. Instead the prosecutors might charge an assister with manslaughter. In 1979 the Swedish right-to-die leader Berit Hedeby went to prison for a year for helping a man with MS to die19.

Norway has criminal sanctions against assisted suicide by using the charge "accessory to murder". In cases where consent was given and the reasons compassionate, the courts pass lighter sentences. A recent law commission voted down de-criminalizing assisted suicide by a 5-2 vote. A retired Norwegian physician, Christian Sandsdalen, was found guilty of wilful murder in 2000. He admitted giving an overdose of morphine to a woman chronically ill after 20 years with MS who begged for his help. It cost him his medical license but he was not sent to prison. He appealed the case right up to the Supreme Court and lost every time. Dr.

17 Euthanasia, in http://www.cmf.org.uk/literature/content.asp?context=article&id=151
Sandsdalen died at 82 and his funeral was packed with Norway’s dignitaries, which is consistent with the support always given by intellectuals to euthanasia.  

**Finland** has nothing in its criminal code about assisted suicide. Sometimes an assister will inform the law enforcement authorities of him or her of having aided someone in dying, and provided the action was justified, nothing more happens. Mostly it takes place among friends, who act discreetly. If Finnish doctors were known to practice assisted suicide or euthanasia, the situation might change, although there have been no known cases.  

**Germany** has had no penalty for either suicide or assisted suicide since 1751, although it rarely happens there due to the hangover taboo caused by Nazi mass murders, plus powerful, contemporary, church influences. Direct killing by euthanasia is a crime. In 2000 a German appeal court cleared a Swiss clergyman of assisted suicide because there was no such offence, but convicted him of bringing the drugs into the country.  

**New Zealand** forbids assistance under 179 of the New Zealand Crimes Act, 1961, but cases were rare and the penalties lenient. Then, out-of-the-blue in New Zealand in 2003 a writer, Lesley Martin, was charged with the assisted suicide of her mother that she had described in a book. Ms. Martin was convicted of manslaughter by using excessive morphine and served half of a fifteen-month prison sentence. She remained unrepentant. That same year the country's parliament voted 60-57 not to legalize a form of euthanasia similar to the Dutch model.  

**Colombia's** Constitutional Court in 1997 approved medical voluntary euthanasia but its parliament has never ratified it. So the ruling stays in limbo until a doctor challenges it. Assisted suicide remains a crime.  

**Japan** has medical voluntary euthanasia approved by a high court in 1962 in the Yamagouchi case, but instances are extremely rare, seemingly because of complicated taboos on suicide, dying and death in that country, and a reluctance to accept the same individualism that Americans and Europeans enjoy. The Japan Society for Dying with Dignity is the largest right-to-die group in the world with more than 100,000 paid up members.  

The law in **Canada** is almost the same as in England; indeed, a prosecution has recently (2002) been brought in B.C. against a grandmother, Evelyn Martens, for counselling and assisting the suicide of two dying people. Mrs. Marten was acquitted on all counts in 2004. One significant difference between English and Canadian law is that no case may be pursued by the police.
without the approval of the Director of Public Prosecutions in London. This clause keeps a 
brake on hasty police actions.

In **England** and **Wales** there is a possibility of up to 14 years imprisonment for anybody 
assisting a suicide. Oddly, suicide itself is not a crime, having been decriminalized in 1961.
Thus it is a crime to assist in a non-crime. In Britain, no case may be brought without the 
permission of the Director of Public Prosecutions in London, which rules out hasty, local police 
prosecutions. It has been a long, uphill fight for the British – there have been eight Bills or 
Amendments introduced into Parliament between 1936-2003, all trying to modify the law to 
allow careful, hastened death. None has succeeded, but the Joffe Bill currently before 
Parliament is getting more serious consideration than any similar measure. As in **France**, there 
are laws banning a publication which leads to a suicide or assisted suicide.

Assisted suicide is a crime in the Republic of **Ireland**. In 2003 police in Dublin began 
proceedings against an American Unitarian minister, George D Exoo, for allegedly assisting in 
the suicide of a woman who had mental health problems. He responded that he had only been 
present to comfort the woman, and read a few prayers. This threatened and much publicized 
case had disappeared by 2005.\(^\text{24}\)

**Hungary** has one of the highest suicide rates in the world, caused mainly by the difficulties the 
peasant population has had with adapting to city life. Assistance in suicide or attempted suicide 
is punishable by up to five years imprisonment. Euthanasia practiced by physicians was ruled 
as illegal by Hungary's Constitutional Court (April 2003), eliciting this stinging comment from 
the journal *Magyar Hirlap*: "Has this theoretically hugely respectable body failed even to 
recognize that we should make legal what has become practice in everyday life." The journal 
predicted that the ruling would put doctors under commercial pressure to keep patients alive 
artificially.\(^\text{25}\)

**Russia**, too, has no tolerance of any form of assisted suicide, nor did it during the 60-year 
Soviet rule. The Russian legal system does not recognize the notion of 'mercy-killing'.
Moreover, the 1993 law 'On Health Care of Russian Citizens' strictly prohibits the practice of 
euthanasia. A ray of commonsense can be seen in **Estonia** (after getting its freedom from the 
Soviet bloc) where lawmakers say that as suicide is not punishable the assistance in suicide is

\(^{24}\text{Ibid.}\)

\(^{25}\text{Ibid.}\)
also not punishable.\textsuperscript{26}

The only four places that today \textit{openly} and \textit{legally}, authorize active assistance in dying of patients, are: \textbf{Oregon}, \textbf{Switzerland}, \textbf{Belgium} and \textbf{Netherlands}.

\textbf{OREGON:} In October 1997, the Death with Dignity Act legalised physician assisted suicide, and specifically prohibited euthanasia where a physician or other person directly administers a medication to end another's life.

The Act requires that the patient must be 18 years of age or over; a resident of Oregon; capable (defined as able to make and communicate health care decisions); and diagnosed with a terminal incurable and irreversible illness that will lead to death within 6 months. Patients who meet these requirements are eligible to request a prescription for lethal medication from a licensed Oregon physician. There are a number of further conditions necessary for receipt of the prescription, including repeated requests, a consulting physician must confirm diagnosis and capacity, the patient must be advised of palliative care and pain control and the patient must be requested, but not required, to notify their next of kin of the prescription request.

Physicians and health care systems are under no obligation to participate in the implementation of the Act\textsuperscript{27}

\textbf{SWITZERLAND:} Active euthanasia is illegal under Article 114 of the Swiss Penal Code, although the Code provides for differential penalties depending upon motive. Euthanasia is illegal in Switzerland, but assisted suicide is tolerated. Switzerland alone does not bar foreigners, but careful watch is kept that the reasons for assisting are altruistic, as the law requires. In 2001 the Swiss National Council confirmed the assisted suicide law but kept the prohibition of voluntary euthanasia.\textsuperscript{28}

\textbf{BELGIUM:} In September 2002, Belgian law allows doctors to help kill patients who, during a terminal illness, express a wish to hasten their own death. Belgium is now the third jurisdiction after the Netherlands (April 1, 2002) and the state of Oregon (1997) to legalize euthanasia.

Senator Philippe Mahoux, a Socialist, helped draft the law, which he views as "recognition" that a dying patient in "constant and unbearable physical or psychological pain" should be "the only judge of their quality of life and the dignity of their last moments," ignoring the fact that palliative care has advanced to the point where such illness need no longer be accompanied by physical suffering. Belgian law speaks only of 'euthanasia' being available under certain

\textsuperscript{26} http://www.assistedsuicide.org/suicide_laws.html
\textsuperscript{27} British Medical Association, physician Assisted Suicide, The law in http://www.bma.org.uk/ap.nsf/Content/Physician+assisted+suicide:+The+law#USA
\textsuperscript{28} http://www.assistedsuicide.org/suicide_laws.html
conditions. 'Assisted suicide' appears to be a term that Belgians are not familiar with. It is left to negotiation between the doctor and patient as to whether death is by lethal injection or by prescribed overdose. The patient must be a resident of Belgium though not necessarily a citizen. In its first full year of implementation, 203 people received euthanasia from a doctor.

**NETHERLANDS:** On April 10, 2001, a Dutch law permitting both euthanasia and assisted suicide was approved. That law which went to effect on April 1, 2002, requires that the physician "has terminated a life or assisted suicide with due care. This requirement – that the procedure be carried out in a medically appropriate fashion – transforms the crimes of euthanasia and assisted suicide into medical treatments. Specifically allows euthanasia for incompetent patients. Persons 16 years old and older can make an advance "written statement containing a request for termination of life" which the physician may carry out. The written statement need not be made in conjunction with any particular medical condition. It could be a written statement made years before, based upon views that may have changed. The physician could administer euthanasia based on the prior written statement. Teenagers 16 to 18 years old may request and receive euthanasia or assisted suicide. A parent or guardian must "have been involved in decision process," but need not agree or approve. Children 12 to 16 years old may request and receive euthanasia or assisted suicide. A parent or guardian must "agree with the termination of life or the assisted suicide. A person may qualify for euthanasia or assisted suicide if the doctor "holds the conviction that the patient's suffering is lasting and unbearable. There is no requirement that the suffering be physical or that the patient be terminally ill." The Netherlands permits voluntary euthanasia as well as physician-assisted suicide, while both Oregon and Switzerland bar death by injection.

### 1.7 EXPLICATION OF TERMS.

**1.7.1 WITHHOLDING AND WITHDRAWING TREATMENT.**

Withdrawing or withholding medical treatment is more often an issue of good clinical judgement than an ethical dilemma. Where the ethics of a situation are complicated, an

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30 [http://www.internationaltaskforce.org/hollaw.htm](http://www.internationaltaskforce.org/hollaw.htm)
Understanding of basic ethical principles is more useful than rigid guidelines.\textsuperscript{32}

-Duncan Vere-

There is always a major problem in making a distinction between withholding and withdrawal of treatment. The distinction is not always clear for example in a situation where we stop a treatment by withholding the next step. If we interrupt a series of discrete chemotherapy treatments one today and another tomorrow, we can say that we are withholding the treatment or that we are withdrawing the chemotherapy.

Again sometimes, the distinction between the two is clear, A clear instance is connecting a ventilator to a patient and disconnecting it.

The distinction between withholding and withdrawing treatment can distort our moral judgement. A general conviction hold for example, that it is more difficult to justify withdrawing treatment and withholding it, it is more difficult to withdraw treatment than withholding life sustaining treatment from a patient especially when he will die moments after the withdrawal. \textsuperscript{33}

The withdrawal of treatment is often easier to justify morally than withholding it in the first place. This is simply because in question of withdrawal, we have important information that we do not have in cases of withholding, namely, we know how the therapy actually affects the patient’s s condition. \textsuperscript{34}

However, treatment often carries risks and a doctor needs to weigh up the balance between the potential for doing good and potential for harm. Some people are not given anti-biotic by the doctor when they have a sore throat, they are often let down, but the doctor has been weighing up the small chance of the drugs making any difference, against the very risk that over use of antibiotics can lead to.

There are times when a doctor may wish to withhold treatment because although the patient thinks he or she is ill, the doctor will not agree and knows that any treatment could by harmful. In fact there are many reasons why a doctor may decide to avoid, delay, stop, start a particular treatment. Below are some reasons\textsuperscript{35}

\begin{itemize}
  \item \textsuperscript{32}http://www.cmf.org.uk/literature/content.asp?context=article&id=166
  \item Devettere, R.J.p.52.
  \item \textsuperscript{34}Ibid.
  \item \textsuperscript{35}http://www.cmf.org.uk/literature/content.asp?context=article&id=166
\end{itemize}
Avoid  |  Delay | Start  | Stop  
---|---|---|---
there is no reason to think that it will help  | the patient is showing some signs of recovering, in which case wait. If the recovery does not continue then treatment could start  | it seems likely to help and risks are small compared to the likely benefits  | the patient is not showing any improvement after a reasonable amount of time  
it might help, but cause serious harm as well  | the treatment only works for a limited period and then becomes ineffective or damaging  | while it is uncertain whether the treatment will help, give it a try and be prepared to stop if it doesn't work  | it is harming more than helping  
the patient refuses treatment  | Symptoms are transitory but may indicate disease, so keep tablets with you and take if the symptoms reappear  | though unlikely to help, the patient may be one of a minority who could respond and the risk is small  | it was an experimental treatment and has failed  
the patient is already getting better  |  |  | the patient is dying and the treatment is not one to ease suffering  
the nature of the illness is unclear  |  |  | the patient asks for the treatment to stop  

1.7.2 CAUSING DEATH AND LETTING DEATH HAPPEN.
The distinction between intentional causing to death and letting die is too simplified to serve as a substitute for moral reasoning. It is disingenuous to ignore the causal impact. Example is the withdrawal of a ventilator from someone who will die without it.
The distinction between intentionally causing death and letting Death happen is not clear because the provider’s actions play a definite causal role in a patient’s death. In order to understand the two well, let’s look at the following behaviours,
- physician gives a lethal injection to the patient.
- Physician assists a patient with suicide.
- physician gives a dying patient medication needed foe pain relief although the drugs will hasten death.
- Physician withdraws nutrition and hydration through tubes or lines
- physicians withdraw needed life sustaining equipment.
-physician withholds nutrition or sustaining treatment,\textsuperscript{36}

In the following behaviours above, one through the five, all involve causal impact on the death of the patient while the causal impact is strongest in the first and no causal contribution in no six. Withholding nutrition and treatment is the only real case of letting die on the list. What happens when a ventilator is removed from a person needing it, here the disease and the withdrawal are the causes of death.

\textsuperscript{36} Devettere, R.J. p53.
CHAPTER TWO

2.1 WHAT IS EUTHANASIA?

The word euthanasia has its origin from two Greek words, ‘eu’ which means well or good and ‘thanatos’ means death. Literally defined, euthanasia means a good death. Thus euthanasia is generally understood as the bringing about of a good death simply referred to as mercy killing. It could be seen as a painless death provoked by medical intervention.

The Collins English dictionary defined euthanasia as ‘the act of killing someone painlessly especially to relieve suffering from an incurable illness’. On the other hand Webster’s New World Dictionary of American English see euthanasia as an act or practice of causing death painlessly so as to end suffering advocated by some as a way to deal with persons dying of incurable, painful diseases.

Euthanasia occurs when a person kills another for the sake of that person killed. Furthermore, various terms has been appended to the term euthanasia all subscribing towards showing mercy for the suffering and terminally ill patient. The most popular of these terms is the one known as ‘mercy killing, good death, easy death, painless death, gentle death and dying well. In fact all these names given to Euthanasia by its proponents argue that the purpose is not to invade the person's right to life but only to substitute a painful death for a painless death.

Two important issues are clearly involved in euthanasia – 1) It involves a deliberate taking of human life either owns life or another person’s life. 2) the destruction of the life of the other is for the sake of the victim, that is the person whose life is terminated. In euthanasia, the victim could be suffering from an incurable or terminal disease and this is what in fact what distinguishes it from other forms of taking human life. In fact the key factor in euthanasia is the intention behind the act.

In legal terms, euthanasia is the intentional killing of a patient as part of his/her medical treatment. It occurs when a doctor, friend or relative intentionally ends a person’s life to lesson their misery.

Euthanasia can be achieved either by acting deliberately or by not taking action deliberately. At this juncture, it is good to establish three situations that should not be termed as euthanasia. 1) Stopping or deciding not to initiate a medically useless treatment is not euthanasia. A medically useless treatment is one where the suffering it causes would outweigh any benefits.

Webster’s New World Dictionary, 1993, p.469.
2) Competent people always have permission to refuse treatment, thus physicians can not force them to have treatment against their will, if the person dies as a consequence of this, and the doctor is not performing euthanasia.

3) When giving treatment aimed at relieving pain and other symptoms when the treatment may also carry some risk of shortening life is not euthanasia, it is rather called ‘double effect’.

2.2 TYPES AND FORMS OF EUTHANASIA.

There are three basic types of euthanasia namely voluntary, non-voluntary and involuntary euthanasia. But we shall only deal extensively with voluntary euthanasia, which is our main concern in this paper.

2.2.1. VOLUNTARY EUTHANASIA.

This is mercy killing with the consent of the terminally ill person. It is the killing of a person or assisting the suffering person to kill him/herself. This must be carried out strictly at the request of and for the sake of the person killed. It is sometimes called assisted suicide. The B.B.C English Dictionary has it that an act of euthanasia is held to be voluntary only if there is full disclosure of relevant information to a consent freely given by, the intended competent recipient of the act. Voluntary euthanasia presupposes the determination of the patient to take control of the extent of medical intervention in his or her terminal illness. It springs from the desire for auto-determination on when and how treatment should be halted to enable the patient die with dignity and not be kept alive artificially by machines.

Voluntary euthanasia still holds even when the suffering person is no longer competent to assert his or her wish to die. An example is when a person committed to his doctor the desire to die when his or her life becomes hopelessly endangered by an incurable disease. Since the decision was taken with full knowledge and consent, anyone who ends the person’s life at the appropriate circumstances simply executes the wishes of the sick person and the act is simply voluntary euthanasia. In voluntary euthanasia, it does not matter whether at the time of taking the person’s life, he or she was competent or not to revise his or her wishes.

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39 http://www.cmf.org.uk/literature/content.asp?context=article&id=151
Netherlands was the first to legalise voluntary euthanasia under established condition in 1973 by the court. The conditions which can allow voluntary euthanasia in the Netherlands are 1) the decision to die must be the voluntary and considered decision of the informed patients. 2) there must be mental or physical suffering which the sufferer finds unbearable. 3) there is no other reasonable or acceptable solution to the patient to improve the situation. 4) the doctor must consult another superior professional.

In fact the main thrust of voluntary euthanasia is that the patient specifically request that his or her life be ended. And the request must come from someone who is either subject to intolerable pain or disability or who is suffering from an illness, which is seen as being terminal. Here the decision to die may be made prior to the development of the illness in question or during its course.

In his explanation of voluntary euthanasia, R.J. Davettere writes;

> Voluntary euthanasia occurs when the patient voluntarily asks to be killed. 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. 42

For him, if the above requirements are met and the patient wants to be killed, then it is a matter of voluntary euthanasia.

J. Gay-Williams in his own conception see euthanasia as intentionally taking of a life of a presumably hopeless person. For him suicide can count as euthanasia but not passive euthanasia because the latter does not involve intentional killing.

According to Stanford internet encyclopedia of philosophy, there are five individually necessary conditions for candidacy for voluntary euthanasia. A person must

(a) Suffering from a terminal illness;

(b) Unlikely to benefit from the discovery of a cure for that illness during what remains of her life expectancy;

(c) as a direct result of the illness, either suffering intolerable pain, or only has available a life that is unacceptably burdensome (because the illness has to be treated in ways which lead to her being unacceptably dependent on others or on technological means of life support);

(d) Has an enduring, voluntary and competent wish to die (or has, prior to losing the competence to do so, expressed a wish to die in the event that conditions (a)-(c) are satisfied); and

(e) Unable without assistance to commit suicide.43

2.2.2 INVOLUNTARY EUTHANASIA.

According to the encyclopaedia of Ethics, an act of euthanasia is involuntary if the intended recipient refuses or opposes the proposed killing.44 Involuntary euthanasia occurs when a patient is competent to request or consent to treatment but is not consulted and is intentionally killed. It is just the direct opposite of voluntary euthanasia. Involuntary euthanasia is a compassionate act to end the life of a patient who is perceived to be suffering and could make a voluntary request but has not done so. Involuntary euthanasia happens when any person especially medical personnel kills a suffering patient who would have been able to give or withhold consent either because no one consulted him or her, or when asked he or she refused to give consent because he or she wanted to live.

According to Mason and McCall, “the motive of bringing relief to the suffering patient in involuntary 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”45

2.2.3 NON VOLUNTARY EUTHANASIA.

Non voluntary euthanasia occurs when a patient is not in a position to understand their circumstances; they may be mentally incapacitated and therefore cannot exercise their judgement. It is the direct opposite of voluntary euthanasia. It occurs when the person whose life is ended cannot express any view whether to live or to die, but the decision for euthanasia became the responsibility of either the medical personnel taking care of the sick or the family members. The victim here could not take any decision on account of hopeless and terrible illness in the case of an adult, or he is a handicapped newborn infant.

43 http://plato.stanford.edu/entries/euthanasia-voluntary-
44 Encyclopedea of Ethics, 2001, p.492.
45 Mason and McCall Smith, 1999, pps 558-560.
In voluntary euthanasia for an adult, the sickness must have rendered him or her incompetent to take decision on whether to continue to live or to die, and he or she had not previously authorised any one to kill him or her under any circumstances.

2.2.4 ACTIVE AND PASSIVE EUTHANASIA.

The distinction between active and passive euthanasia is thought to be crucial for medical ethics, the idea is that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient. This doctrine seems to be accepted by most doctors and it was endorsed in a statement adopted by house of delegates of the American medical association on December 4\textsuperscript{th}, 1973.

-James Rachels-

The three forms of euthanasia can be active or passive. It is active when acts done on a patient are intended to kill. It involves some positive actions that are intended to bring about the death of a patient and which actually results to his/her death. On the contrary, passive euthanasia brings about the death of a patient also. A distinction is often made between active and passive euthanasia. It has been a great debate among thinkers. According to James Rachels, active euthanasia is taking a direct action designed to kill the patient such as giving the patient a lethal injection. For him the distinction between active and passive euthanasia has a crucial significance in medical ethics. Passive euthanasia on the other hand is allowing the patient to die by withholding treatment. For Rachels, this distinction has no moral significance and using it leads to confused moral thinking.

But Tom L. Beauchamp defends the distinction and argues that it should play an important role in our moral reasoning. He is of the opinion that active euthanasia is morally preferable to passive euthanasia that prolongs the sufferings of the patient.\textsuperscript{46}

According to him, suppose a doctor agrees to withhold treatment, as the conventional doctrine says he may. The justification for 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. He continues to argue that if one simply withholds treatment, it may take the patient longer time to die, and so

\textsuperscript{46}Beauchamp T.L, in Beauchamp, T.L, 1995, p.449.
he may suffer more than he would if more direct action were taken and a lethal injection given. This fact for him 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. Stressing further he writes that “Part of my point is that the process of being allowed to die can be relatively slow and painful, whereas being given a lethal injection is relatively quick and painless”. He continues to argue that killing is not in itself any worse than letting die, which follows then that active euthanasia is not any worse than passive euthanasia. Arguing further he affirms that, 

the important difference between active and passive euthanasia is that, in passive euthanasia, the doctor does not do anything to bring about the patient’s death. The doctor does not do anything to bring about patients death, he kills him. The doctor who gives the patient with cancer a lethal injection has caused his patient’s death, whereas if he merely ceases treatment, the cancer is the cause of the death.

In his arguments, James Rachels 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 is wrong, but withholding treatment and allowing a patient to die is allowable. He made three strong criticisms of the doctrine thus, 1) that it results in unnecessary suffering for patients who die slowly and painfully rather than quickly and painlessly. 2) that the doctrine leads to moral decisions based on irrelevant considerations. 3) that the distinction between killing and letting die assumed by the doctrine is of no moral significance.

According to James Rachels, the distinction between active and passive euthanasia is thought to be crucial for medical ethics. He drew from the guidelines of the American medical association which prescribes the intentional termination of life of any human being, be it in the cases of euthanasia, but allows a patient to die when there is clear evidence that biological death is imminent. The chief object of his attack is the statement adopted by the House of Delegates of the American medical Association in 1973 which reads thus.

The intentional termination of the life of one human being by another –mercy killing –is contrary to that for which the

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medical profession stands and is contrary to the policy of the American Medical Association. The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgement of the physician should be freely available to the patient and/or his immediate family.50

In his reply to James Rachels on active and passive euthanasia, Beauchamp agrees with Rachels that the active and passive distinction is sometimes morally insignificant, but it does not follow that the distinction is always morally irrelevant in our moral thinking about euthanasia. He therefore presents utilitarian arguments for Active and Passive euthanasia. He attacked the views of Rachels on the ground that he does not appreciate the moral reasons that give weight to the active and passive distinction. Also he tried to provide a constructive account of the moral relevance of the active passive distinctions and offered reasons showing that Rachels may nonetheless be correct in urging that we ought to abandon the active passive distinction for purposes of moral reasoning.

2.3 WHAT IS PHYSICIAN ASSISTED SUICIDE?
Over the last few years, there has been increasing debate over whether patients should be able to ask doctors to end their life if they feel no longer want to live. This is often referred to as doctor assisted dying or physician assisted suicide. In cases of the so called physician assisted suicide, the doctor provides the lethal medication that the patient then administers. It is a form of voluntary active euthanasia. In fact PAS is one of the perennial ethical problems in medicine as well as an issue that involves law and public policy.

When a physician is in the role of the enabler, he receives a request by a patient for assistance in committing suicide. The physician assesses the patient’s medical condition, makes the difficult decision to help the suicidal individual and then responds to the request for assistance by providing a potentially lethal prescription as well as information on how to use the prescription to achieve the patient’s desired goal of death.51 This is just what is called PAS. It is in fact the intentional assistance given to a person precisely a patient by a physician to enable

that patient terminate his or her life upon the patient’s request. In her own words, Margaret P. Battin writes that “In this changed view dying is no longer something that happens to you but something you do.”

Physician assisted suicide is notable with the following features.

a) The agent and the subject. Which are the physician and the patient.

b) The intention of the act. This infact concerns the intention of both the physician and the patient, mainly bringing about the death of the patient.

c) The motive of the action; here involves the reason for the action and in most cases concerns what is of benefit to the patient.

d) The cause factor. This deals with what the agent does and what is actually done, that result in the death of the patient.

d) The outcome. This is the end result of the action.

2.3.1 WHY DO PATIENTS WANT THIS OPTION?

The end of life and suffering inevitably raises many fears. Some feel they will not be able to cope and do not want to lose their ‘quality of life’. Others do not want to see their loved ones suffer. All of these feelings are entirely understandable. However, some current laws allows doctors to increase pain relief for patients even if it may cause a shortening of the patients life. This principle is known as double effect and has been upheld by some courts in the overwhelming majority of jurisdictions. Again, some reasons why patients request for voluntary euthanasia and PAS include; Being a burden, Being dependant on others for personal care, Loss of autonomy, loss of control, loss of control of bodily functions, loss of dignity, loss of meaning in their lives, pain and physical suffering, poor quality of life, ready to die, saw continued existence as pointless, tired of life, unable to pursue pleasurable activities, unworthy dying, and wanted to control circumstances of death.


53 http://wwwjama.ama-assn.org/cgi
FIGURE 1.\textsuperscript{54} (VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.) pictures show the different features and things associated with voluntary euthanasia and physician assisted suicide.

Is euthanasia moral? Does anyone have the right to choose death?

### 2.3.2 THE PRINCIPLE OF DOUBLE EFFECT

The principle of double effect allows a doctor to administer pain relief to a patient that might have the foreseeable but unintended effect of accelerating the patient’s death. Deliberately accelerating a patient’s death is criminal in the overwhelming majority of jurisdictions, but it is the intention of the doctor that is critical both ethically and legally. If his intention was to control pain, then it is acceptable. If however, his intention was to a deliberate intervention to end life, then such an action contravenes the current law.

Some doctors and layers argue that a treatment has double effect like pain killing drugs given to cancer patients relieve suffering, but on occasions they also accelerate their death. This is called ‘double effect’ is seen as being acceptable as the intention was not kill the patient, but to reduce his pain.

The phrase ‘double effect’ is unfortunate in that it suggests that two things were intended, namely both the reduction of pain and the death. It is often clearer to talk about the intention of a treatment. In the above case; the intention is to make the person more comfortable. An unlimited effect is that death may happen a bit sooner.

This of course does not preclude someone giving a drug and saying that their intention is to stop pain, while causing death was the real aim. However, looking at patient and drug records can often reveal the real intention or motivation behind individual treatment decisions.

Again, another complication with decisions about giving pain relieving drugs to cancer patients is that until the patients have received the drugs no one knows whether they will do harm. Some patients find that once the pain is controlled they show a measure of recovery. In fact far

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55 Care, Euthanasia and physician Assisted suicide, 2003, p.3
Care (Christian Action Research And Education) is a registered charity organisation.
from shortening the person’s life, experts in palliative care say that when properly used, pain relief shortens the life in only 1 in 1,000 cases.

In fact the doctrine of double effect relies on the distinction between what we directly intend to do and what we merely foresee will result from our act. An example is when a doctor wants to remove a cancerous womb from a pregnant woman, the doctor here does not directly intend the death of the foetus, and the direct intention is to save the woman’s life. if there were a way of doing this which allowed the foetus to live, the doctor would take that way. So the doctor here have to remove the foetus, the death of the foetus is an unwanted side effect of a laudable intention, and the doctor is not regarded as killing the foetus.

2.3.3 OATHS AND DECLARATIONS BY THE PHYSICIANS.
Medical practitioners since 2000 years ago have used oaths and declarations as a way of committing themselves to particular ethical principles. Studying them however show the value of human life. Below are some oaths and declarations.

HIPPOCRATIC OATH (CA. 400BC)
The Hippocratic Oath was attributed to Hippocrates the Greek physician. Physician since the ancient period till now refer to this Oath. It has been a Guide for the medical professions. The Oath read thus;

I SWEAR by Apollo the physician, and Aesculapius, 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 laboring 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!  

**DECLARATION OF GENEVA (1948)**

This declaration was adopted by the general Assembly of the World Medical Association, Geneva Switzerland on September 1948. The oath seems to be a response to the atrocities committed by doctors in Nazi Germany. It requires the physician not to use his medical knowledge contrary to the laws of humanity. The oath reads as follows;

At the time of being admitted as a member of the medical profession I solemnly pledge myself to consecrate my life to the service of humanity: I will give to my teachers the respect and gratitude which is their due; I will practice my profession with conscience and dignity; The health and life of my patient will be my first consideration; I will respect the secrets which are confided in me; I will maintain by all means in my power, the honour and the noble traditions of the medical profession; My colleagues will be my brothers: I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient; I will maintain the utmost respect for human life, from the time of its conception, even under threat, I will not use my medical knowledge contrary to the laws of humanity; I make these promises solemnly, freely and upon my honour...  

**INTERNATIONAL CODE OF MEDICAL ETHICS (1949)**

The international code of medical ethics was adopted by the third general Assembly of the medical association at London in October 1949. It reemphasised that the doctor must always bear in mind the importance of preserving human life from the time of conception until death.  

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57 [http://www.donoharm.org.uk/gendecl.htm](http://www.donoharm.org.uk/gendecl.htm)  
DECLARATION OF OSLO (1970)
This declaration was adopted by the 24th World Medical Assembly of the World Medical Association in Oslo 1970. The declaration reaffirmed the utmost respect for human life from the time of conception.59

This was adopted by the 44th World Medical Assembly Marbella Spain in September 1992. In the statement, the World Medical Association seeks to inform national Medical Association of some of the facts and issues related to Medical malpractice claims. In their statement they reaffirmed that Physician assisted suicide like euthanasia is unethical and must be condemned by the medical profession.60

2.3. 4 DUTIES OF THE PHYSICIANS IN GENERAL.61
In his book, Ekennia outlines the duties of the physician in general as the following;

a) A physician shall always maintain the highest standards of professional conduct.
b) A physician shall not permit motives of profit to influence the free and independent exercise of professional judgement on behalf of patients.
c) 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.
d) A physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence or who engage in fraud or deception.
e) A physician shall respect the rights of patients, of colleagues and other health professionals and shall safeguard patient confidences.
f) A physician shall act only in the patient’s interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient.
g) A physician shall use great caution in divulging discoveries or new techniques or treatment through non professional channels.
h) A physician shall certify only that which he has personally verified.

59 http://www.iit.edu/departments/csep/codes/coe/World_Medical_Association_Declaration_of_Oslo.html
60 http://www.wma.net/e/policy/m2.htm
61 Ekennia ,J:N,2003,p. 163
2. 3. 5 DUTIES OF THE PHYSICIANS TO THE SICK\textsuperscript{62}.

a) A physician shall always bear in mind the obligation of preserving human life.

b) A physician owes his patients complete loyalty and all the resources of his science.

Whenever an examination or treatment is beyond the physician’s capacity,

He should summon another physician who has the necessary ability.

c) A physician shall preserve absolute confidentiality on all he knows about his patients even after the patient has died.

d) A physician shall give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

\textsuperscript{62} Ibid. p.163
CHAPTER THREE

3.0 ARGUMENTS FOR VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.

3.1 AUTONOMY AND SELF DETERMINATION.
Defenders of voluntary euthanasia argue that man is a free being and a self autonomous rational animal that is capable of freely making the best decision for himself at any given time.

In fact one of the major ethical documents in the field of medical ethics in 1970s was the one proposed by the national commission for the protection of human subjects which proposed three ethical principles among which was patient autonomy.

The notions of self determination and autonomy were employed mainly to justify withdrawal of unwanted life sustaining treatments, later however they were being used in another way.

Some patients began to insist that self determination and autonomy enabled them to take their lives and to ask physicians to take their lives.

Brock, D. writes that,

Self determination is valuable because it permits people to form and to live in accordance with their own conception of good life, at least within the bounds of justice and consistence with not preventing others from doing so as well. In exercising self determination people exercise significant control over their lives and thereby take responsibility for their lives and for the kinds of persons they become, a central aspect of human dignity and the moral worth of persons lies in individuals’ capacity to direct their lives in this way. 63

In his argument in support of voluntary euthanasia and physician-assisted suicide, he maintains that individual self-determination has special importance in choices about the time and manner of ones death. He argues that most people are very concerned about the nature of their last stage of their lives. In fact it reflects not just a fear of experiencing substantial pain or suffering or being abandoned by loved ones when dying but also a desire to retain dignity and control to the extent possible during this last period of life.

More so in line with the argument of self determination and autonomy is right. For centuries our culture has championed liberty, the right to choose, as a fundamental right, which follows that if liberty is a human right, there seems to be no reason why a person cannot freely choose to kill him or herself or ask somebody to do it for him or her.

In line in support of this argument, R.J. Devettere writes,

If autonomy and self determination are accepted as fundamental moral principles or moral values, then voluntary request for assistance in suicide or for lethal injections will seem morally justified to some, if autonomy is understood as a principle whereby whatever I choose is thereby morally right, then it can be argued that my choice to be killed is morally and that I can ask my physician to help me.  

3.2. RELIEF OF SUFFERING.

Advocates of voluntary euthanasia and physician assisted suicide argue that the pain of dying is sometimes uncontrollable and that showing mercy by taking the life of the suffering sick is preferable. Proponents argue that it is not designed for man to suffer endlessly in misery and pain. There arises a situation where death becomes the most imperative solution to human suffering and pain.

Opponents of voluntary euthanasia argue that suffering can be controlled by medication, but advocates of voluntary euthanasia and assisted suicide maintains that this makes no sense; they argue that if dying people are suffering terrible intolerable pain and want to die, it is more humane to honour requests for euthanasia than to induce somnolence by drugs while waiting inevitable death.

According to R.J. Davettere this argument seems to hold water, thus he affirms,

Because it is based on two of the noblest human feelings, compassion and mercy in the face of another’s medicine, and good physicians are always eager to alleviate pain, for some, this is reason enough to argue that physician respond

to the pleas for euthanasia or assistance in suicide. If a suffering patient believes with good reason that he will be better off dead, then the physician refusing to help can appear to be lacking mercy and compassion if she refuses to kill him or help him commit suicide.  

3.3 BURDEN TO SELF, FAMILY AND SOCIETY.
Defenders of voluntary euthanasia and physician assisted suicide claim that it is useless to allow one to continue to be a burden to the society, family and one self. The burden could be expressed in terms of time, money or even the emotional cost of caring for someone who is in need. According to D.W. Brock, “life itself is commonly understood to be a central good for persons, often valued for its own sake, as well as necessary for the pursuit of all further life sustaining treatment, then the patient, either explicitly or implicitly, commonly decides that the best life possible for him or her with treatment is of sufficient poor quality that it is worse than no further life at all, thus life is then no longer considered a benefit by the patient but has now become without value or meaning and a burden”. In the same vain, it has been argued that it is useless to waist precious time and resources caring for the non-viable, the heavily wounded and the terminally ill. A lot of works exist for the physician and society to care for those who the society regards as “no use” or those who have outlived their usefulness to the society and themselves. In such situations, it is always best bring to the death of such persons in the society. Again human resources are limited, so it is not wise to waste it on the terminally ill. The sick should not be allowed to continue to live by extra-ordinary means since it is time and money consuming.

3.4 ARGUMENT FROM MODERN MEDICINE.
Another strong argument in support of voluntary euthanasia and physician assisted suicide is rooted in the claim that the two acts are no more than a normal evolution in modern medicine faced with three changing circumstances.

65 Ibid. p. 371.
This argument holds that with the new medical researches and better diagnosis, we now know more about the inexorable and painful degeneration of certain diseases. Hence the certainty of what will be a painful dying suggests to some that we might try to make the inevitable death easier for the patient.

Again, although many people influenced by Christianity once saw meaning and value in suffering, fewer do today, hence, they see no reason for enduring a miserable end and seek euthanasia to avoid it.

In line with this argument, R.J. Davetere writes,

> It is true that medical practice involves, and significant stages in this evolution are apparent from a widespread conviction that death was an enemy that must be kept at bay because its victory would be a defeat for the physician and his craft, medicine has developed the more mature idea that the physician, with his equipment and remedies, should retreat in some cases, in the medical ethos now developing, the physician often welcomes death and sometimes helps it arrive by withdrawing treatment.  

This argument sees no difference between the withdrawal and lethal injections or between heavy sedation for pain and deliberate lethal overdoses. Proponents of this argument view voluntary euthanasia and physician assisted suicide as consistent with the legitimate medical desire to prevent the indignity of personal disintegration that accompanies some deaths, as an extension of normal caring for a patient who does not want the suffering and indignity of a terrible and messy death.

According to him,

> Dying patients after all, desire only what everyone wants: a good death. if a good death is a blessing, as so many have said for long, then medical assistance in dying is an act of beneficence part of the total care a physician provides for her patient. In this way, euthanasia and physician assisted suicide can appear compatible with the noble aims of medical practice.  

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67 Devetere, R.J p.372.
3.5 CRITICISMS OF THE ARGUMENTS FAVOURING EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.

3.5.1. CRITICISM OF THE PATIENT SELF DETERMINATION ARGUMENT.

It has been argued that the argument favouring euthanasia and physician assisted suicide based on self determination, right to choose and autonomy all contain a major limitation because they cannot by themselves established what is morally right or wrong.\(^{69}\)

The point of ethics will be missing if we say that something is morally right simple because it is autonomously or freely chosen. The function of ethics is to determine that what is freely chosen is morally good, which means that it will truly contribute to the agents good. A person may think that killing is good, and freely choose it, but is not only enough. Ethical reasoning should and must show killing will be truly be good, or less worse, for those engaging in it. It is the responsibility of patients to make important decisions or choices, but no choice becomes morally justified because it is simply chosen.

Self determination, choices, and personal responsibility are important moral notions, but they are not moral reasoning.

In line with this argument, R.J. Davettere writes,

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\text{....even if we accepted the argument from self determination, it would justify euthanasia and assisted suicide only for those people with the capacity to request it. just as not everyone has the capacity to give informed consent for treatment, so not everyone has the capacity to request euthanasia or assistance with suicide, the requirement for recognising the validity of self determination when euthanasia is the issue will have to be at least as stringent as the requirement for informed consent when accepting or rejecting life sustaining treatment is the issue.}^{70}\]

It follows also that sickness especially lengthy ones affects the reasonableness and voluntaries of decision making. Again, the argument from self determination alone is not strong enough to

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\(^{69}\)Ibid, p 373.

\(^{70}\)Ibid. p.373.
justify assisted suicide and euthanasia. It is really an adequate argument or a sufficient reason justifying euthanasia and physician assisted suicide.

In fact advocates of voluntary euthanasia and physician assisted suicide do not claim it is right to kill people or to help them kill themselves, simply because they want to be killed, they always give another reason to show why the killing is the right thing to do and that other reason is rooted in compassion for the patient’s suffering.

3.5.2 CRITICISM OF THE ARGUMENT BASED ON RELIEF OF SUFFERING.
The argument claims physicians should, in cases where the sufferings is intractable and death inevitable, respond in a spirit of mercy and compassion to the patients’ desire for euthanasia or assistance in suicide. This argument is seen as a limited one, since voluntary euthanasia and physician assisted suicide are moral options only when patients are experiencing, or expect to experience, severe intractable suffering that cannot be otherwise controlled. This means patients in an indefinite coma or persistent vegetative state are not candidates for euthanasia, even if their advance directives indicate this is what they would want. They are not candidate for euthanasia because they are not suffering and no merciful act can benefit them.

It has been argued that the relief of suffering argument is even more limited than this because suffering can almost always be relieved without killing the person.71 It is possible to medicate patients so heavily that they are beyond awareness. Bearing in mind that intention is very important in ethics, in giving a medication for pain is fundamentally different from the intention in giving a lethal injection. It is one kind of moral action to give drugs in order to mask pain and quite another to give drugs in order to kill.

3.5.3 CRITICISM OF THE ARGUMENT BASED ON NORMAL AND MODERN MEDICAL PRACTICE.
In line with this argument, it has been observed that the argument in favour of voluntary euthanasia and physician assisted suicide from the idea of normal practice are never persuasive in ethics.

71 Ibid, p. 375
It has not been clear at all that responding to the desire to be killed with assisted suicide and voluntary euthanasia is truly a part of medical practice. The decision to take a person’s life 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 in fact an existential decision involving the destruction of human life and not a clinical decision involving treatment of disease or of pain.

3.5.4. ARGUMENT AGAINST EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.

Highly publicised cases of terminally ill patients asking doctors to help them die have kept euthanasia in the news, it is easy to feel sympathy for people with serious illness, and we may wonder how we would cope in their position and think that we would want euthanasia ourselves, however we need to think carefully about the wider implications of legalising euthanasia.

-Tim Maugham-

3.5.4.1 THE NATURAL LAW ARGUMENT.

Taking ones life or asking others to kill us runs contrary to the natural law which says that good is to be done and evil is to be avoided. Some philosophers have argued that taking ones life or telling others to do that is immoral because it runs contrary to the natural impulse for self preservation and also against human nature.

The argument from nature has been seen by some people to be very weak. The weakness of the argument from nature against euthanasia also arises from the ease with which it can be turned into a reason for euthanasia or suicide. The original proponents of morality eg.the stoics based on ‘acting according to nature’ were very comfortable with taking their lives. They taught death is according to nature and thus we can bring it about at the proper time.

This argument follows that if we accepts freauds analysis of human nature, if follows then that the natural instinct to survive and thrive is accompanied by an equally natural instinct for self–destruction. For the Freudian, the drive to self–preservation is as natural though normally not as powerful as the drive for self-preservation.
3.5.4.2 THE RELIGIOUS ARGUMENT.

Most religious faiths regard intentionally ending of life as morally wrong. A fundamental Christian principle is that human beings are made in the likeness and image of God and therefore worthy of the utmost respect, protection, wonder and empathy.

In the bible, death is the penalty for murder.\textsuperscript{72} The prohibition is formalised in the sixth commandment, ‘you shall not murder’.\textsuperscript{73}

The meaning of the word murder used here derives from the Hebrew ‘ratsach’ which is equivalent to the Greek ‘pheneuo’. The meaning is further defined in four main passages in the first five books of the old testament-the Pentateuch. In fact these passages show that intentional killing of an innocent human being is prohibited. This distinguishes it from unintentional killing (manslaughter), capital punishment and self defence.

The bible takes a very strong stand against most intentional killing of innocent people, Thus for those accepting a moral tradition rooted in the bible, the prohibition ‘doctors must not kill’ seems to be well grounded.

Another strong argument rest on the doctrine of creation. God created the world out of nothing and continues his creative involvement to this day. For Christians and believers, God is the lord and giver of life; he gives life as a gift and takes it , killing therefore is a rejection of the gift of life and Gods sovereignty over it.

We assume a power over life and death if we kill or take another persons life. We act immorally if we usurp Gods sovereignty over life and begin to play God . In Deuteronomy 32:29 the bible says ‘learn that I, I alone, am God, and there is no God besides me, It is I who bring both death and life’

In fact the religious argument has great appeal for many especially those influenced by the biblical doctrine of creation.

Kant argued that morality is an affair of reason not religious revelation, however he employed a religious argument against suicide .for him, we are placed in this world by God for specific purposes and people committing suicide desert their posts and are rebelling against God.

Another philosopher that argued against suicide from the religious point of view is John Locke. According to him, God sent us to preserve ourselves and not to quit our station wilfully. Christians believe that death is not the end .it leads to judgment and either a wonderful existence with God in heaven, where there is no more death, mourning, crying or pain.\textsuperscript{74}

\textsuperscript{72} Cf. Genesis 9:6-7
\textsuperscript{73} Cf. Exodus 20:13.
Euthanasia for Christians is not a merciful release but rather may propel them towards a judgement for which they are unprepared.

However, while the religious argument against euthanasia and physician assisted suicides are very important for the Christians and believers, for non believers it has no impact. Hence, the religious argument against voluntary euthanasia and physician assisted suicide are limited and are based on belief and faith and not shared by all people.

The Catholic Church remains vehemently opposed to euthanasia and assisted suicide in all its forms as a grave sin and a violation of the right of the individual. The catholic church sacred congregation for the doctrine of faith defines euthanasia as “an action or an omission which of itself, or by intention causes death in order that all suffering may this way be eliminated”75

The church’s reactions to the practice of euthanasia and physician assisted suicide can be located in more than thirty seven official documents of the church. Most of it are communicate through Papal encyclicals and Exhortations; Papal conferences and addresses to United Nations. The basis of their opposition is not only that life has an absolute value but because it belongs to God.

For them man holds his life in trust for God. They strongly recognise the principle of sanctity of life. Her teachings labels euthanasia and assisted suicide as immoral.

Pope John Paul II called euthanasia a culture of death (Evangelium Vitae no 64), he was eloquent in his condemnation of cases that threaten life. Speaking to 175,000 persons on Oct 7, 1979 in Washington D.C, he proclaimed,

I do not hesitate to proclaim before you and before the world that all human life from the moment of conception and through all subsequent stages is sacred, because human life is created in the image and likeness of God…..we will stand up every time that human life is threatened.76.

According to Pope John Paul II, euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person. He maintains that, to concur with the intention of another person to commit suicide and to help in carrying it out

74Cf. Revelation 21:4
75 Pontifical council for pastoral Assistance to health care workers, 1994. No.149.
76 Pope John 11, pps. 278-280.
through so called ‘assisted suicide’ means to cooperate in, and at times to be actual perpetrator of, an injustice which can never be excused, even if it is requested.\textsuperscript{77}

The declaration on euthanasia prepared by the sacred congregation for the doctrine of faith rightly observes the rights and values pertaining to the human person, occupy an important place among the questions discussed today. The second Vatican council in this regard solemnly reaffirmed the lofty dignity of the human person and in a special way his or her right to life. The council therefore condemned crimes against life such as any type of murder, genocide, abortion, or wilful suicide. (\textit{Cf.-pastoral constitution gaudium ET spes, no 20})

Infact the catholic church has a firm position on the morality of euthanasia as expressed by the sacred congregation for the doctrine of catholic faith, hence they write that nothing and no one can in any way permit the killing of an innocent human human being, whether a foetus or an embrayo, an infant or an adult, an old person, or one who is suffering from an incurable disease, or a person who is dying.

This document maintains that no one is permitted to ask for this act of killing, either for him or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly, nor can any authority legitimately recommend or permit such an action.

The Lambeth conference of the Anglican communion on August 7, 1998, said that euthanasia is neither compatible with the Christian faith nor should be permitted in civil legislation. The outcome of this conference was that the Christian withholding, withdrawing, declining or terminating excessive medical treatment and intervention….may be consonant with Christian faith in allowing a person to die with dignity.

\section*{OTHER ARGUMENTS AGAINST VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.}

`CMF remains opposed to euthanasia on the grounds that it is dangerous (because it undermines autonomy), unnecessary (because alternative treatments exist), and morally wrong (contrary to all historical codes of medical ethics and the Judaeo-Christian ethic).\textsuperscript{78}`

\textsuperscript{77}Ibid.

\textsuperscript{78}http://www.cmf.org.uk/press_release/?id=47
3.5.5.1 VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE IS UNNECESSARY.

Proponents of euthanasia believe that the terminally ill people have two options, either to die slowly in unrelieved suffering or they receive euthanasia. In fact, there is a middle way out, that of creative and compassionate caring. Performing euthanasia is unnecessary because the dying can be managed effectively at home or in the context of a caring in patient facility. A comparison between the United Kingdom and the Netherlands is an example. In the Netherlands, euthanasia is accepted and there is only a very rudimentary hospice movement. On the other hand, the UK House of Lords committee in 1994 recommend that euthanasia should not be allowed and advised further spending on the UK’s already well developed facilities to care specifically for people who are terminally ill. This argument continues to say that rather than practicing euthanasia it is better to make appropriate and effective care and training more widely available. The legalisation of euthanasia will reduce the availability of palliative care.

3.5.5.2. VOLUNTARY EUTHANASIA IS DANGEROUS.

Euthanasia as an option is very dangerous, for it would encourage vulnerable and potentially confused people to ask to die, rather than asking friends, family and society to take care of them. The terminally ill patients are vulnerable and lack the skills and knowledge to alleviate their own symptoms, they are often afraid about the future and anxious about the effect their illness is having on others, hence they may be confused or have dementia. It is very difficult for them to be entirely objective about their own situation. Again many elderly or terminally ill people may feel a burden to society or family; hence they may feel great pleasure to request

Christian Medical Fellowship (CMF) was founded in 1949 and is an interdenominational organisation with over 4,500 British doctor members in all branches of medicine. A registered charity, it is linked to about 60 similar bodies in other countries throughout the world.

Hospice is a special kind of care for dying people, their families and their caregivers. The goal of Hospice is not to prolong life but to provide medical treatments that alleviate pain or maintain comfort throughout the dying process and to offer support to dying persons and their families. The medical care provided by Hospice is often called “palliative” or “comfort” care. Hospice care is provided at home, in a nursing home or assisted living facility -- wherever the patient resides.
euthanasia voluntarily and freely. In fact they will be particularly sensitive that they are a burden on relatives and the society. Furthermore, when the elderly people feel they are a burden to their family, they will be aware that they are using up emotional and financial resources and may be sad that their Children’s inheritance is dwindling, money that could be helping their grand children in their school training. There is really evidence that where euthanasia is legalised, this pressure does occur. An instance is the state of Oregon in the united state of America. Statistics has shown that 35 percent of patients receiving help to die have confessed that feeling a burden on the caregivers, family and friends was one of the major reasons of their choice of euthanasia. It follows also that where voluntary euthanasia has been legalised, it has led to involuntary euthanasia, an example is the Netherlands where as early as 1990, over 1,000 patients were killed without their consent in a single year. A report commissioned by the Dutch government showed that for 2001, in around 900 of the estimated 3,500 cases of euthanasia, the doctor had ended a person’s life without there being any evidence that the person had made an explicit request.

3.5.5.3 THE ARGUMENT AGAINST A PUBLIC POLICY OF VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE

Proponents of this argument against a public policy often prescind from whether or not euthanasia and assisted suicide are morally right or wrong, and focus instead on the public policy level. Their position is that, regardless of whether you think euthanasia is moral or immoral, it would not be moral to institute a public policy of euthanasia and physician assisted suicide because such a public policy would do more harm than good. They advance several reasons to show why this is so. According to their arguments, there is the possibility of mistakes by those who propose euthanasia. The notion of voluntary is problematic for them, we can never be sure the request to be killed, given the fact we consider most killings tragic and truly voluntary. The more the patients are suffering, the more likely they will be free of depression, weariness, and influence of Medications. Illness distorts judgement and can make us less able to act in a truly voluntary way.

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81 Sheldon t. only half of Dutch doctors report euthanasia, bmj, 2003, 326:1164
82 Public policies are almost always motivated by and incorporate moral considerations. A public policy is comprised of a set of normative, enforceable guidelines that govern a particular area of conduct and that have been accepted by an official public body, such as an agency of government or legislature.
According to R.J, Davettere, 

The last thing a physician want to do is kill somebody as the result of a misunderstanding, but unless we can say for sure that the sick, suffering, medicated person’s request for euthanasia or assisted in suicide is truly well informed and voluntary, then the risk of killing someone by mistake—that is, killing a patient who is not fully informed (including all alternatives) and freely choosing to be killed—remains such a strong possibility that no public policy should allow an environment where it might occur. It is a function of public to forbid situations where there is reason to believe inappropriate or accidental death might happen.  

This argument maintains that every morally sensitive physicians will make every effort to determine whether the person asking to be killed is suffering from any pain or depression that would affect judgement or undermine the ability to choose freely, but determining whether or not the decisions of sick, suffering and dying patients are truly informed and voluntary is most difficult task. There are some merits however in fact in public policy because it will not allow physicians to kill or to help to kill patients.

3.5.5 4 THE EFFECTS OF LEGALIZING VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.

According to R.J Devettere in his book, ‘Practical Decision Making In Health Care Ethics’, the consequences of legalizing euthanasia and physician assisted suicide will lead to the following. Legalization of euthanasia will undermine our commitment to provide the best of care to those dying patients who decline to choose suicide or euthanasia. In a society where other patients in similar circumstances generously exercise their ‘right to die’ and thereby cease to be a drain on personnel and resources. The legalisation of euthanasia will put additional burdens on sick patients because it presents them with another choice, and a most serious one. Patients do not have to make any decision about euthanasia, if it becomes legal, 

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83 Devettere, R.J., 1995, p.378
84 Ibid., pps 378-381.
then it will become an option for them. They may do nothing about it, but doing nothing will then be a choice not to accept the legal option of euthanasia or assistance in suicide. The practice and legalization will undermine the trust that some suffering patients would have in their physician once they know the physician is willing to kill them if they give the word. Some of these patients may feel very vulnerable because they are not insured and are incapable of paying for care. In a society that practice euthanasia, these patients cannot help but worry about the financial pressure their medical treatment and hospitalization places on physicians and institutions. The physician patient relationship is based on trust, and the trust will erode in the minds of perhaps many, if any killing by physicians is socially authorised.

The legalization of euthanasia will change the face of the primary goal of medicine to cure and not to kill. The role of medicine is to comfort but the idea of physician comforting people by killing them is not a major part of medicines ethos. The depenalization of intentional killing by physicians constitutes, in itself, a serious violation of the legal protection of the life of all citizens. Moreover, whenever the committee rules favourably on a case by deeming an act of killing legal, the Public Prosecutor's ability to monitor physician conduct will be compromised, because the Prosecutor will not even see the report of the physician involved in the case. Furthermore, it is likely that cases in which the legal requirements have not been fulfilled will go unreported, since that precedent has already been set. Data on reported cases are provided by the physician who performed the euthanasia; therefore, determinations of whether the legal requirements have been met may very often be biased as well. Adequate control will be impossible. Secondly, such legalization will lead to a broader acceptance and increased practice of euthanasia, which will dramatically change the nature of the patient-physician relationship and terminal ill patients. Once euthanasia becomes a legal option, a patient afflicted with terminal illness or unbearable suffering may have to justify not asking to be euthanized. At the same time, legalization will undermine the efforts and creativity of those committed to providing palliative care to a terminal patient. Such unintended outcomes seem inevitable in a health care system characterized by increasing costs and the need to make choices regarding resource allocation. Legalizing euthanasia is incompatible with the fundamental role of the physician as healer. Since this role and the extent of the physician's competence is regulated by law, such a fundamental change in the physicians competence concerns society as a whole and cannot be considered as a private matter for only patients and physicians. Accepting the euthanasia of minors 12-18 years of age seriously overestimates the capacity of such persons to evaluate the meaning and consequences of a request to be killed. It
places an unacceptable burden on these young people. Legalizing the euthanasia declaration designed to permit a competent patient to request euthanasia in advance, should he or she later become incompetent, is likely to foster a broadening of the requirement of 'unbearable suffering' to 'loss of dignity'. Furthermore it is likely to increase the pressure on the physician to terminate a patient's life when a patient has become severely demented, especially when the patient's family insists on doing that. Such a practice may likely lead to a blurring of the distinction between voluntary and involuntary euthanasia. No wonder that the Dutch Association of Nursing Care Physicians has voiced their unhappiness with this part of the proposal. Finally, although the responsible ministers have admitted during the debate in parliament that a physician who does not want to perform euthanasia to a patient insisting on having it is not obliged to formally refer to a colleague who may be willing to do so, in practice physicians will feel pressured to either perform euthanasia themselves or refer to a colleague. If they refuse to do either, they may run into trouble unless they have indicated in an early stage of the terminal phase of the disease that they object to performing euthanasia. Furthermore, health care professionals who reject euthanasia will likely find it difficult to obtain jobs in certain areas of the health care field.

3.5.5 A CRITICISM OF PHYSICIAN ASSISTED SUICIDE.
   BY RICHARD T. HULL.

In his arguments against physician assisted suicide, Richard Hull maintains that the unspoken problem with physician assisted suicide is that it puts power where opponents don’t want it, in the hands of patients and their loved ones. He wanted to see if there are ways of sorting out who holds the power to choose the time and manner of dying that makes sense. According to him many severely compromised individuals in their depression, loneliness, loss of normal and despair have asked their physicians to assist them in dying, yet later after physicians resisted their requests and others awakened them to alternative opportunities, they have returned to meaningful lives.

Arguing further he asserts;

   No sane advocate of physician-assisted suicide would deny the importance of meeting the demand to die with reluctance and a reflective, thorough examination of alternative options, the likelihood of profound mood swings
during therapy makes it imperative to distinguish between a patient’s acute anguish of loss and his or her rational dismay at the prospect of long term descent into the tubes and machines of intensive care.\textsuperscript{85}

Furthering he maintains that medicine would be transformed for the worse if doctors could legally help patients end their lives. The public would become distrustful, wondering whether physicians were truly committed to saving lives, or if they would stop striving as soon as it becomes inconvenient.

For him doubtless there are physicians who by want of training or some psychological or moral defect, lack the compassion sensitivity to hear a demand for aid in dying and act on it with reluctance, only after thorough investigation of the patients situation. Such physicians should not be empowered to assist patients die. He suggested that power should be restricted to physicians whose primary training and profession is in pain management and palliation; they are best equipped to ensure that reasonable alternatives to euthanasia and suicide are exhausted.

Moreso, patients demanding for assisted suicide should be scrutinized by the same institutional ethics committees that already review requests for the suspension of life sustaining technology as a protection against patient confusion and relatives greed.\textsuperscript{86}

Physician assisted suicide and euthanasia are incompatible with our obligations to respect the human spirit and human life. He regards conscious life as essential to personal identity, hence he writes,

\begin{quote}
There are individuals who like myself, who regard conscious life as essential to personal identity. I find it nonsensical to maintain that it is profoundly morally preferable to be rendered comatose by drugs while waiting life’s natural end, than to hasten death’s arrival while still consciously able to embrace and welcome one’s release. If I am irreversibly comatose, I am dead, prolongation of my
\end{quote}

\textsuperscript{85} http://www.secularhumanism.org/Council/activities.html
\textsuperscript{86} http://www.secularhumanism.org/Council/activities.html
life at that point is ghoulish, and I should not be required to undergo such indignity. Every demand for physician-assisted suicide must be scrutinized and determined to be fully infirmed. To withhold aid in dying beyond that point is, first barbarically cruel, second, it only do so by nonmedical means, possibly endangering others or further magnifying their own suffering. He concludes in his case for physician assisted suicide that the time honoured doctrine of double effect permits administering pain relieving drugs that have the effect of shortening life, provided the intent of the physician is the relief of the pain and not foreseen death of the patient. He defer with people who find comfort in the notion that intention of the agent, not the consequence of his actions, is the measure of morality. According to him, the fact that we permit terminal care regimens to shorten life in any context shows that the line has already been crossed. The fact that physicians must at the insistence of the competent patient or the incompetent 's duly appointed surrogate , withdraw  life sustaining technology shows that physicians can assist suicides and can perform euthanasia on these fortunate enough to be dependent on machines. He maintains that it becomes a matter of simple justice, equal protection before the law, to permit the same privileges to other terminal patients. He concludes by saying ,that the US supreme court has ruled against this argument did not dissuade  the citizens of the state of Oregon from embracing it, States like New York that have turned back such initiatives must bear the shame of  having imposed religious majorities’ philosophies on all who suffer.

3. 5.6 CRITICISMS OF THE ARGUMENTS AGAINST VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.

3.5.6.1 CRITICISM OF THE RELIGIOUS ARGUMENT.
The arguments that are against voluntary euthanasia and PAS have been criticised mainly from the religious point of view. This argument maintains that the religious argument is based on religion and faith thus does not hold water. The Christians draw their morality from God and maintains that whatever that goes against the wish of God becomes immoral.

87 Ibid.
88 http://www.secularhumanism.org/Council/activities.html
But the question is this, since not every person believe in God, the religious argument is therefore has a limit.

Arguing against the religious argument David Nicholas points out that we live in a multicultural secular society which is not Christian, Jewish, Muslim, Hindu, or Catholic, which means that any person expected to enter the parliament for any discussion on matters of euthanasia and PAS to leave religious dogma at the door and instead apply critical rational thinking to their chosen work as lawmakers. He maintains that religious dogma cannot be proved and if a belief in the dogma of their church forbids it, then they should abstain from the voting on that particular bill. Amanda Vanstone on her own opinion in the place of religion in matters like euthanasia and PAS affirms that you are entitled to follow your religious belief but you are not entitled to demand by legislation that everybody else does the same. According to Derek Humphrey in his article “why I believe in voluntary euthanasia and Assisted suicide argues that there are millions of atheist and agnostics and they all have rights to their choices in voluntary euthanasia and PAS. In an argument against religious argument on this issue, he writes ‘another consideration is theological, does suffering ennoble? Is suffering and relating to Jesus Christ’s suffering on the cross, a part of preparation for meeting God? Are you merely a steward of your life which is from God and which only he may take away? My response is this; if your answer to these question is yes, God is my master in all things, then you should not be involved in any form of euthanasia. It just does not fit.

3.5.6.2 CRITICISM OF THE ARGUMENT BASED ON DOCTOR-PATIENT RELATIONSHIP.

The argument that the acceptance of voluntary euthanasia and physician assisted suicide practices will quickly destroy the traditional bond of trust between doctor and patients has been criticised by proponents of voluntary euthanasia and physician assisted suicide on the ground that the argument has been answered following the practices of voluntary euthanasia and physician assisted suicide in the Netherlands and Oregon. The argument maintains that no evidence of breakdown of relationships has emerged since those doctors who are ethically opposed to hastening the end of life don’t engage in voluntary euthanasia and PAS. The laws in

90 Ibid.
the Netherlands, Oregon all give medical professionals the right to be involved- a conscience clause.

Morso, many patients hold their medical advisors in higher regard if they know that he or she will go to great length to keep them from terminal suffering even to the extent of providing, if necessary a gracious final exit.
CHAPTER FOUR

4.0 A CRITICAL ETHICAL COMPARATIVE ANALYSIS OF VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.

A very clear and sharp distinction exists between voluntary euthanasia and physician assisted suicide. In fact the physician does the killing in euthanasia and the patient does it in the physician assisted suicide.\(^{92}\) In order to make the best ethical comparative study of voluntary euthanasia and physician assisted suicide. It is very pertinent to look at the following themes which will help us to tackle the main task of this work which is making a comparative study

4.1 THE PRINCIPLE OF AUTONOMY AND BENEFICENCE.

The issue of patient’s autonomy is based primarily on the principle of individual autonomy, rooted in the liberal western tradition that stresses the importance of individual freedom and choice. In fact recent development in ethics tend to unfold the reality that moral responsibility of actions and omissions in medicine are best conceived in terms of basic rules, rights, virtues and fundamental principles. Though the rules, rights and virtues play more vital roles in health care ethics, principles still provide the most comprehensive starting point in issues within this area. They are deeply embedded in the tradition of medicine and health care in that they point to an important part of morality that may be, has been traditionally neglected, but now need to be placed at the foreground.\(^{93}\)

The issue of patient autonomy is closely associated with several ideas in biomedical ethics as voluntariness, self-determination, privacy etc. The term autonomy originated from the ancient Greek words. “autos” self and “nomos” (rule) referring to political self-government in a city state.\(^{94}\) Later the term has to be applied in ethics especially in the area of biomedical ethics, hence shifting the meaning to being what concerns to the state to individual only. According to Beauchamp and Leroy Walters,

\[\text{…..personal autonomy has come to refer to personal self – governance: personal rule of the self by adequate}\]

\(\text{\(^{92}\) Devettere, R.J, 1995.p365.}\)
\(\text{\(^{93}\) Beauchamp, T.L in Gillon, R., (ed) 1994, p4.}\)
\(\text{\(^{94}\) Ibid.p 58.}\)
understanding while remaining free from controlling interference by others and from personal limitations that prevent choice. Autonomy so understood, has been analysed in terms of freedom from external constraints and the presence of critical mental capacities such as understanding planning and deciding.\textsuperscript{95}

It is good to note here that the principle of respect for person’s autonomy has for a long time been the necessary ground for the proponent of euthanasia and physician assisted suicide. The major argument for them is that since different people are embodied individuals, anything that happens to our bodies happens to us. People should have significant control of their lives and should make decisions for their lives. A doctor that assists a terminally ills patients in voluntary euthanasia is doing that based on the respect he has on the individual autonomy, but this right to individual autonomy does not guarantee a duty or obligation for the physician. A physician who prescribes a lethal drug for a patient does not do this based on the fact that it is obligatory. On the other side of the coin, a physician who terminates the live of a patients is also doing that based on the duty he has for the patient to respect his individual last right. Some have argued that the primary aim of the physicians is to obey and respect the wish of the patients with regards his autonomy.

The principle of beneficence is an ethical principle that plays a significant role in the issue of Physician assisted suicide. It expresses the obligation of the physician to help others for their important and legitimate interest by removing or preventing harm.

In fact the prevention of harm is mainly associated with the principle of beneficence but is more related to the issue of non maleficence. The two are intertwined in such a way that they are often envisaged as pursuing the same goal –taking steps in helping others, not merely the omission of harm causing activities but also working towards the good of others.\textsuperscript{96} These two principles in medicine are applied to the relationship that exits between the patient and the physician. In his own points, Thomas Percival argues that beneficence and maleficence fix the physician’s primary obligation and some cases triumph over the patient’s right to autonomy especially in serious circumstances of conflict. According to him,

\textsuperscript{95} Beauchamp, T.L & Walters, L. 1995, p 22.
\textsuperscript{96} Beauchamp, T.L in Gillon, R., pps.7-8.
To a patient ….who makes inquiries, which, if faithfully answered, might prove fatal to him, it would be a gross and unfeeling wrong to reveal the truth. His right to it is suspended and even annihilated; because, its beneficial nature being reversed, it would be deeply injurious to himself, to his family, to his family and to the public. And he has the strongest claim, from the trust reposed in his physician, as well as from the common principle of humanity, to be guarded against what ever, would be detrimental to him….97

Its worthy of note here that one of the factors that actually distinguish Physician assisted suicide from euthanasia is very well concerned with the principle of beneficence and non-maleficence –the motive of the action. Its emphasis is on the motive of the physician which requires him to do what will be for the benefit of the patients and not what the patients feels benefits him or her.

4.2 DECISION MAKING IN VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.

In other to analyse clearly whether there is a moral difference between voluntary euthanasia and PAS, it is also pertinent to know exactly when a patient takes decision and the circumstances and motives surrounding his request for choosing to die. Historically, the professional idea of the physician –patient relationship held that the physician directed care and made decisions about treatment, the patient’s principle role was to comply with doctor’s orders. The Paternalistic approach often took account of the patient’s general preferences and attitudes towards treatment. It gave the patient only a minimal role in making choice. However in the face of irrational decision making or preferences by patients, the physicians are encouraged to overlook them as not being in the patient’s true interest. Paternalism98 have been for the past

97Percival.T.,medical Ethics ;or a code of Institute and precept, adapted to the professional conduct of Physicians and Surgeons, Manchester ,S,Russel, 1803,pps.165-166
98Paternalism refers to treating individuals in a way that a parent treats his or her child. But in ethical theory the word is more narrowly used to apply to treatment that restricts individual autonomy. Paternalism is the intentional limitation of the autonomy of one person by another, where the person who limits autonomy appeals exclusively to grounds of beneficence for the person whose autonomy is limited. The essence of paternalism is an overriding of the principle of respect for autonomy on grounds of principle of beneficence.
three decades replaced by the concept of shared decision making in which both the physician and the patients make active and essential contributions.

In shared decision making, the patients brings a knowledge of their own subjective aims and values through which the risks and benefits of various treatment options can be evaluated, while the physicians brings his medical knowledge and expertise in diagnosing and treatment of the patients. In fact shared decision making which I see as a kind of division of labour oversimplifies the complexities of the roles and contributions of physician and patients. It has been concluded that in shared decision making, proper respect for the patient autonomy and self determination means accepting the patient’s treatment preference. Some have argued that the primary aim in decision making is for the benefit of the patient first and foremost. According to Brock, D and Wartman;

The first value is the well being of patients which can require the physician to attempt to protect them from the harmful consequences of their choices when this judgement is irrational .the second value is respecting the rights of patients to make decisions about their own lives when they are able.99

In fact whenever a competent patient makes an irrational decision about treatment, which are contrary to their health, these two values will be in conflict. In decision making, the physician ensures that their patients are well informed. He sees that each patient uses correct information about relevant alternatives. There are situations where irrational decisions are made by the patients. An irrational decision is one that fails to promote a set of basic aims and values that belongs to the physician or to standard guidelines of medical practices. We must note here that there are some ways a patient’s role in making decision can be limited or lost. First ,the patient ‘s capacity to make ,or to make known ,her decisions may be lost or diminished when he is unconscious or be conscious but is so overwhelmed by medication , disease , pain , or confusion that he is not capable of making decisions .secondly, when a person becomes a patient ,he enters an environment where other people are also making decisions about his care. Not only physicians but nurses, other providers, and the institutions itself have a say in what they do because they are responsible for their actions .At times, their disagreement will limit the patient’s ability to make an effective decision. Another limitation can come from law. Here

the patient may want a physician to kill him but the law forbids it, so the physician will refuse. The debate about competence focus on whether patients or subjects are capable, psychological or legally, of adequate decision-making. Competence in decision-making is closely connected to autonomous decision-making and to questions about the validity of consent. The issue of competence is connected with voluntary euthanasia and assisted suicide because the decision here must have to be voluntarily taken by the patient.

As a general principle, competent patients have the responsibility of their own health, and should be permitted to make decisions about their life. A competent person is one that has the capacity to decide on what is good for him or herself. Associating competence with rationality, Thomas Mappes writes that one can be judged to be competent when he make a rational choice and this rationality of individual choice is based on the following 1) when the goal sought for is beneficial to him or her in its entire ramification, 2) when individuals are properly capable of choosing the best means to some chosen ends.

4.3 CAN VOLUNTARY EUTHANASIA BE DISTINGUISHED FROM PAS?

The distinction between euthanasia and physician assisted suicide is necessary since it concerns the patient-physician relationship. In both of them the physician plays an active role in the killing. In voluntary euthanasia, the physician alone causes the death and in physician assisted suicide the patient causes it. The physician plays an active part in the killing in physician assisted suicide because he orders or provides the lethal overdose and the proper instructions for suicide. In fact it may be helpful to think of physician assisted suicide as medical suicide and voluntary euthanasia as medical killing. In a case where a man requested a physician to provide him with lethal overdose and the instructions on how to kill himself, here the physician is very much an active agent if the man takes his life Teaching a person how to kill someone, or himself and providing him with the poison to do that is also not different from actually injecting the lethal dose.

At this juncture it is pertinent to make some moral reasoning on voluntary euthanasia and physician assisted suicide, thus, ‘killing and kill’ are the most appropriate words to use in the discussions of euthanasia and assisted suicide. Both voluntary euthanasia and physician

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assisted suicide are killings. In voluntary euthanasia physicians kill their patients and in physician assisted suicide, the physician help patients to kill themselves. Voluntary euthanasia and PAS have the same goal, which is bringing about the death of the patient. In PAS, the physician makes available the necessary means and information and the patient perform the action himself but in voluntary euthanasia the doctor is responsible for both the means and action that cause the death of the patient.

4.4. Are There Morally Relevant Differences Between Voluntary Euthanasia and PAS?

Some writers maintain that voluntary euthanasia and PAS are not that morally different. Daniel Callahan in his view maintains that the distinction between voluntary euthanasia and PAS is not morally significant. According to him, a physician who provides a patient with a deadly drug and instructions about its use to bring about death bears as much responsibility for the death of patient himself. For him, the doctor who kills directly by injection in PAS or give others the pills to kill themselves are fully blameworthy (or praiseworthy if one accepts such actions as ethically acceptable) for what occurs. He writes that in PAS-the doctor or physician is knowingly a part, a necessary part of the causal chain leading to the death of the patient.  

In his own view, Dan.W.Brock in his article “physician—Assisted suicide is sometimes morally justified” writes that in physician assisted suicide, the patient acts last whereas in voluntary euthanasia the physician acts last by ending the life of the patient. He maintains that the moral difference is obvious and important. In euthanasia the physician kills the patient whereas in PAS the patient kills himself. He argues that if there is no significant intrinsic moral difference between PAS and voluntary euthanasia, why then should some public or legal policy permit one and not the other. The British medical Association in a discussion paper from the medical ethics department argues that enabling competent patient to end their lives is perceived by many as entailing less responsibly and as such being therefore less blameworthy than ending their lives for them……the inclination to perceive a clear motives of people who let others die are generally less malicious than those of people who kill.

However the moral question is whether physicians and patients can morally justify these killings when they are voluntary and not motivated by compassion and mercy. On the one hand also, Voluntary euthanasia and physician assisted suicide are similar in a crucial way. In both voluntary euthanasia and physician assisted suicide, the physician is seen as the moral agent who is deeply involved in causing the death of the patient.

In his own view, R.J. Devettere in comparing euthanasia and physician assisted suicide writes,

Moral reasoning about euthanasia and physician assisted suicide, as well as debates about whether these should be public policy and legally allowed for those who want to die this way, should recognise the strong similarity between euthanasia and physician assisted suicide. While there are differences between medical killing and medical suicide, the similarity between the two is strong that they stand or fall together. In euthanasia, the physician does the killing, in physician assisted suicide, the physician and the patient form a team to do the killing.  

But the moral questions about voluntary euthanasia and and physician assisted suicide still remains, is it morally good for physicians to kill their patients or help to take their lives. In an answer to this moral question, he writes,

The specific moral question is, when, if ever, is it morally good for physicians to kill patients who request it, or to help patients kill themselves?, to morally justify the killings, both the physician and the patient must show how the killing makes their good, or at least avoids the less worse. Patients thinking of killing themselves must show how the killing will contribute to their good or avoid the less worse, and Physicians thinking of killing patients must likewise show how the killing will contribute to their personal good and avoid the less worse. It is never enough for a physician to justify his role in the killing by saying that it was the patient’s request or that it was good for the patient.

105 Davettere, R. J., p.366.
However voluntary euthanasia and PAS have almost the same goal, which is bringing about the painless death of the patient. They differ however in both the motives and cause factor. The motive of both voluntary euthanasia and PAS is just for the best interest of the subject.(patient) but the main difference lies in the fact that in voluntary euthanasia, the physician does the act based on the request of the patient and for the interest of the patient. Here the doctor brings about the death of the patient directly either by giving a lethal injection that causes the death of the patient or by withdrawing life sustaining treatment.

In voluntary euthanasia, we have to note clearly that the physician brings about the death of the patient who is critically ill with immense pain and no hope of survival.

Consent and intention plays an important role in voluntary euthanasia. Since voluntary euthanasia can still be distinguished from non and involuntary euthanasia. The voluntary request of the patient must be there before it must be regarded as voluntary euthanasia. In PAS, the final action that brings about the death of the patient is carried out by the patient himself. The doctor or physician only helps the patient to bring about his or her death. According to Miles et al, the patient is the principle whereas the doctor is the accessory, the principle is the decedent (patient) while the doctor is an assistant or fascinator – providing the means.
4.5 FIGURE 2. ILLUSTRATING THE DIFFERENCES AND SIMILARITIES B/W VOLUNTARY EUTHANASIA AND PAS. (EMPHASIS, MINE)
In the above illustration, I tried to show the differences between voluntary euthanasia and physician assisted. In both, death is the intended and final end. In voluntary euthanasia, the doctor acts last while in physician assisted suicide the patient acts last. In voluntary euthanasia, the patient is passive while the doctor is active while in physician assisted suicide the patient is active while the doctor is passive.

4.5 ETHICAL IMPLICATIONS OF THE PRACTICE OF VOLUNTARY EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE.

The practice of voluntary euthanasia and PAS has many implications at different levels in our society. Right from the early ages, traditional medical ethics codes have never sanctioned voluntary euthanasia. The Hippocratic Oath states “I will never administer poison to anyone where asked” and “be of benefit, or at least do no harm”107.

The 1949 international code of medical ethics declares that a doctor must always bear in mind the obligation of the preserving human life from the time of conception until death. Also in 1992 statement of Marbella, the world medical association confirmed that physician assisted suicide like voluntary euthanasia is unethical and must be condemned by medical profession. Thus with the practice of voluntary euthanasia and physician assisted suicide, the doctor patient relationship will be damaged. It will be against the medical practice which is based on the ethics of preserving life and relieving suffering. Doctors have a privileged relationship with their patients. It is one that is fundamentally built on trust, trust that the doctor will always act in a way that seeks to do them no harm. This relationship has been recognised and fostered in a series of ancient and modern oaths and codes of practice. The practice of voluntary euthanasia and PAS would give the doctors enormous new powers over life and death. This has the real possibility of removing the patients inmate trust in their doctors108. A good example is the Netherlands where disabled people are already not trusting their doctors and fearing not to be admitted to hospitals which in fact should be places of care and safety rather than death zones. Again, the society would start to lose the idea of the benefits that can come from learning to serve and care for people in need. Another ethical implication is that voluntary euthanasia and PAS could start to alter the way that society views both death and disability and as a consequence, society would become less caring for the ill. People who are difficult or costly to

108 http://www.cmf.org.uk/literature/content.asp?context=article&id=168
be cared for may be seen as second rate citizens. People could also become detached from reality, believing that there are quick fix solutions to all difficult problems.

Some have argued for the practice of euthanasia based on the individual right to autonomy and self determination. But bearing in mind what John Donne said “no man is an island, entire of itself; everyone is a continent, a part of the main”\textsuperscript{109}

This means that the actions of a person who takes his or her own life have profound effects on those who live through the tragedy. This follows that the person who exerting their right to autonomy has removed the same right from the survivors.

Again, the exercise of autonomy with respect to voluntary euthanasia and PAS could decrease our notion of the value or worth of vulnerable people.

As for me, autonomy is fine and good in so far as it reflects the unique individuality of each human being, created in the image of God and ultimately accountable to him. But to use our autonomy responsible, we need to balance our rights (the thing we may do), responsibilities (the things we must do) and restrictions (the things we must not do) Autonomy is not therefore the same as saying that people have the right to do whatever they like.

\textsuperscript{109}http://www.cmf.org.uk/literature/content.asp?context=article&id=168.
CHAPTER FIVE

5.0 CRITICAL EVALUATION AND CONCLUSION

5.1 MY POSITION.

Having made an ethical critical comparative analysis of voluntary euthanasia and PAS. It has become obvious that the two have the same goal and intention which is bringing about the death of the patient. But the main difference lies in the fact that in voluntary euthanasia the doctor is responsible for the means and the death of the patient while in PAS the doctor prescribes the means while the patient carries the action that brings his or her death. Some have argued that there is no moral difference between voluntary euthanasia and PAS since their goal and intention tends towards the same which is the death of the patients. I wish to differ with them and maintain that PAS and voluntary euthanasia seems to have a moral difference in terms of the gravity of the offence. Though the two are morally bad. Physician assisted suicide I think is morally less bad compared with voluntary euthanasia. I wish to argue in line with Dan Brock that the moral difference is obvious and very important in this ethical argument. My argument lies in the fact that prescribing and instructing a person on how to do something is not the same as doing it oneself. A typical example is teaching and telling a person to go and steal and stealing it by oneself. In this case, if the person that is instructed on how to steal goes ahead and steal, do we apportion the same blame to the person that instructed him? What of if the person decides not to steal again, do we say that he has stolen since many argue that intention is what matters in morality. This applies to the same case with voluntary euthanasia and PAS.

Instances have shown that half of the request for voluntary euthanasia was as a result of depression and evidences show that greater number of patients that requested voluntary euthanasia later changed their mind. Let me buttress my point with this story. A 60 year old Peter was found to have lung cancer following a chest x-ray carried out to investigate a bad cough. The cancer was advanced and could not be cured. Over the next few weeks Peter became breathless when he walked and developed pain in the chest. He also became withdrawn and depressed and worried more and more about the stress his illness was causing his wife. He later went to a physician to help him die because he could see no point in carrying on with

Brock, D.W., in Weir, R.F., p.87.
more suffering. The physician prescribed him with lethal medicine. Peter went home after
listening to physician assisted suicide news in the television later changed his mind. He went to
hospitals and talked with other patients. He stopped asking to die even though his condition
was gradually deteriorating. However he died one year later having told his story and how glad
he was not to have died when he wanted to but to have changed his mind to live even though
he was dying.

One can see from this story that physician assisted suicide is different from voluntary
euthanasia since one can still change his mind in the cause of the action. The gravity of the
offence is also less than that of voluntary euthanasia. But in voluntary euthanasia once the
request has been made by the patient, the doctor follows the action thereby killing the patient. I
wish to maintain that if at all the two must be practiced, let it be only physician assisted suicide
which I think is less bad.

Again, taking into consideration the arguments that favour and oppose voluntary euthanasia
and physician assisted suicide. I wish to maintain that a balance must have to be strike. After
all, there is no moral or legal obligation for physicians to comply with a patients request for
PAS even in Oregon nor is the physician under any obligation to refer the patient to a physician
who would honour the request, if the patients desire to pursue PAS makes it impossible to
continue caring for the patients, the obligation remain to continue providing care and comfort
until arrangements are made for another physician to assume care. One should apply a
critical thinking to this ethical debate on voluntary euthanasia and PAS. Bearing in mind that
we live in a society of pluralism and tolerance where some advocate for voluntary euthanasia
while some oppose it. More so we should take in account that some people believe in
situational ethics, secular humanism and even in moral relativism. Opponents of
voluntary euthanasia and PAS based their arguments among others on the sanctity of life which
points out strong religious and secular traditions against taken human life, the protection of the
integrity of the medical profession as we have noted already in this work.

112 Situational ethics refers to a particular view of ethics in which absolute standards are considered less important
than the requirements of a particular situation. The standard use may therefore vary from one situation to another,
and may even contradict one another.
113 Secular humanism is an attempt to function as a civilised society with the exclusion of God and his moral
principles.
114 Moral relativism is the view that ethical standards, morality and positions of rights and wrong are culturally
based and therefore subject to a persons’ individual choice. We can decide what is wrong for ourselves. Moral
relativism says its true for me, if i believe it.
In fact the opponents points to the historical ethical traditions of medicine which strongly opposed the taking away of life. Following these arguments by opponents of voluntary euthanasia and PAS, I think voluntary euthanasia PAS is against the religious belief, hence morally wrong. On this ground I seem to oppose physician assisted suicide and voluntary euthanasia on the ethical principles embodied in the Hippocratic Oath “neither will I administer a poison to anybody when asked to do so, nor will I suggest such to a course.”\textsuperscript{115}In fact the essence of the oath is patient welfare. “I will use treatment to help the sick according to my ability and judgement, but never with a view to injury and wrong-doing…into whatever house I enter, I will enter to help the sick and will abstain from all wrongdoing and harm.”\textsuperscript{116} However, we should try as much as possible to accommodate the wish and belief of Jewish, liberals, humanist and even the atheist.

Christians with their religious argument on voluntary euthanasia and PAS though rational should not impose their positions, dogmas and laws on the secular society. Though it would be basically wrong to assume that those who approach medical ethics from a religious point –view are uncritical and authoritarian in their moral thinking.\textsuperscript{117} No wonder Amanda Vanstone on her opinion on the place of Religion in the secular democracy writes,

Your religion is your business and no ones else’s. it follows that I attach very little importance or interest in arguments over religious dogma. my personal view is that when you make religion an issue ,you drag it into the political domain and you tarnish it……..you are entitled to follow your religious beliefs but you are not entitled to demand by legislation that everybody else does the same.\textsuperscript{118}

Furthermore I wish to suggest in line with Berthrand Russell that to bring an end to the moral debate on voluntary euthanasia and physician assisted suicide. That “what we need is not the will to believe but the will to find out”\textsuperscript{119}And the way to find out is to research, weighing both sides of the arguments on voluntary euthanasia and PAS and then balancing the harm and the good to society and passing any bill irrespective of personal preference.

\textsuperscript{115} www.physiciansnews.com.
\textsuperscript{116} Ibid.
\textsuperscript{117} Mason & McCall Smith, 1999,p..5.
\textsuperscript{118} http://www.atheistfoundation.org.au/ve.htm
\textsuperscript{119} Ibid.
5.2 CRITICAL EVALUATION.
This work aims at making a critical comparative analysis of voluntary euthanasia and physician assisted suicide. The reader after going through this work is bound to raise some arguments. I wish to maintain that the essence of any academic work is to raise some questions that need critical answers. In an attempt to do justice to this critical study. I started with the introduction, background of the study and the history of voluntary euthanasia and physician assisted suicide. I tried to explain some major terms that are associated with voluntary euthanasia and PAS. I also in the course of this work tried to explain what euthanasia and PAS are all about taking into considerations the types of euthanasia. The reader should not misunderstand me wherever I use the word euthanasia because my major concern in this work is voluntary euthanasia. I made a little review of James Rachels view on passive and active euthanasia and Tom L B Beauchamp reply to him to make some necessary clarifications. Also addressed in this project is why patients request voluntary euthanasia and PAS and the various duties of the physician especially to the patients. Furthermore, I tried to present the various arguments that favour and are against voluntary euthanasia and PAS.I combined the both voluntary euthanasia and PAS in the arguments .I have tried to apply a more critical method on the issue of both voluntary euthanasia and PAS.Appraising the position of both sides. In the arguments of the two positions, I noticed that there have been series of opinions, all moving towards the morality of the act. I realised that their arguments though tends to be a phenomenon of recent times, but indications show that there were traces of them in the ancient days. The Graeco Roman conception of life and the formulation of the Hippocratic Oath are all indications that the problem of whether a physician should assist or not in voluntary euthanasia and PAS manifested in the ancient days. A more critical look at the arguments suggests that the two different positions argue from a very strong point of view. Reacting to the two positions, I tried as much as possible to be critical and rational in maintaining a position. I tried to maintain a middle position taking into consideration that our world is a secular society. Later I tried to present some of the criticisms of the various sides of the arguments. I went further to explain the effect of legalising voluntary euthanasia and PAS. I did a little review of Richard Hull article “A case for physician Assisted Suicide to buttress the arguments against voluntary euthanasia. Furthermore, in chapter four of this work which is my main project, I tried to discuss the
principle of autonomy which is very important in the understanding the right of the patient in choosing death. I also tried to have a look at decision making in voluntary euthanasia and PAS since the patient takes the choice of ending his or her life and the factors surrounding it. Moreso, the question of whether voluntary euthanasia is different from PAS, and whether there are any moral differences were argued. Here I took my own personal stand and argued that there are still some moral differences. I tried to illustrate my points using a diagram. Lastly in this work, I examined some ethical implications of the practice of voluntary euthanasia and PAS.

5.3 GENERAL CONCLUSION.

From my discussions so far in this work and all the various arguments from the various sides, I would say that it has become very obvious that the debate on voluntary euthanasia and PAS will continue in our world in as much as we live in a secular world. However, the sole aim of my arguments in this work is not to support voluntary euthanasia nor PAS but to make a critical analysis of the two.

I would rather suggest that both proponents and opponents of voluntary euthanasia and physician assisted suicide should reason together in order to help the medically ill patients since life has the highest value. They should use their knowledge to help in finding a final solution the medically ill patients rather than engaging in endless moral debates on whether there is any moral difference and legal justification of voluntary euthanasia and physician assisted suicide.

The sole aims of medicine and the physician are to cure patients and help them preserve life. It would be inimical and contradictory to the medical profession when a physician is actively and deliberately involved in taking away the life that he or she should have saved. Every physician ought to understand that he/she has ethical obligation that transcends self–interest, personal emergency, and even social and physical, and economic forces in our world.

The British medical association in their clarion call affirms; ultimately we do not believe that the arguments are sufficient reason to weaken society’s prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that we all are equal. We do not want that protection to be diminished. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundations of a policy that would have such serious and widespread repercussions. Dying is not only a
personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be forseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of the society as a whole.\textsuperscript{120} The best way of giving a person true dignity, and respecting their value is to care for them and make their life as comfortable and fulfilling as possible. This is much stronger action than simply giving up on them and promoting their death. In many respect I think when death comes, the more natural it is the more dignity it affords. I think that if Voluntary Euthanasia and physician assisted suicide are allowed, “the right to die would become the duty to die, what terminally ill people need is to be cared for and not to be killed.”\textsuperscript{121}


\textsuperscript{121} Cf.Daily Mail, April 4th 2005.
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