The End

A thesis focusing on Euthanasia and The Patient

Is it ethical for a patient to ask someone else to help them die?
If it is, who is (ethically) the best person to ask to kill the patient?

AUTHOR
Shakila A. Rossi

Master’s Theses in Applied Ethics
Centre for Applied Ethics
Linköping University, Sweden
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SUPERVISOR
Prof. Anders Nordgren
Linköping University, Sweden
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Suffering from a terminal illness, or being chronically sick or severely disabled is not pleasant, which most of us will never experience life like this. However, there are people who are living in precisely that kind of constant, excruciating pain, agony and misery, 24 hours of the day, 365 days a year, stuck in a “living Hell” with no way of ending their enforced but unwanted torment – other than the highly controversial ‘therapy’ of euthanasia.

Those of us who are relatively healthy have a choice in how and when we end our lives. We can decide to wait until our life ends naturally, or we can speed up the process by committing suicide in whatever manner we choose. But, because of their illness or disability, the patients discussed in this thesis are being denied that same choice – because they must ask for help to die, they have had their right to decide matters such as when, where and how to go, for themselves taken away from them by people who believe that they know better than the patient what is best for them.

In Chapter 1, I will clarify some of the many, often contradicting, definitions and ideas associated with euthanasia.

In Chapter 2, because death is a very personal subject and everyone has different reasons why they want to die, I have used extracts from two very personal letters explaining why they sought euthanasia.

In Chapter 3, I will show how a patient considering euthanasia can use two Ends and Means arguments (Utilitarianism and Deontology) to decide if killing themselves would be the moral course of action to end their suffering. I will also discuss the morality of euthanasia eastern and western society.

In Chapter 4, the discussion turns to who would be the best person to help the patient die. I will examine how euthanasia can comply with various professional and personal codes of conduct and discuss the ideal character of the would-be euthaniser.

In Chapter 5 (the final chapter) I will conclude by using the information from the previous chapters to answer two important questions:

1. Whether it is ethical for a patient to even be thinking about euthanasia in the first place
2. Who is (ethically) the best person to ask to kill the patient

This thesis is not about whether or not euthanasia should be legalised (as I will explain – euthanasia is already going on, albeit illegally) but to discuss the morality of asking someone else to go against all matter of strictly enforced and deeply ingrained legal, moral and professional rules imposed by society in order to help the patient die.
In memory of Giancarlo Rossi

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Linköping in June 2005
Shakila A. Rossi
The End

A thesis focusing on Euthanasia and The Patient
by Shakila A. Rossi

Introduction

Picture yourself in a war zone:- there are bombs exploding everywhere, vital structures crumbling and falling apart, blood and various body parts lying scattered among the debris. The constant sound of screaming is ringing in your ears and you feel that, with all this death and destruction going on all around you, your brain is turning to jelly and you are slowly losing your grip on sanity. To say that you are terrified of what is happening is an understatement. The worst part is that you have no control of the situation and can never get away from it. All this pain, agony and misery is going on 24 hours of the day, 365 days a year, for the rest of your life.

Now, imagine that war zone is inside your body – it’s your body’s vital structures (organs, bones etc.) are crumbling and falling apart, it is your blood being scattered among the debris. The constant sound of screaming is your own and it is your sanity that’s slowly dissolving into the ether. To say that you are terrified of what is happening both inside and outside your body is an understatement. The worst part - you have no control of the situation and can never get away from it. All this pain, agony and misery is going on 24 hours of the day, 365 days a year.

For the rest of your life.

Suffering from a terminal illness, or being chronically sick or severely disabled is no pretty picture - far from pleasant, and thankfully most of us will never have to experience life like this. However, there are people who are living in precisely that kind of constant, excruciating pain, agony and misery, 24 hours of the day, 365 days a year, at this present moment. These people are stuck in a “living Hell” (a phrase that I have seen often repeated during my research into this subject), with no way out.

Actually, there is a way out – Euthanasia.
Euthanasia (from the Greek words ‘eu’ meaning good, happy and ‘thanatos’ meaning death – so literally ‘good or happy death’) is one of the most controversial issues within both the medical profession and society as a whole. Even the mere mention of death tends to have people running for cover in an effort to avoid discussing such a morbid subject and the very thought of intentionally killing another human being can (and, under normal circumstances, usually does) provoke such strong reactions as fear, anger, condemnation, revulsion and sheer distain.

But what if these people actually want to die? It is easy for an able-bodied person to take their own lives in any manner of ways and, rather like a good Martini; an able-bodied person can choose to commit suicide anytime, any place, anywhere. It is not so easy, however, for those who are chronically sick, terminally ill or severely physically disabled in some way.

The chronically sick, terminally ill or severely physically disabled patient (from hereon in referred to as “the patient”) more often than not, requires help performing even the simplest day-to-day tasks in order to keep them alive and relatively healthy, many of which able-bodied people take for granted. It follows that they would also need assistance in order to end their lives.

However, there are two major problems with euthanasia:-

1. Because the resulting death is permanent, no-one can reverse the procedure and allow the patient to resume living again.
2. Those persons who intentionally assist with the ending of the patient’s life are liable, under certain rules, to be charged with murdering the patient, even if the patient themselves has given their unequivocal, independent consent to the procedure.

The subject of euthanasia is an interesting topic because we all live by a system of rules, be they religious, legal, communal, cultural etc. which we are ethically obliged to follow in order to protect ourselves and our rights. For example when it comes to taking the life of another, the following rules apply:-

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1. Thou shalt not kill. (the 6th commandment from the Christian Decalogue)
2. Do not take life, which Allah made sacred, (Qur'an 17.33)
3. The intentional killing of a human being by any other human being is illegal. (British Murder Act 1965)

Whilst these rules (and others like them) serve their purpose of making the world a safer place, they make no distinction between patients who want to die, patients who want to carry on living and patient’s who (according to various interested parties) are better off dead. These rules are frightening patients who have no other hope of ending their suffering. If no-one is willing to help them, are we not condemning these patients to live a life of pain and misery? Would we not be forcing these patients to endure what amounts to constant physical and mental torture, against their will? Doesn’t torturing people go against all manner of moral codes, not just legal, moral, religious or cultural?

And even if the patient does find someone willing to take the risk in order to help them, doesn’t the worry of what might happen to the helper after their death, just add to the patient’s worry and suffering?

This thesis is not about whether or not euthanasia should be legalised (although this question does feature significantly throughout this thesis) but more to address the problem as to who is (ethically) the best person to ask to kill the patient, if it is indeed ethical for a patient to even be thinking about euthanasia in the first place.

Because of all the legal and moral risks and uncertainties involved with euthanasia, the motivation behind this thesis is to give an idea of the thought process which a patient considering euthanasia may go though, and to show that patients seriously considering getting help to end their lives are not necessarily crazy to be thinking in that manner

**Methodology** – You (the reader) must keep in mind that this thesis is written from the perspective of the chronically sick, terminally ill or severely physically disabled patient – it is their life on the line and it is their decision whether to ask or not that we are discussing in this thesis.

*Continues next page...*
How I intend to do this is by first describing just what euthanasia is and what the different types of euthanasia are. Then I will show how the patient may come to a rational, purely moral decision about whether or not asking for euthanasia is a moral act. After that, I will show how the patient can come to an equally rational, moral decision as to who will be asked to perform the act. In concluding, I will attempt to answer the over-riding question: Is it ethical for a patient to ask someone else to kill them?

As you will see in the Bibliography, I have referred to a significant number of websites for information. Of course books feature significantly – the foundations of ethics are well documented and explained – but there are widely differing ways of interpreting these thoughts. In order to formulate credible thought, the patient must understand the foundations on which the ethics encompassing euthanasia are built on.

However, (assuming the patient dies as a result of an act of euthanasia) the patient will not be around to cope with the backlash that often accompanies acts of this nature (see http://en.wikipedia.org/wiki/Terri_Schiavo#Activism_and_protests where death treats were issued as a result of a positive euthanasia decision). In choosing the right agent to perform euthanasia, the patient must be aware that, although people have their ideas of what constitutes morality, not everyone has heard of the likes of Peter Singer, Immanuel Kant et al. and as yet, the philosophical thoughts of such accessible (and less academic) figures like Bob Dylan and Monty Python have yet to appear in any philosophical tome outside of the Internet. (It is plausible to assume that more ‘non-learned’ people have seen the film "Monty Python and the Holy Grail" than have ever picked up a copy of the books listed in the Bibliography). The potential agent will have to face this backlash, possibly alone and feasibly from those who are either ignorant of ‘scholarly’ philosophical thought on the subject or refuse to listen to it.

Also – we live in an ever-changing world and at least two of the fields mentioned heavily in this thesis (medicine and legislation) are constantly changing. Prison sentences fluctuate depending of current ruling and the climate of the time, and new and improved drugs and therapeutic methods are being developed as you are reading this.

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For this thesis to argue its case properly and in a fair manner, all the facts must be as up-to-date as possible – and information can be up-dated easier and far quicker on the Internet than in print. (In my defence, it must be noted that the method of my arguments are sourced primarily from books)

There are too many ways in which current euthanasia thinking is being abused (too many murders being disguised as euthanasia e.g. the on-going case of the world’s most prolific serial killer, (the late) Dr. Harold Shipman), because there are so many differing morals surrounding the issue, few of which are crystal clear. It stands to reason that if the morality of Euthanasia is muddled, so is the legislation regarding the subject (law and morality do tend to go hand-in-hand). What makes the situation worse is that the majority of people refuse to discuss the issue, leaving those who cannot talk about it to suffer the most – some even pay for their silence with their lives.
Chapter 1. What is Euthanasia?  
1. What are the differences between euthanasia, suicide and mercy killing?  
2. What are the differences between the different types of euthanasia?

Chapter 2. Why would someone choose death over living?  
1. What is dignity?  
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Chapter 5. Conclusion  
1. Is it ethical for a patient to even be thinking about euthanasia?  
2. Who is (ethically) the best person to ask to kill the patient?

Bibliography
Chapter 1. What is Euthanasia?

As mentioned in the introduction to this thesis, the word Euthanasia comes from the Greek words ‘eu’ meaning good, happy and ‘ihanatos’ meaning death – so euthanasia literally means ‘good or happy death’.

A random sample of definitions reveal that there are a whole host of differing theories as to what the actual term ‘euthanasia’ means – for instance:-

1. …act or practice of painlessly putting to death persons suffering from painful and incurable disease or incapacitating physical disorder. (euthanasia. Encyclopædia Britannica. Retrieved May 15, 2005, from Encyclopædia Britannica Online.)
2. The intentional killing by act or omission of a dependent human being for his or her alleged benefit. (The key word here is “intentional”. If death is not intended, it is not an act of euthanasia) - www.euthanasia.com/definitions.html
3. …there is no legal definition of euthanasia, because it is not recognised by British Law. It is defined by intent; that is, when one person intentionally facilitates the death of another person - www.nhsdirect.nhs.uk
4. …is the practice of killing a person or animal, in a painless or minimally painful way, for merciful reasons, usually to end their suffering - http://en.wikipedia.org/wiki/Euthanasia

Many people view euthanasia as tantamount to killing or putting to death a fellow person (phrases used in all four definitions above), which is perfectly true in a sense, but one must take into account the agent’s intentions behind their actions. Because of all the differing ideas as to what euthanasia is, the purposes of this thesis will be better achieved by combining the above definitions into one succinct definition that we can work with (leading to fewer misunderstandings) – which leads me to defining the term Euthanasia as:-

“The intentional facilitating by one or more persons (hereby known as the agent) to painlessly putting to death a dependant person in order to prevent further unavoidable suffering to that dependant person.”

1. What are the differences between euthanasia, suicide and mercy killing?

There is a big difference between euthanasia and two other controversial end-of-life scenarios, those of suicide and mercy killing:-
SUICIDE – as with the previous definition of euthanasia, there are many ways to describe suicide - A random sample of which is given below:-

1. (from Latin *sui caedere*, to kill oneself) - is the act of intentionally ending one's own life -  http://en.wikipedia.org/wiki/Suicide
3. …the action of killing oneself intentionally -  www.nhsdirect.nhs.uk
4. ‘Självmord’ (the Swedish word for suicide) is a literal translation of ‘self-murder’ (my observation)
5. The intentional act of killing oneself through committing self-murder by taking one’s own life thereby bringing about one's own death (my definition)

With cases of suicide, the patient (who may not necessarily be physically ill but more likely to be going through an extreme emotional response to something) brings about the cause of their own death without any help from anyone else (unlike euthanasia where at least one other person helps the patient, in some way, to end their life). In a sense, suicide is a form of self-administered euthanasia, but because the agent is usually dead as a result of the action of the suicide, they are somewhat difficult to prosecute.

Since the United Kingdom decriminalized suicide with the Suicide Act of 1961, suicide is no longer a crime (before then, suicide was widely considered to be a major crime in England, Scotland and Wales because the suicide was believed to have gone against the Will of God (as it was only He who had the power to take life), and, as punishment, the suicide's property was seized by the king. Victims of suicides were interred in an unmarked grave, on unconsecrated grounds along public highways, with a stake driven through the heart.) However, assisting someone to commit suicide (that is intentionally providing someone with the information, guidance, and/or means for them to take their own life – discussed later on in this chapter) remains a crime to this day. It is mainly this issue which has so many pro-euthanasia and pro-choice groups up in arms and demanding a change in the law allowing the agent to kill the consenting patient without fear of prosecution.

Even though the definition of suicide has not changed, the public's attitude to it has changed. Most modern societies now view cases of suicide not as acts of defiance against the Almighty, but as acts of self-release from whatever burden had been placed upon the victim.
MERCY KILLING – Whilst trying to find definitions for this subject, I found that many sources would use the term ‘mercy killing’ as a synonym for ‘euthanasia’. I disagree with this definition, and to prove my theory, I will use a scenario previously cited by Thomas Anderberg:-

Suffering from severe pain, [Igor] asks Boris to help him end his life and thereby points to a shelf above the bed, where Boris can see a gun. Boris asks why he doesn’t shoot himself – that would certainly be the easiest way out, he claims as would clear him, Boris, of all suspicion. Igor then desperately claims that he is unable to do such a thing for fear of failure, and holds up his trembling hands as proof. Boris feels pity for his friend, takes the gun and shoots him through the head. (Anderberg, 22)

In this scenario, although Igor is suffering from severe pain, he can still move. The only thing stopping him from pulling the trigger himself is fear of failure. Even though his hands are trembling (from fear or illness, we do not know) it is still within the realms of possibility for Igor to aim and fire the gun, and thus, commit suicide as explained earlier. Therefore, apart from Igor’s fear of missing his target and ending up in even more pain, there is no legitimate reason to involve Boris at all.

Many people confuse mercy killing with euthanasia because there are more people than just the patient involved – where the agent (in this case Boris) acts out of compassion, mercy or a sense of duty towards the patient. In the above scenario (as Anderberg points out), Boris acts out of mercy towards his friend even though Igor is able to do the deed himself. However, it is generally agreed that euthanasia involves patients who are physically or mentally incapable (i.e. those who are dependant on others – see Definition 1 of euthanasia on page 8 of this thesis) to kill themselves, otherwise if they could, they would commit suicide. If they, like Igor, are physically and mentally able of choosing euthanasia over their current situation, but are psychologically unable to kill themselves, perhaps they should think again.

Following the above – this leads me to defining mercy killing as:-

“The intentional killing of a patient by one or more persons for benevolent reasons, at the request of the said patient, even though the patient is capable of killing themselves without help”.

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2. What are the differences between the different types of euthanasia?

In order to fully understand the concept, it is necessary to examine the four different types of euthanasia:

**Non-voluntary euthanasia:** When the person who is killed was unable to request or give any consent to euthanasia, but is euthanized anyway (see Glover 191, Beauchamp & Childress 145, Singer 179, www.euthanasia.com/definitions.html) A case of euthanasia may be called non-voluntary for two reasons:

a. When the situation of a patient merits consideration for euthanasia but, the will of the patient remains unknown for some reason (e.g., the patient is comatose) and they can therefore not explicitly express their desire (or not) for euthanasia. The decision whether to euthanize or not is made on their behalf.

b. Where an individual lacks the ability to either comprehend their situation and/or understand what euthanasia will mean for them, and hence cannot make a clear, valid decision as to whether or not to go for euthanasia (those such as under-aged children or the mentally incapacitated fall into this category). As with the first reason, the decision whether to euthanize or not is made on the patient’s behalf.

**Involuntary euthanasia:** Perhaps the most controversial of all the types of euthanasia, this is when the person who is killed is competent and fully capable of giving their consent to euthanasia, but has either not given any form of consent or has expressly declined any offers of euthanasia. Euthanasia is then performed against the wishes (or without the consent of) the patient. (see www.euthanasia.com/definitions.html, Glover 191, Beauchamp & Childress 145, Singer 179)

It is often said that to permit any type of euthanasia is to eventually permit murder, which involuntary euthanasia is often confused with because the patient is killed against their will. Neither of these is necessarily so, and to show this, I will use the following scene from the film "Monty Python and the Holy Grail" (1975):-
Scene 2 - "Monty Python and the Holy Grail"

[MORTICIAN, dragging a cart loaded with dead people, comes into view, ringing a bell]

MORTICIAN: Bring out your dead! Bring out your dead!

[CUSTOMER carrying elderly DEAD PERSON over his shoulder, approaches MORTICIAN]

CUSTOMER: Here's one -- nine pence.
DEAD PERSON: I'm not dead!
MORTICIAN: What?
CUSTOMER: Nothing -- here's your nine pence.
DEAD PERSON: I'm not dead!
MORTICIAN: Here -- he says he's not dead!
CUSTOMER: Yes, he is.
DEAD PERSON: I'm not!
MORTICIAN: He isn't.
CUSTOMER: Well, he will be soon, he's very ill.
DEAD PERSON: I'm getting better!
CUSTOMER: No, you're not -- you'll be stone dead in a moment.
MORTICIAN: Oh, I can't take him like that -- it's against regulations.
DEAD PERSON: I don't want to go in the cart!
CUSTOMER: Oh, don't be such a baby.
MORTICIAN: I can't take him...
DEAD PERSON: I feel fine!
CUSTOMER: Oh, do us a favour...
MORTICIAN: I can't.
CUSTOMER: Well, can you hang around a couple of minutes? He won't be long.
MORTICIAN: Naah, I got to go on to Robinson's -- they've lost nine today.
CUSTOMER: Well, when is your next round?
MORTICIAN: Thursday.
DEAD PERSON: I think I'll go for a walk.
CUSTOMER: You're not fooling anyone y'know. Look, isn't there something you can do?
DEAD PERSON: I feel happy... I feel happy.

[WHOP – MORTICIAN HITS DEAD PERSON ON THE HEAD WITH A HEAVY STONE – KILLING HIM OUTRIGHT]

CUSTOMER: Ah, thanks very much.
MORTICIAN: Not at all. See you on Thursday.

(From the film "Monty Python and the Holy Grail" (1975), written by Graham Chapman, John Cleese, Terry Gilliam, Eric Idle, Terry Jones, and Michael Palin)
At first glance, this case seems like a clear-cut case of murder as the Dead Person did not actually want to be killed, but if you look closer; a case for involuntary euthanasia can be made. It all depends on the motivation the Mortician had for hitting the Dead Person with the heavy stone.

If the Mortician killed the Dead Person solely to get his hands on the Customer’s nine pence, then it would be outright murder, because the Mortician’s motive is a purely selfish one with no regard for the Dead Person and his wishes. However, if the Mortician had killed the Dead Person because he had realised that the Dead Person was too senile to realise that he was not getting better and that he would be better off dead, then it would be a case of involuntary euthanasia, because the Mortician’s motive would have been to ease the Dead Person’s suffering. The fact that he gets nine pence for his trouble is not an issue. (This is assuming that the Mortician has sufficient medical knowledge to diagnose the Dead Person).

**Voluntary euthanasia:** This can be called when the patient who is being killed has explicitly, voluntarily, repeatedly and without coercion requested to be killed - either verbally or in a written document such as a living will, in an effort to avoid further, otherwise unavoidable suffering – and the agent acts directly to end the patient’s life for them (see Glover 182, Beauchamp & Childress 145, Singer 179, www.euthanasia.com/definitions.html).

In other words, using the Monty Python example from above, if the Dead Person had specifically asked the Customer and/or the Mortician on several occasions, to end his life and they finally did so, this could be seen as a case for voluntary euthanasia.

For such a request to be given serious thought by any agent the patient must be in a rational state of mind, fully informed about their condition and euthanasia, and hopelessly ill with no chance of recovery. The primary (if not sole) intentions of all other parties concerned must be to relieve the patient of their intolerable suffering by hastening their death in a dignified manner.

Although euthanasia remains illegal in the United Kingdom, Sweden and most other parts of the globe, voluntary euthanasia (Assisted Suicide – discussed later – in particular) has been subject to positive legislation in Belgium, Switzerland and most recently Columbia. It has also been tolerated in the Netherlands but contrary to popular opinion, euthanasia has never been legalised.
Under the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act (which came into effect on 1 April 2002), Dutch doctors (and only doctors) who engage in euthanasia are exempt from prosecution if they follow, and can prove that they have followed, certain strict guidelines. (The situation in The Netherlands will be discussed further in Part 4. Source: Leaflet - The Termination of Life on Request and Assisted Suicide (Review Procedures) Act – Euthanasia, Ministerie van Volksgezondheid, Welzijn en Sport – NL).

Assisted suicide: As explained earlier – intentionally providing a patient with the information, guidance, and/or means for that patient to take their own life with the intention that what is provided will be used for this purpose (see also Beauchamp & Childress 144, Glover 183, www.euthanasia.com/definitions.html). The patient is then free to kill themselves – thereby releasing the agent from any suspicion of actual murder. However, although it is still illegal (in the United Kingdom) to assist a suicide bid (as mentioned earlier), a debate still rages as to whether it is morally acceptable to provide any assistance to the patient when it is known that this help will result in the patient’s death. A controversial aspect to assisted suicide is "physician assisted suicide" (PAS), where it is a doctor who helps the patient to kill themselves. I will discuss this issue further in Part 4 of this thesis. Assisted suicide can also be regarded as a form of active euthanasia.

There are two different ways in which the act of euthanasia can be performed:-

Active Euthanasia: Intentionally causing a person's death by performing an action such as by giving a lethal injection or depriving the patient of oxygen (e.g. suffocation with a pillow). By engaging in active euthanasia, the agent is personally and directly causing the patient’s death. (listed as Euthanasia By Action - www.euthanasia.com/definitions.html)

Passive Euthanasia: Intentionally causing death by either withdrawing treatment (e.g. switching off breathing apparatus) or by withholding treatment, that is not providing the necessary and ordinary (usual and customary) life sustaining care, treatment, food and water. (listed as Euthanasia By Omission - www.euthanasia.com/definitions.html ) Both of these actions will leave the patient to die at their own pace, without interference.

It is fair to say that passive euthanasia does not actually go against the law, even in non-euthanizing countries (‘life extending – non life enhancing treatment’ such as life support machines are withdrawn or withheld all the time if they are thought not to be of any benefit to
the patient), but it is avoided as much as possible, and is seen as a last resort. It is preferred (in some circles) to active euthanasia as no-one can be accused of directly killing the patient because the patient would have died anyway due to whatever disease or trauma they have suffered. This way, the patient is not kept forcefully alive for a few stolen moments of agonising pain, and they can leave the mortal world whenever their body tells them that they are ready. However, others prefer Active euthanasia, because this would involve less pain for the patient.

There is another way of bringing about the early death of a patient, that is not strictly speaking euthanasia, and that is to use the Principle of Double Effect (as mentioned by Singer 209-10 and Glover 198-9). This is where the physician administers an extremely high dose of pain relief in order to ease the suffering of the patient, even though it is obvious that such a high dose of whatever drug is being administered will be lethal to the patient.

Put it this way - If the patient uses morphine (a drug commonly used for pain relief) over a long period, their tolerance increases and higher doses of morphine are needed to control their pain. If the underlying cause of the pain remains untreated (which is most often the case in the type of patient I am discussing in this thesis) there comes a time when the dose of morphine needed is too much for the patient’s body to handle. An overdose of morphine usually results in limp muscles, fluid in the lungs leading to breathing difficulty, lowered blood pressure, slow pulse rate and drowsiness leading to coma and death (morphine overdose symptoms listed at: www.drug-overdose.com/morphine.htm). With the Principle of Double Effect, the physician must decide whether or not to give that high a dose of morphine to the patient, whilst knowing what will happen if that dose is administered.

I do not think that this scenario can be strictly defined as euthanasia, because even though the physician knows that the patient will die if given the treatment, the primary motivation for the physician is to ease the pain that the patient is suffering. The fact that the patient will die as a result of the treatment is more of an unfortunate side effect than the primary goal.
When assessing any case that purports to be euthanasia, it is vital to look at the motivation behind the agent’s actions (by motivation, I mean what makes the agent behave in the way that they do – feelings, experiences, outside factors etc.). As is shown in my example of involuntary euthanasia, it is very easy to disguise a murder as euthanasia (the same is possible with the other types of euthanasia). The fact that the patient had asked for help to die, or whether the patient’s family and physicians had made a clear case for any of the above types of euthanasia, bear no moral standing whatsoever unless the agent’s motivation behind the killing is primarily (if not solely) to ease the patient’s suffering. If any other factors are cited, then the death cannot be said to be as a result of euthanasia.

It must also be made absolutely clear that a death cannot be claimed to be as a result of euthanasia unless it was the intention of the agent to hasten that patient’s death through their action (or lack of action as the case may be) in an effort to cease that patient’s suffering (by intention, I mean what the agent was trying to achieve when they behaved the way that they did – e.g. within the realms of the Principle of Double Effect, the agent’s intention is to relieve the patient’s suffering, not to cause the patient’s death). Thus, some medical actions, such as passing up on treatments that would have little (if any) benefit for the patient or withdrawing treatment that is just not working, that are often mistakenly called "passive euthanasia" are not euthanasia at all, as there is no intention of killing the patient. Situations as these are seen as good medical practice and are allowed by law when they are properly carried out.

**In short** – a death can only be claimed as euthanasia if:—

a) the intention of the agent is to deliberately hasten the patient’s death

b) the primary (if not sole) motivation behind the agent’s actions is to stop the patient’s suffering

**In addition**: This thesis only deals with patients who directly ask for help to die – making only voluntary euthanasia and assisted suicide relevant to thesis. For cases to count as either voluntary euthanasia or assisted suicide – consent (either directly or via a living will) must be given by the patient.
Chapter 2. Why would someone choose death over living?

“Do you remember once asking me why I wanted to end my life? I wasn’t able to answer then but I hope that this will explain.

You didn’t know me before this evil curse took over my body. I was a big, strong man, not just physically, but mentally too. I had worked out what my purpose was in life a long time ago - I was born to be a journalist. I loved life, loved to travel, loved to meet people, loved the strength, power and presence that I had and I loved the way I could make grown men, those trumped-up idiots who thought they had power over the little people, weep like babies with just a few words.

Now look at me. I can’t do the things that made me smile anymore. I can’t walk alone in the fresh air anymore. Hell, I can’t walk anymore! I can’t cook, drive or change the TV channel. I can’t even speak. I can barely use my fingers to type this letter. I know that there are other ways of communicating, but without my voice and mobility, I cannot live the life nor do the job that I love. There is no quality to my life anymore – I don’t live – I just exist. I am useless. More than useless in fact – I am nothing.

I lie on my bed, wasting away, wishing that it would just stop… I’m being spoon-fed, washed, dressed, strapped into a glorified baby buggy and spoken to like an imbecile – It feels like the last fifty years have meant nothing. I haven’t even got the strength to kill myself – I have to get someone else to do even that for me!! This is my life and it’s f***ing humiliating!

I want to die before I am totally stripped of my dignity. I don’t want to suffer anymore. If I die now, there is still a chance that people will remember the old me, the fighter, the hard-bitten hack who tried to make a difference in this world - not the wretched, dependant cripple that I have become.

People live on in memories.”

(Extract from a letter written in 1999 by a patient who died naturally a month later from complications resulting from Multiple Sclerosis)

“Before I got married, I was an air hostess. I would fly around the world, partying wildly and generally living a wonderful, glamorous life. Even after I got married, I would still travel to exotic locations, still being glamorous and living the high life – although it wasn’t the high life to me, it was my life. I was beautiful – with long golden blonde hair and a petite figure which I carried well. I know that you will think me vain, but I was really something back then and I couldn’t care less what people thought of me.

Then I was diagnosed with Motor Neuron Disease – my death sentence. Slowly, the disease has not only robbed me of my mobility, it has also taken my looks, my confidence and my life. I know that looks and carriage mean very little but I never was, nor ever will be, the kind of person to win a Nobel Prize. These things mattered to me. Now I can’t even look after myself. My husband (who thankfully didn’t run off when my health deteriorated – I was so worried that he would leave me) has to feed, wash, cut and do my hair and make up, and dress me – although I am very thankful, he has no sense of female style!

Because of my condition, my husband is also my full time carer, and as such we have a very limited income, so we can’t afford luxuries like haircuts, spas or holidays – the things that make life worth living. From being a jet-setting glamourpuss – I now look and feel more like a scarecrow! This is not me! This is not my life, but because of what other people think, I am still forced to live it. I don’t want to live, and my close friends and family don’t want to see me suffer anymore – but no-one can do anything about it for fear of being charged with my murder.

Me living for a few weeks longer is not going to make a blind bit of difference to anyone, but an early death will end my suffering and will allow my loved ones to get on with their own lives. If I could, I would commit suicide, but because I need help to die, people think that they have a right to interfere and put me through more torture.

Without my looks and mobility, my confidence has taken a nose-dive and my dignity has been badly compromised. I don’t feel like a woman anymore - and I don’t want to go on living.”

(Extract from a letter written in 2003 by a patient who died naturally six weeks later from complications resulting from Motor Neuron Disease)
I have included these letters in my thesis because the question as to why someone would choose death over life is a really difficult one to answer if one is not in a similar position to the patient. If given the choice between life and death, most of us would choose life – after all, humans are busy creatures and we all have numerous tasks to accomplish before we eventually go and meet our Maker. But (as is clearly demonstrated by the extracts) the chronically sick, terminally ill or severely physically disabled patient such as those who are being discussed in this thesis, are not in the same position as the rest of us.

At the heart of the euthanasia debate are widely differing and conflicting opinions concerning the value of existence and the meaning of life itself, and whether we, as human beings, have the right to decide the issue of life versus death for ourselves rather than leaving it up to time, fate or the Almighty.

Perhaps the question ought to be ‘What makes people want to live?’ Again, this is a difficult question to answer because ‘life’ means different things to each and every one of us. Whilst we are physically fit and able, we have the ability to achieve whatever we want to – or to use the famous quote from Bob Dylan, “A man is a success if he gets up in the morning and gets to bed at night, and in between he does what he wants to do.”

(www.brainyquote.com/quotes/quotes/b/bobdylan122816.html)

However, the type of patient that we are discussing is more often than not, unable to do the things that they may want to due to their handicap. Their quality of life is often severely compromised by a myriad of physical conditions which may include incontinence, nausea, vomiting, breathlessness, paralysis and difficulty in swallowing – not to mention the psychological problems that often accompany such devastating diagnoses - depression, fear of loss of control or of dignity, feeling a burden, or (like the patients at the start of this chapter) dislike of being dependent.

Having to live like a ‘wretched, dependant cripple’ is no-one’s idea of a good life (there are some who would not even call it a life). If the patient can’t do the things that they want to do in between getting up and going to bed, then (if we follow Dylan’s reasoning) that person is not a success – they are a failure. No-body likes being a failure.
It is hardly surprising then that given a choice between living a failed, miserable, agonising life (or what amounts to it according to the patient) or dying before reaching that point (thereby avoiding total loss of control and dignity and risking failure in life) – some people would choose death over living.

5. What is dignity?

Euthanasia is often described as ‘death with dignity’, and the two letters previously cited both mention a wish to die before being stripped of their dignity. But what exactly is dignity - and why is it so important to the patient?

[Dignity is] The value that a human being has simply by existing, not because of any property or action of an individual
(www.bbc.co.uk/religion/ethics/euthanasia/glossary.shtml)

To be fair, this definition does not really go far enough to explain exactly what dignity is (even Beauchamp & Childress 137, admit that the term ‘dignity’ is vague) – but it is difficult to define because dignity is a sensation which is felt – in very different ways – by everyone. For example, in the first letter, the MS patient describes his dignity in terms of his status as a journalist and his physical and mental strength. He feels stripped of his dignity because he “…is being spoon-fed, washed, dressed, strapped into a glorified baby buggy and spoken to like an imbecile…” which is not how a strong, healthy man of his status should be treated.

There is a different interpretation of dignity from the author of the second letter. Here, the MND patient describes her dignity in terms of her looks, confidence, carriage and femininity. She feels that her dignity has been badly compromised by her illness because she feels less like a glamorous woman and more like a scarecrow.

The idea of dignity originated from the widely held religious belief that, because humans are created in the image of God, we are essentially ‘God’s representatives on Earth’ and therefore we are born with certain rights over and above our fellow creatures (such as the freedom to think and the freedom to act upon those thoughts) all of which enable us to praise God and improve the quality of our own lives and those around us. By denying the patient their God-given right to this kind of freedom, we are effectively ‘enslaving’ the patient (the enslavement being done through the patient’s disability), which in turn, demeans them as a person by taking away their sense of value and dignity.
Arguing the case that dignity is a gift from the Almighty, Saint Augustine said that “A Christian is always responsible for his or her decisions. It is unacceptable to claim that one must follow all laws, since certain laws are more reprehensible if they fail to respect the dignity and rights of all men and women.” (Ready Reference Ethics, V1, p227-8, C2) The same could be said whatever one’s religion.

Later on, Immanuel Kant suggested that dignity meant the moral value of an object, subject or action and that all objects, subjects and actions either have a level of price or a level of dignity.

“In short, Kant claims that when things have a price, this entails that there is something for which it would be morally acceptable to trade for them. By contrast, a human being [who is not a “thing”] has dignity and there is nothing else – neither power, nor pleasure, nor good consequences for all of society – for which it is morally acceptable to exchange any human being.” (Encyclopaedia of Ethics (2nd ed.) v 1, p 405, c 2)

This reasoning led Kant to the following conclusion – If nothing can be bartered for dignity, then one person’s dignity must be equal to everyone else’s dignity. Or to put it more simply – everyone is equal, regardless of any property, status or action.

It therefore follows that, “If someone is really acting ethically, we assume that they are acting ‘on principle’; we do not expect to find that they are making up special rules for themselves. And if they pass judgement on others we do not expect them to be doing so on the basis of rules that do not also apply to themselves.” (Horner & Westacott, 139)

Or to quote The Bible "Do unto others as you would have others do unto you" (Matthew, chapter 7, verse 12 – various versions of this quote also appear in the texts of other religions). This belief that everyone is morally equal (according to Kant) forms the basis for all other moral laws, thoughts and actions. (Incidentally, it is also the best way of describing Kant’s most famous piece of thought – The Categorical Imperative – which will be further examined in Part 3)

Unfortunately, many people such as our letter-authors are often treated as though they were “things” because they need the help of others to do even the simplest of tasks. They do not have a say over which TV channel to watch, because they cannot physically change the channel – and (probably without meaning to) it is all too easy for other people to impose their
thoughts, views, beliefs or choice of TV channel onto the hapless patient, in the belief that their choice is better for the patient than what the patient themselves wanted. This leaves the patient in a position where everyone who is supposed to be caring for them is ignoring their views. Kant may say that the patient has been forced to trade their dignity for the help of third parties.

2. Why is dignity so important to the patient?

Even though dignity means different things to different people, we are all morally equal and therefore, we all deserve of the kind of respect that we would give to others if we were in their position.

Well, that is what is supposed to happen but unfortunately, this is not a perfect world where we all respect each other regardless of any property, status or action. Our standing in society and the ways in which we contribute to society play particularly big roles in defining us as individuals. However, those who are chronically sick, terminally ill or severely physically disabled feel, more often than not, that they are unable to contribute to society to the extent, or in the way, that they want. And if the patient feels that they cannot contribute to society, then their status in the social hierarchy is lowered, sometimes to the extent where they feel that they are useless and not worthy of the esteem, respect or honour that is awarded to them by the very same society (referring back to the two definitions of dignity at the start of this chapter).

Because of all these negative feelings, patients can feel that they have very little left in terms of respect and dignity and often believe (rightly or not) that their dignity is being compromised because people are not treating them in the manner which they think that they deserve and are being disrespected as human beings. And yes, despite their condition, these patients are still human beings – they have not evolved into some other sub-human species (and therefore still worthy of the Divine gift of dignity).

It is understandable then, that the patient might want to hold on to whatever is left of their dignity, in order to preserve some vestige of the person that they were before they were stricken with their affliction.
3. **Is there such a thing as death with dignity?**

Dignity is not just about how the patient feels within themselves – it also concerns how others see them. From my own experience, watching a person dying is far from a pleasant experience and many people would consider conditions such as those mentioned below highly undignified:

- Coolness around body extremities
- Vision-like Experiences
- Changes in breathing - shallow or irregular breaths
- Confusion and ‘withdrawal from the world’
- Patchy discoloration, or blueing, of the skin
- Dilated, sunken or ‘glassy’ eyes
- Sleepiness or feelings of weakness and lethargy
- Loss of muscle function (going limp)
- Evacuation of solids, fluids and gases from the body
- Loss of bodily senses and co-ordination
- The body going through a general process of shutting down

(sources:- [http://endoflifecare.tripod.com/Caregiving/id89.html](http://endoflifecare.tripod.com/Caregiving/id89.html), [www.hospicenet.org/html/preparing_for.html](http://www.hospicenet.org/html/preparing_for.html), and [www.kansascityhospice.org/content/pubs/death.htm#4](http://www.kansascityhospice.org/content/pubs/death.htm#4)

As it is almost impossible to interview anyone who has been through the dying process themselves (on account that they would be dead), we are unable to even guess how they feel about dying process or whether they themselves considered it to be dignified experience.

However undignified physical death may be, the moment of death could be seen as a good thing mentally (especially if the patient is not aware of just how bad they are in the final moments). There have been numerous reports of patients entering a serene moment of calm just before dying. This would be a fair indication that the patient had been at peace before their meeting with the Almighty.

So to answer the question, death itself is not physically dignified, but it can be seen as mentally dignified. Therefore a death with dignity is a death in which the patient believes that they retain the elements of dignity which he or she values at the moment of passing.
**Pain and Suffering**

Apart from their loss of dignity, there are two types of suffering that patients considering euthanasia experience – physical pain and mental suffering. Imagine that you could not do the job you love. Imagine that you could not walk in the fresh air anymore. Imagine that you could not cook, drive, travel or change the TV channel. Imagine that you could not write or even speak. Imagine looking and feeling like a cross between a hedgehog and a map of the London Underground because of all the tubes inserted into your body and all the needles piercing your skin. The two people whom I quoted at the start of this chapter needed no imagination. That is how they had to live. And they were depressed, miserable and enduring constant agony because of it.

Advanced medical techniques may be saving many lives and pro-longing others to way beyond the range of normal human endurance, but this is leaving many patients hospitalised, house-bound or even bed-ridden for weeks, months, even years. These machines can show signs of life even when the essence of the patient has already left the body. Their body may still be functioning on a rudimentary level but what made that patient ‘alive’ has gone.

What is the point of having a life if you cannot enjoy yourself once in a while? Numerous studies have shown that depression is a major contributing factor in cases where the patient’s health is deteriorating. Forcibly keeping a depressed patient alive, against their will is not going to do anyone any good, especially the patient, who’s right to the existence of their making and choosing is being denied to them (non-existence is a form of existence).

Some patients die quickly, others die peacefully in their sleep (or unconscious), but some people are forced to die slowly and painfully in hospitals, wired to computers and all manner of (at times invasive) machinery, stupefied by drugs, tended to by strangers, using resources that could save the life of another patient who wants to live - all for the sake of a few excruciating, wretched extra months of existence.

If we really cared about the patient, we would want no harm to come to them. An agonising, drawn-out death is both physically and psychologically harmful to the patient whereas a peaceful death is not harmful – especially if that is what the patient wants and there is no other way of ending their suffering permanently.
Chapter 3. What are the established philosophical views on Euthanasia?

Does the end of the patient’s suffering ever justify the bringing about the early, forced death of the patient? When thinking about ending their lives, the patient knows that there can only be one end – death. What is in question is the means by which they achieve that end. Do they die early and limit the suffering, or do they let nature take its course? In this section, I will explain how the patient can use two different methods of ethical decision-making - deontological and utilitarianism – to make their own choice about euthanasia.

1. Peter Singer

The most basic rule in Utilitarianism entails that the person must in some way, bring about the greatest good for the greatest number of people (or ‘try to please all the people all of the time’). The person has a moral obligation to go with the action that would bring the best consequences for the most number of people (this is why utilitarianism is often called consequentialism – with the consequence being the greatest happiness).

These good consequences depend not only on the quantity of pleasure but also on the quality of the experiences which go into producing the pleasure and how these pleasures and experiences shape the individual and those around them.

Utilitarianism was pioneered by the English philosopher Jeremy Bentham, who believed that morality should equal an effort to promote as much happiness as possible in the world whilst not necessarily adhering to any religious, legal or social commandments, rules or laws which the either the person or the majority find restrictive or just plain wrong. (Bentham may have possibly got the idea from Saint Augustine – see Part 2)

Another English philosopher, John Stuart Mill, expounded on Bentham’s ideas and suggested that morality be considered as the effort to minimise (if not eliminate) pain as far as possible or/and to maximise life’s choices and pleasures as far as possible.

But when it comes to euthanasia, the real big-hitter in the utilitarian quarter is the highly controversial Australian philosopher Peter Singer (who now teaches under armed guard at Princeton University in the USA). Singer is what is termed a preference utilitarian – i.e. one who is concerned not so much with pain and pleasure as with allowing people to satisfy as many of their preferences as possible.
Of course, there is nearly always an element of pain and indignity in illness, but as I have explained earlier, dignity means different things to different people – the same can be said of pain. It is a fact that every body is different and it follows that every body has different preferences and differing pain thresholds. It would be considered unfair (and downright cruel) by most people to force someone with a low pain threshold (be that pain physical or psychological) to endure a level of pain unacceptable to them just because people with higher pain thresholds are able to endure that level of pain. This is especially so when there is a viable solution (i.e. euthanasia) that would put an end to the patient’s suffering for good.

‘Just as preference utilitarianism must count a desire to go on living as a reason against killing, so it must count a desire to die as a reason for killing’ (Singer 195). Therefore, if a patient who can and constantly does express a wish to be euthanized then (provided that they are in full mental health and free from coercion) the patient’s wish to die before the onset of indignation, more serious symptoms or to spare loved ones continued anguish should be honoured. As mentioned in Chapter 1, the withdrawal or withholding of ‘life extending – non life enhancing treatment’ such as life support machines, from patients who have absolutely no hope of recovery, is not an unusual occurrence within the medical profession - meaning that under certain circumstances; passive euthanasia is not so much of a problem.

With this in mind, Singer begs the question that, if it is OK to let the patient to die slowly and often in considerable pain (passively by the non-use of life extending – non life enhancing futile treatment), why is the patient’s request and consent to euthanasia not an adequate defence against a murder charge (Singer 193) if the only way to actively limit the patient’s distress is by hastening their death – after all, the same consequence occurs in both scenarios in that the patient ends up dead anyway? In an effort to alleviate the patient’s distress (and for no other reason) Singer contends that under certain circumstances, it would be moral to kill consenting patients.

Singer (196) does concede that allowing euthanasia to take place brings along a whole gamut of problems – the obvious one being ‘How can we stop people killing patients for their own personal gain and passing their deaths off as euthanasia?’ Even if the patient has given their express consent to be killed, how can we be absolutely certain that their decision really was the result of the patient acting from their own free will and not as a result of coercion by other interested parties? And is the patient in a fit enough state mentally to be able to make such a momentous decision in the first place?
Our certainty of each case must be as rock solid as possible before any act is carried out because it is not as if we can bring the patient back from the dead if it later becomes clear that we have inadvertently made the wrong decision!

As a possible solution, Singer (196) cites the following examples of rules, which, if used as a basis for those engaging in euthanasia, will allow patients who genuinely want to be euthanized the freedom to make that choice whilst at the same time protecting patients who wish to stay alive from being killed by unscrupulous interested parties:-

- [That euthanasia] is carried out by a physician.
- The patient has explicitly requested euthanasia in a manner that leaves no doubt of the patient’s desire to die (either directly or via a living will)
- The patient’s decision is well-informed, free and durable.
- The patient has an irreversible condition causing protracted physical or mental suffering that the patient finds unbearable.
- There is no reasonable alternative (reasonable from the patient’s point of view) to alleviate the patient’s suffering.
- The doctor has consulted another independent professional who agrees with his or her judgement.

However, utilitarianism is not just about finding the best way to please the individual; it is also about pleasing as many people as possible. Unfortunately, when a person becomes ill, it is not just that person who suffers. Illness affects everyone from the friends and family of the patient, through to the healthcare providers. Even other patients and (in such cases as epidemical diseases like SARS - which has been bothering the entire planet since 2003) society as a whole can be affected by just one sick individual.

Singer himself was put into this position when his mother was diagnosed with a terminal illness. The view of euthanasia held by his mother (who had previously been a physician) remains unknown, but if she had decided on euthanasia and the decision to carry out that request had fallen on her son, Singer would have euthanized her. However, the rest of the family (including his sister) disagreed with him. A decision to euthanize may have pleased his mother, but it would have affected the rest of the family negatively – and because utilitarian law dictates that the agent must adhere to the preference of the greater number, Singer was forced to follow the majority and allow his mother to die slowly but naturally.
There is one other argument that I would like to throw into the ring which I believe Singer would approve of - an unavoidable fact that may seem to be cruel and irrelevant when discussing patients who are chronically sick, terminally ill or severely physically disabled in some way is that euthanizing consenting patients would save money, time and resources for those who want to stay alive. Singer agrees with Elisabeth Kübler Ross when she claims that ‘Given personal attention and the right medication...people come to accept their deaths and die peacefully without pain’ (Singer 197) - however he points out that ‘Unfortunately, only a minority of dying patients now receive this kind of care’ (Singer 198). In keeping with utilitarian thinking of the greatest good for the greatest number, it follows that this kind of resource sharing makes much more sense than using those same resources to force unwilling patients to stay alive whilst denying willing patients the chance to carry on living.

Even with rules such as Singer’s entombed in law, there is no guarantee that everyone will follow them – or not try to twist those rules to their own advantage. It is understandable that some patients may fear being euthanized against their will or coerced into giving their consent to the procedure, but as Singer says, ‘Against a very small number of unnecessary deaths that might occur if euthanasia is legalised we must place the very large amount of pain and distress that will be suffered if euthanasia is not legalised.’ (Singer, 197)

In conclusion – Utilitarianism (under Peter Singer) maybe in favour of euthanasia (providing that this decision is made freely and clearly) but the views of others may outweigh that of the patient.

2. Jonathon Glover

In his book ‘Causing Death and Saving Lives’, the English ethicist Jonathon Glover points out the rather obvious fact that ‘When unassisted suicide is possible, there is no need [for the patient] to ask for help.’ (Glover, 183)

Life is a precious thing but, in accordance with to Glover’s train of thought, ‘It is more often desirable to encourage the person considering suicide to have second thoughts than it is to help him kill himself...But despite the case for a general social policy of discouragement, it may in a particular instance be right to provide the help needed for suicide’ (Glover 183)
Further down the page, Glover (183-4) believes that if there is a real possibility that the patient’s condition will improve, assistance in dying should not be provided because the patient will do it themselves (that is commit suicide), unaided, at a later date – and there will be no doubt as to what the patient really wanted. However, if the patient’s request is subject to certain conditions (i.e. that the decision has been seriously and clearly thought through, the request is not the result of a temporary emotional state; the patient’s life appears to an outward observer as not worth living and the state is permanent and highly unlikely to improve), the situation (according to Glover) is different. To not help the patient in this state is a violation of their right to decide what to do with their life.

Having said that, only the minimum amount of help is acceptable – ‘If assisted suicide is possible, it is always preferred to voluntary euthanasia. If we know that a person himself knowingly took a lethal pill, there is by comparison with euthanasia little ambiguity about the nature of his decision’ (Glover 184). This (as with Singer’s rules earlier) affords some protection to the agent.

One side effect cited by Glover (186-7) is that by allowing euthanasia, some patients, who would rather not be euthanized, may feel obliged to ask for it in order to spare their loved ones from further distress or to stop being a burden on others. Some patients may even be coerced into asking for euthanasia even if the patient himself is against the idea.

Another side effect that Glover points out (187) is that research into either easing or curing the ailment that is making the patient want to die or research into improving palliative care for people like the patient, may be held back in favour of the easier alternative of killing the patient. (In his defence, Glover does state that ‘A hospital with a voluntary euthanasia policy could still have a staff that did all they could they could to make euthanasia request unnecessary’ (Glover 187))

Neither of these problems poses any threat as long as there is unequivocal proof that the patient’s request for euthanasia is purely voluntary and thoroughly thought-out. In addition, the side effects mentioned above must pale in comparison to the patient’s current, dire state

In concluding, Glover believes that ‘...voluntary euthanasia is justified in cases where we know that the person would commit suicide if he could, and where we believe that the conditions that would make it right to allow or assist in a suicide are satisfied.’ (Glover, 185)
Immanuel Kant

Like Utilitarianism, Deontology (also known as obligation theory) follows certain rules – one of the main ones being Immanuel Kant’s Categorical Imperative ("Do unto others as you would have others do unto you") which I have previously mentioned in connection with dignity in Chapter 2. This means that we have an unconditional obligation to act in a way that we expect that others would act if the situation were reversed – regardless of our own wants and feelings.

The Catagorical Imperative can be broken down into five formulations, of which the following three are relevant to this discussion:-

- The first formulation (Formula of Universal Law) says: "Act only in accordance with that maxim through which you can at the same time will that it become a universal law." [act in the way that you think everyone should act]

- The second formulation (Formula of Humanity) says: "Act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means." [don’t use people to get your own way]

- The third formulation (Formula of Autonomy) is a synthesis of the first two. It says that we should so act that we may think of ourselves as legislating universal laws through our maxims. We may think of ourselves as such autonomous legislators only insofar as we follow our own laws. [follow how you think the universal law means you to act]


There have been other philosophers (Fichte, Hegel, Schelling and Schopenhauer to name a few) whose works have followed in the same vein as Kant, but as I have already mentioned his work earlier in this thesis (plus the fact that even for an 18th century philosopher, he is still seen as one of the greatest philosophers of all time ("Kant, Immanuel." Encyclopædia Britannica. 2005. Encyclopædia Britannica Online), with his thoughts still influencing this modern era) I will stick with the master of deontological thought – Kant himself.
Sometime during the 18th century (after much thought), Kant came to the conclusion that there are some binding universal moral laws (which are termed *a priori* concepts) that exist prior to any thoughts, experiences or sensory-based empirical evidence that we get to know through reasoned thought involving various categories of understanding – one of which (according to Stevenson 164) is causality (the law of cause and effect). It does not matter what we do or how we think, these laws come into play to shape our final thought processes and our actions (or at least they should if we are truly moral people!)

The law of causality leads in turn to The Categorical Imperative, which, by considering how an action might affect ones self if the tables were reversed, enables us to act in a better way (a more moral way) towards others. (You may notice a similarity between this and Kant’s explanation of dignity in Chapter Two of this thesis – the same ‘no special rules’ rule also applies here). It is often said that the Categorical Imperative forms the basis of human morality. It is as though by virtue of being a rational human, you have entered into a tacit agreement not to, say, harm anyone else. Because every other rational human has also entered into the same agreement, you can go about your daily business without fear of certain attack. This agreement is often reinforced during our childhood (“Don’t do that! You wouldn’t like it if someone did that to you!”) Therefore, because there are some actions that we would never wish upon ourselves (such as being killed) we are morally obliged not to do the same to others, meaning (amongst other things) killing people is always wrong! Kant makes the point that morality and ethics must be universal in its application to everyone (because everyone has tacitly agreed to it by virtue of being born human), so if one person can’t kill another person at any time, then no person can kill any person throughout time.

Deontology goes slightly further than that by saying that there are some actions which are right or wrong in themselves purely because of the type of action they are, even if that action will result in the best consequences. These actions do not even need explaining why they are wrong, they just are morally abhorrent. So, unlike utilitarian consequentialist thinking, it is not just the consequence of the action that matters, how that consequence is reached also matters.

Euthanasia falls into this category. Because killing people is not just wrong but morally abhorrent, it follows that euthanasia is also wrong, whatever the circumstances. Deontologists maintain that it does not matter how or even whether a patient can contribute to society, because human beings have the ability to ration and to use reason to consider their own
greatest welfare, humans are to be valued for their own sakes and not simply used as a means to an end. Even though every person is different and has a unique worth, we as human beings are all still equal to one another, regardless of any property, status or action.

Kant believed that, because human beings are such unique creatures, our mere individual existence affects society. Suicide (and by extension euthanasia) was the destruction of a uniquely valuable human self for the sake of some mere wish to relieve pain or misery. Any notions of dignity that are attached to any property, status or action of the patient plays no part in the deontological life or death equation because all notions of property, status or action are disregarded in favour of the patient’s right to life. What matters is that the patient is a fellow human being with their own self-worth (which breeds a form of self-dignity), and to take such a basic good as life away from the incapacitated patient is to devalue and disrespect the worth of the patient.

In deontology, we have a moral duty to look after and not to let any harm come to the incapacitated patient (the patient cannot look after nor defend themselves so we must do it for them) even if our natural inclination is to euthanize them and put the patient out of their misery, because killing them would be harming them. This sense of duty is such a strong force in deontology that it is said that Kant once told someone that even when a man who wants to kill your friend asks you where your friend is you shouldn't lie about their whereabouts – because lying is always wrong!

This sense of moral duty is not just confined to carers. When the life of a human becomes threatened, the natural inclination is to fight the condition in an effort to live longer. Kant believed that adherence to morality superseded adherence to autonomy. Kant also believed that despite the autonomous nature of humanity, each human (whether ill or not) recognises a moral 'ought' in them (an inner conscious or guiding spirit if you want), which in turn leads to a duty to preserve her or his life – meaning that the moral ‘ought’ goes against which goes against wanting euthanasia (The patient ought to want to live and not to want euthanasia).

A patient wanting euthanasia in preference to a longer life may think that they are acting in a rational manner but in reality they are thinking irrationally, and because we have a duty to protect those who are chronically sick, terminally ill or severely physically disabled, we must disregard their request as irrational behaviour. Of course they are going to die, but we are all going to die at some point!
Just because the patient wants to escape their pain and suffering is not a good enough reason to interfere with the natural order and help nature take its course – nature can find her own way!

Deontology advocates taking the action which fulfils and respects human nature, which normally entails us to fight in favour of life, regardless of our feelings or those of the patient. However, it is by no means true to say that deontology is wholly against euthanasia. In fact, there are ways to use deontological argument to argue for it.

One of the slogans that anti-euthanasia supporters frequently use (also used in deontological argument) is that everyone has a right to life. That is true until someone waives their right to life by repeatedly asking to be killed. If that happens, the duty not to kill the patient is voided. In fact because people have a right to consider and follow the path to their own greatest welfare, when someone requests voluntary euthanasia, not only are they waiving their right to life; they are also asserting their right to die (this they believe is their greatest welfare).

As I said before, deontology protects the incapacitated patient by using our sense of duty not to kill people because people have a right to life. If (by waiving it) the patient has no right to life then here is no duty not to kill.

As for the patient – waiving the right to life means that they no longer have a duty to live – ergo they can do what they like with their life, including doing away with it altogether.

The Russian/American Philosopher Ayn Rand points out another anomaly in that if, under the natural order that Kant is so fond of, we have a duty to stay alive but under the same natural order, we will all die anyway, do we not have a duty to die? If this is so, would that not render Kant’s argument against inciting an early death entirely absurd? (http://en.wikipedia.org/wiki/Categorical_imperative)

One other peculiarity that I wish to draw attention to before I finish with Kant is his reasoning why human beings are so unique amongst the other creatures in this world is because of human’s capacity to use thought and reason to improve themselves and their environment. Deciding that life is not worth living (especially if the patient has thought through and repeated their request for euthanasia several times without any outside interference) demonstrates quite clearly that the patient’s capacity to use thought and reason to improve themselves and their surroundings is working – their environment would improve if they died.
If an objective outsider analyses the situation without emotion (emotion does not figure in deontology) it would be startlingly clear that the patient’s situation would improve – they would not suffer anymore – and their environment would benefit from their death – carers can go onto other duties and there would be more resources for other patients.

4. Beauchamp and Childress

In the same manner as Kant, the American ethicists Tom Beauchamp and James Childress believe that actions can be judged to be right or wrong on the basis of whether or not the said action conforms to a set of rules or principles. In the fifth edition of their book ‘Principles of Biomedical Ethics’ (2001) Beauchamp and Childress put forward the four following primary moral principle clusters of biomedical ethics:

![Fig 1. Table illustrating the four primary moral principle clusters of biomedical ethics](image)

<table>
<thead>
<tr>
<th>Moral Principal Cluster</th>
<th>Meaning</th>
<th>Relevant Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESPECTING AUTONOMY</td>
<td>A norm of respecting the decision-making capacities of autonomous persons</td>
<td>Does my action interfere with the patient’s right to decide for them self?</td>
</tr>
<tr>
<td>NON-MALIFICENCE</td>
<td>A norm of avoiding the causation of harm</td>
<td>Who may be harmed by my action?</td>
</tr>
<tr>
<td>BENEFICENCE</td>
<td>A group of norms for providing benefits and balancing benefits against risks and costs</td>
<td>Who benefits from my action</td>
</tr>
<tr>
<td>JUSTICE</td>
<td>A group of norms for distributing benefits, risks, and costs fairly</td>
<td>Does my proposed action treat everyone fairly?</td>
</tr>
</tbody>
</table>

Source: Beauchamp and Childress – page 12

How Beauchamp and Childress relate these moral principles relate to the question of euthanasia is thus –
Causing death by withdrawing life supporting measures (including medication, nutrition and machinery) is permissible in most medical institutions if the patient’s level of health is either not improving or being sustained at a level acceptable to the patient whilst using these measures.

Beauchamp and Childress point out the (quite frankly baffling) contradiction made between the patient’s right to refuse treatment in order to bring about their death and the same patient’s ‘non-right’ to arrange the same death via a third party employing a less painful and distressing medical method.

‘Assuming that the principles of autonomy [i.e. that the patient is compositementis – of sound mind and judgement] and non-maleficence [avoidance of harm] justify foregoing of treatment, the same form of justification might extend to physicians prescribing barbiturates or providing other forms of help requested by seriously ill patients.’

‘At the moment, medicine and law are in the awkward position of having to say to such patients, “If you were on life sustaining treatment, you would have the right to withdraw treatment and then we could let you die. But since you are not, we can only allow you to refuse nutrition and hydration or give you palliative care until you die a natural death, however painful, undignified or costly.” This seems tantamount to condemning the patient to live a life or to suffer an end to life that he or she does not want.’ (Beauchamp & Childress, 147)

Whether the patient wants to stay alive or not, the arguments that Beauchamp and Childress use suggest that euthanasia is only morally wrong when outside interference, unsanctioned by the patient, obstructs the patient’s interest. Conversely, if the patient makes a free, autonomous choice for euthanasia because they truly believe that their futile existence would benefit from an early end, then euthanasia cannot be said to be harmful – ergo killing the patient cannot be morally wrong - ‘To the contrary, not to help such persons in their dying will frustrate their plans and cause them a loss, thereby harming them. It can also bring them indignity and despair. From this perspective, causing death is not always an evil act.’

(Beauchamp & Childress, 148) In other words, forcing a patient who wants to die to live is wrong, and (using the same justification arguments) forcing a patient who wants to live to die is equally as wrong (the patients who are battling for their lives will die if life-supporting measures are being taken up unwillingly by patients who want to die).
Not only is hearing a plea for euthanasia respecting the autonomy of the patient (see Fig 1, row 1), assisting the autonomous patient in their request to bring about their death complies with the need for non-maleficence (Fig 1, row 2). Add the fact that not only will the patient benefit from euthanasia (Fig 1, row 3), but other patients will get access to the medical resources that have been forgone (plus friends and relatives will finally be able to grieve for the patient) and the fact the resulting this re-distribution of recourses is much fairer and more just for everyone (Fig 1, row 4) – and one sees that all four of the moral principle clusters proposed by Beauchamp and Childress have been fulfilled.

Beauchamp and Childress conclude by saying that ‘We can conceive of no moral grounds for restricting the liberty of a competent individual to make such a request for aid-in-dying.’ (Beauchamp & Childress, 148)

5. Religious and Cultural views (Eastern Hindu vs. Western Christian)

Both religion and culture have sets of ethical rules by which the population live – rules governing how one should live, act and die. Often, a region’s culture stems from the religious roots and the beliefs held by the population.

Other major religions are discussed in the next chapter, but for now I have chosen to concentrate on Eastern Hindu culture and Western Christian culture for two reasons – they are quite different from each other and they are both cultures that I myself have had the privilege of witnessing at first hand (having spent almost half of my life living flitting between an eastern society (Mauritius – where although many religions co-exist, Hinduism has a slight majority of followers) and two western societies (the United Kingdom and lately, Sweden – both places where Christianity is the major religion) surrounded by a family committed to caring for the sick and injured.

**Christianity** – there are many branches of Christianity (all with differing ideas about how one should live a virtuous life) but on the whole, Christians are against euthanasia because life is a gift from God and only He has the right to take it away.
Some of the beliefs in Christianity are similar to those taught in Judaism and in particular, Islam (see Part 4) in that the patient does not own their body or life, as it is God who created both - the patient is only ‘borrowing God’s property’. Some Christians, in common with some Muslims, also believe that suffering brings the patient that bit closer to God (‘Jesus suffered for our sins’), and should therefore not be interfered with. Some sections of the church (amongst them, the Roman Catholics) go even further and preach that by killing the willing patient, the agent is interfering not only with the natural process of death but with God’s will, which is not acceptable. Like Deontology, Christianity advocates taking the action which fulfils and respects (God given) natural human nature, which would normally entail us to fight in favour of life, regardless of our feelings or those of the patient. If God wants the patient to die, then He will take the patient when He is good, ready and without interference.

One issue of great concern to Christians is where the soul goes after death. According to Hick (123-4) ‘…the Judaic-Christian belief in resurrection … postulates a special divine act of re-creation. This produces a sense of utter dependence upon God in the hour of death…’

Resurrection in this case doesn’t mean being brought back from the dead as Jesus was (that was a special case according to Hick), nor does it mean being re-incarnated into a different earthly body (which is what Hindus believe happens to the soul under certain circumstances when a person dies – read further). Here resurrection means that when a person dies, their soul is brought to life (so to speak) but on a different world to our Earthly one (Heaven or Hell). Without souls, human beings revert to being dust ("Earth to earth, ashes to ashes, dust to dust" goes the Book of Common Prayer) therefore it is safe to say that it is the soul that makes the person. So where the soul ends up upon death is of great concern to Christians.

Unlike believers of Eastern religions, Christians believe that not only does the outcome of all actions get judged by God, but how these outcomes are achieved also matter. This means that God has a lot to judge the patient by – much that He alone can judge good or bad. Mortals have no way of knowing whether actions on Earth have been good enough to enter the Kingdom of Heaven, so Hick is correct in saying that Christians are dependent on God and His judgement and mercy. Add the fact that the Christian God has been known to get angry if people go against Him (The Ten Plagues of Egypt mentioned in The Bible is just one example) and one can understand why Christians can be somewhat hesitant to meet their Maker (and why euthanasia is largely undesirable within Christianity).
However, as is pointed out by *Death and Dying* (Corr, Nabe, Corr, 500) ‘Much of [Jesus’] ministry involved healing, reducing the suffering of others’. This could be interpreted that Christians have a duty to follow Christ’s example and having failed to cure the patient, at least make the patient’s transition to the side of God as comfortable and pleasant as possible. Could this not be interpreted as sanctioning euthanasia? If done incorrectly, euthanasia can make the original complaint even more painful, but if done correctly, euthanasia is a comfortable and pleasant way for the patient to make the journey to God’s side.

**Hinduism** – as with Christianity, there are many branches of Hinduism (all with differing ideas about how one should live a virtuous life) but within Hinduism, the thoughts as to whether euthanasia is acceptable are not as clear as they are within Christianity.

In general (according to Stevenson 98-9) Hindus believe in the following:-

- **Ahimsa** – the principle of non-violence and respect for all living things
- **Atman** – the idea of re-incarnation where the soul is recycled until it has reached Moksa
- **Dharma** – the divine, personal and moral laws and duties that must be followed by each person (Dharma is mainly determined by the individual’s conscience)
- **Karma** – the idea that your present actions will affect what happens to you in the future
- **Moksa** – the release from the cycle of re-incarnation into a state of complete bliss which can only be achieved with good karma

Many Hindus believe that forcibly separating the soul from the body (as is done though euthanasia) is a bad idea because it goes against the principle of Ahimsa (taking a life, even at the request of the patient, is violent because it takes away the very substance which makes the body alive and able to function). Those who go against ahimsa (including both the agent and the patient) receive bad karma.

Damaging the karma of both the patient and the agent will mean that something equally as bad will happen to them sometime in the future – or in the next life in the case of the patient – which will make it that much harder for both of them to achieve Moksa.
However the laws of Dharma allow thoughts of euthanasia to be decided by the consciences of the people concerned. To explain – using utilitarian thinking, if the patient’s conscience genuinely believes that death is preferable to their life now, and the agent’s conscience honestly believes that more happiness would be brought about by the death of the patient; the laws of Dharma can be interpreted to say that not only is it acceptable for the agent to kill the patient, but that it is also acceptable for the patient to ask for euthanasia and to die as a result.

The ahimsa principle of non-violence can itself be used to argue for euthanasia – as is pointed out in *Death and Dying* (Corr, Nabe, Corr, 500), suffering is a form of violence, and to intentionally end the patient’s suffering is to end the violence contained within the patient’s body (cast you mind back to the war analogy that I used in the Introduction to this thesis).

There is even a form of euthanasia/suicide that is permissible under certain circumstances and within certain branches of Hinduism. Prayopavesa, or fasting to death, is acceptable because it is non-violent and because death takes a while to happen, it gives the patient a chance to get their physical and spiritual affairs in order whilst preparing those around them for the patient’s death.

The intentional removal of a feeding tube or the foregoing of medication at the request of the patient (which often happens in cases of euthanasia) could easily be seen as prayopavesa because the patient is intentionally starving their body of essential nutrients (if one regards medication as nutrient to the ailing body) in order to die.

Now that we have discussed the religious background of each society, I will now explain how these religious thoughts have affected the concerns of each society over euthanasia.

**As to culture** – It is clear to see that the Christian aversion to early death has filtered though into modern western medical ethics – in that euthanasia is largely illegal (contrary to public opinion, euthanasia still remains illegal in The Netherlands – circumstances there will be discussed later in this thesis). Palliative care is much preferred in Western culture to euthanizing the ailing patient, even if that care is not doing the patient any good and they are still suffering. Christianity also encourages the support of hospices where the patient is cared for in their final hours by specialists surrounded by the kind of technology designed to prolong life as long as possible.
This is not how patients are treated in Eastern culture. *Death and Dying* (Corr, Nabe, Corr, 117) backs up my own experience in that the Eastern patient generally prefers to die at home surrounded by loved ones in a familiar surrounding.

**Fig 2.** Life expectancy in Mauritius, the United Kingdom and Sweden

<table>
<thead>
<tr>
<th>Life expectancy at birth: Mauritius</th>
<th>Life expectancy at birth: United Kingdom</th>
<th>Life expectancy at birth: Sweden</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average life exp: 72.38 years</strong></td>
<td><strong>Average life exp: 78.38 years</strong></td>
<td><strong>Average life exp: 80.4 years</strong></td>
</tr>
<tr>
<td>male: 68.4 years</td>
<td>male: 75.94 years</td>
<td>male: 78.19 years</td>
</tr>
<tr>
<td>female: 76.41 years (2005 est.)</td>
<td>female: 80.96 years (2005 est.)</td>
<td>female: 82.74 years (2005 est.)</td>
</tr>
<tr>
<td><strong>Population:</strong> 1,230,602 (2005 est.)</td>
<td><strong>Population:</strong> 60,441,457 (2005 est.)</td>
<td><strong>Population:</strong> 9,001,774 (2005 est.)</td>
</tr>
</tbody>
</table>

Maybe it is because life expectancy is significantly lower in Mauritius than in the UK (see table below) which in a country with the population the size of Mauritius means that almost everyone will have had some experience of death sooner and more often that their UK or Swedish counterparts, or perhaps it is the eastern tradition of hanging portraits of deceased relatives, garlanded with flowers, around the house, but in countries like Mauritius - death is not something which is feared as much as it is in Western countries like the United Kingdom and Sweden.

Using the law of Karma (i.e. your present actions will affect what happens to you in the future) as a starting point, because on the whole Mauritian patients prefer to be looked after by their relatives and die in their own homes or other familiar surroundings, it follows that their relatives (in particular the grown up children of the sick) have a duty to care for the patient and provide the kind of palliative care that is available in Western hospices, themselves (that is if they too want to be looked after by their children in the same manner – which most people do).

Eastern society also expects the children (or the nearest relative if there are no children) to personally care for the patient - after all the patient had cared for them when they needed it previously, so now it is payback time!
The downside of this ‘at home with the family’ type of palliative care is that Mauritian patients who go down this route have extremely limited access to life-prolonging equipment, without which the patient would most certainly die sooner anyway. Plus the temptation to end the patient’s suffering (which, as I have mentioned previously, can be sanctioned under certain circumstances for the Hindu patient) can be overwhelming when their loved ones are constantly being reminded of how much the patient is suffering.

Because Mauritius is such a mix of differing religions and cultures, all living on a small island, in relative peace side-by-side, it is not seen as ‘the done thing’ to interfere with what is essentially a cultural matter. Although technically speaking, euthanasia is illegal in Mauritius, it is still carried out ‘behind closed doors’, and as long as everything is – and can be proved to be - above board, the whole subject of euthanasia and assisted suicide remains a private issue between the patient and their carer.

This is not the case in either Sweden or the United Kingdom. In Sweden, "Actively assisting a death" is an offence liable to up to five years in prison whereas in the not-quite-so liberal United Kingdom, the same offence can result in a prison sentence of up to 14 years (www.discardedslies.com/entries/2005/03/mercy_killings.php – backs up what I already knew).

The same Kantian maxim used previously is used to argue that the patient in the United Kingdom or Sweden is entitled to the best medical care available – which would be at a hospice surrounded by specialists with specialist life-prolonging equipment (that is what the patient would want for their nearest and dearest – so they should want the same for the patient)

Just like eastern society, western society also expects the children (or the nearest relative if there are no children) to want what is best for the patient - after all the patient had cared for them when they needed it previously, so now it is payback time! But unlike the east, Hospice care is seen as the best option.

The downside of the western preference for hospice care is that the patient is often surrounded by strangers (however well-meaning) and away from familiar surroundings with their family paying them visits and then leaving them. Strangers, however well qualified on their fields, do
not really know their patient intimately, like a loved one would – so it is really difficult (if not impossible) to determine exactly what the patient wants to do with their life.

Of course, the situation is not so lucid in this multicultural age of cheap flights, Internet and free-thinking. Many people are now becoming open to the ideas that have been previously been the preserve of other cultures, religions and societies. Significant percentages of Hindus contribute to society in both Sweden and the United Kingdom, just as a significant percentage of Christians contribute to society in Mauritius. Their thoughts and beliefs also contribute and influence those around them – adding to the melting pot of the global cultural society as a whole. So to say that the West is against whilst the East is for is far too simplistic. When it comes to controversial subject like euthanasia – even if there are laws and guidelines to be followed, everyone has their own view and, because euthanasia can still be performed albeit illegally, everyone is free to make their own choice.

**Conclusion:**- The patient has to, if considering euthanasia, not only think about how the act would affect them, but also how it would affect their nearest and dearest – not just in terms of loosing their loved one, but also how society will revere what they have done in terms of caring for the incapacitated patient. Not everyone is open to the idea of an early, forced death and this can have significant implications for those left behind.
Chapter 4. Who should be asked to perform Euthanasia?

Now that we have gone through some of the issues surrounding whether or not the patient should be thinking about euthanasia, we can turn our attention to who the patient could ask for help to die, if they so wished.

Beauchamp and Childress (32-7) single out the following five specific virtues that they believe the patient should be looking for in a potential agent:

**Fig 3.** The table below illustrates the five specific virtues to look for in a potential agent:

<table>
<thead>
<tr>
<th>Virtue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compassion</strong></td>
<td>‘Physicians and nurses who express no emotion in their behaviour often fail to provide what patients most need - When compassion appropriately motivates and expresses good character, it has a role in ethics alongside impartial reason and dispassionate judgement.’ (Beauchamp and Childress, 33-4)</td>
</tr>
<tr>
<td><strong>Discernment</strong></td>
<td>‘The person of discernment is disposed to understand and perceive what circumstances demand in the way of human responsiveness. – The virtue of discernment brings sensitive light, acute judgement, and understanding to action. Discernment involves the ability to make judgements and reach decisions without being unduly influenced by extraneous considerations, fears, personal attachments and the like.’ (Beauchamp and Childress, 34)</td>
</tr>
<tr>
<td><strong>Trustworthiness</strong></td>
<td>Trust is a confident belief in and reliance upon the moral character and competence of another person [to] act with the right motives and in accordance with appropriate moral norms. (Beauchamp and Childress, 34)</td>
</tr>
<tr>
<td><strong>Integrity</strong></td>
<td>Moral integrity means soundness, reliability, wholeness and integration of moral character [and] fidelity in adherence to moral norms ...and standing up in their defence when necessary. (Beauchamp and Childress, 35-6)</td>
</tr>
<tr>
<td><strong>Conscientiousness</strong></td>
<td>An individual acts conscientiously if he or she is motivated to do what is right because it is right, has tried with due diligence to determine what is right, intends to do what is right and exerts an appropriate level of effort to do so. (Beauchamp and Childress, 37)</td>
</tr>
</tbody>
</table>
To be considered as a person of virtuous moral character (and therefore worthy of the patient’s trust), the potential agent must display all of the virtues and follow all of the basic moral principles as stated by Beauchamp and Childress in their book. However, even Beauchamp and Childress admit that in the real world, very few people can fulfil all of the requirements.

There are many people to whom the patient could turn to who could help them end their life but in this section we will focus on the following 6 options:-

1. The Doctor (How does Euthanasia sit ethically with the Hippocratic Oath/Geneva?)
2. The Nurse (Ditto Nursing Code)
3. The “Person of the Cloth” (Priest, Nun, Holy Person etc.)
4. The Friend or Relative
5. A Euthanasia machine

With the possible exception of the machine, everyone listed above would, under normal circumstances, be against killing the patient, but the patient asking for their help to die radically changes the situation.

1. The Doctor

Question – What is the function of the Doctor? Is their job to make their patients (i.e. we members of the human race) the healthiest possible or just reasonably fit enough to live relatively normal lives?

Fig 4. Bell Curve demonstrating the relative health of an average population
As the Bell Curve diagram (Fig 4.) demonstrates, most of us enjoy a relatively normal level of health (the odd sniffle, ache or sprain but nothing too serious). Only a minority are classed as either unhealthy or extremely healthy (by which I mean in optimal health as enjoyed by some professional sportspeople). As most of us do not spend a great deal of our time under the orders of doctors or trainers, this diagram proves that you don’t need to be able to break the four minute mile or leap tall buildings in a single bound to lead a normal life.

Although there are times when having the health and fitness level of an extremely healthy Olympic athlete would help with day-to-day living, that level of extreme health and fitness is not necessary in order to lead reasonably good lives.

So, if the function of the Doctor is not to turn us all into Nietzschean supermen (physically that is), what is their function? To really get into the heart of this question, we have to go back to Ancient Greece and pay a visit to the father of medicine, Hippocrates.

Hippocrates was an advocate of the maxim *Primum non nocere* ("first, do no harm"); however he is best known for the Hippocratic Oath, which until the Declaration of Geneva oath was adopted in 1948, was recited by all medical students on completion of their studies.

The lines of the Hippocratic Oath (English translation) which are relevant to this discussion on doctors and voluntary euthanasia are as follows:-

I. I will prescribe regimens for the good of my patients according to my ability and my judgement and never do harm to anyone.
II. To please no one will I prescribe a deadly drug nor give advice which may cause his death.
III. But I will preserve the purity of my life and my art.
IV. In every house where I come I will enter only for the good of my patients…
V. …keeping myself far from all intentional ill-doing…

(Full oath can be seen at:- [http://en.wikipedia.org/wiki/Hippocratic_Oath](http://en.wikipedia.org/wiki/Hippocratic_Oath))
**Point I** – If a change in the patient’s regime could ease the patient’s physical and mental suffering then it is all fine and good, but if the patient is on the verge of death, any regime prescribed by the doctor will not make a blind bit of difference. Forcing the patient to undergo a regime that would have little if any effect on their health would most likely do more harm than good – especially if the patient has no desire to have their life extended just for the sake of a few pain-ridden hours. Would not this be considered as harming the patient?

**Point II** – The doctor may not be giving advice on how best the patient could die, but someone else may. It is not all that difficult for someone with no medical training (e.g. the patient’s loved one) to obtain lethal doses of drugs (or even lethal drugs for that matter). Even the humble aspirin, if taken in a sufficiently high enough dose, can kill a human being. However overdosing on drugs such as aspirin can involve some quite nasty symptoms like fever, convulsions, rapid heart rate, hyperventilation, tinnitus, gastrointestinal bleeding, violent vomiting, dizziness and hallucinations. If you add these to the symptoms already suffered by the patient in the course of their illness, this combination would most certainty lead to the patient dying a horrific, violent death.

Would it not be less harmful, for both the doctor and the patient, to administer an overdose of morphine (symptoms of which include limp muscles, lowered blood pressure, slow pulse rate and drowsiness leading to coma and death – much less violent than aspirin)? Point II does not rule out the doctor following the Principle of Double Effect (as discussed in Part 1 - where the doctor administers a lethal dose of painkillers to the patient in order to ease their pain, but where the patient’s death would be a side effect).

**Point III** – The purity of the Doctor’s life and art maybe preserved, but what about the purity of the patient’s life and art? As demonstrated by the two letters in Part 3, the purity of the patient’s life and art has already been severely affected – euthanasia would stop it being compromised even further. The doctor is lucky in that they can, and do, have a say in how they conduct themselves, but because the patient is trapped by their illness, this leaves them at the mercy of others like doctors. The patient is left unable to safeguard the purity if their own lives and arts – unlike the doctor.
Point IV – What if the only good for the patient is to lessen their suffering and there are no pain relief drugs available (it does happen)? What if the patient does not want to go through yet another round of aggressive treatment just for the sake of a few pain-filled hours? Does the patient get no say in their treatment?

Point V – deliberately forcing a patient to undergo treatment that they have expressly said that do not want (by asking for euthanasia) is intentional ill-doing!

After the hardship and medical advances of Second World War, the Hippocratic Oath was seen as outdated (no-one prayed to Apollo, Æsculapius, Hygeia, or Panacea anymore) so, in 1948, it was replaced by the much lesser known Declaration of Geneva oath. This oath was last revised by the World Medical Association in 1983 and is still in current use. The passages taken from the Geneva oath which are relevant to this particular discussion are as follows:-

1. I will practice my profession with conscience and dignity;
2. The health of my patient will be my first consideration;
3. I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient;
4. I will maintain the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity;

(Full oath can be seen on the World Medical Association website:- www.wma.net/e/policy/c8.htm)

Point 1. – How can a doctor maintain a clear conscience whilst forcing an unwilling patient to undergo unwanted treatment (especially if that same treatment could be used to treat a patient who actually wants to live)?

Point 2. – Just like the rest of us, a patient who feels that they are not being listened to and taken seriously will get depressed (if they are not already depressed enough by their illness). Depression is a major factor in the health of the patient, so if they get depressed, their health will suffer. The doctor must also consider the mental health of the patient – which means taking into consideration the amount of pain (mental and physical) that the patient is suffering and comparing it with either the likelihood of a cure for that patient’s advanced condition, or the quality of the extra hours that the patient would gain if any treatment proceeded.
Point 3. – Euthanasia can be requested by any patient, regardless of religion, nationality, race, party politics, or social standing, and it can be performed by anyone regardless of the same. If there really is no hope of the patient recovering and that any treatments could be better used elsewhere – providing that consent to kill was given voluntarily – none of these issues matter anyway.

Point 4. – To respect human life, one must also respect the dignity of human life, in particular the dignity of the patient and what is left of their life. It is inhuman to subject an incapacitated and unwilling patient to further treatment that would most likely leave them in an even more undignified state just for the sake of a few unwanted hours – during which the patient will be forced to live a horrendous life whilst having had their dignity grossly violated against their will.

These oaths give an idea of where, spiritually, the doctor may believe that their professional ethics lie, however the patient must also consider the fact that by asking their doctor for euthanasia, they are, in effect asking them to break the law. These spiritual oaths cannot be used as the sole form of defence in a court of law.

In the United Kingdom, the medical profession is regulated by the General Medical Council (the GMC), who’s “Duties of a Doctor registered with the General Medical Council” (the full text of which can be seen at www.gmc-uk.org/standards/good.htm) state the following:-

‘Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:

- make the care of your patient your first concern;
- treat every patient politely and considerately;
- respect patients' dignity and privacy;
- listen to patients and respect their views;
- give patients information in a way they can understand;
- respect the rights of patients to be fully involved in decisions about their care;
- recognise the limits of your professional competence;
- be honest and trustworthy;
- make sure that your personal beliefs do not prejudice your patients' care;
• act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise;
• avoid abusing your position as a doctor; and
• work with colleagues in the ways that best serve patients' interests.

*In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.*

As one can clearly see, within the GMC, the needs of the patient must always come first. Medicine today is a lot different to how it was, even back in 1983. People are more health conscious and know more about how their body functions. Doctors are no longer treated as ‘demigods’ who’s advice must be followed and treated as law and, as a result, people are asking questions and having more of a say in how they are treated. All patients must be treated with the same respect and dignity (the GMC guidelines make no distinction on grounds of health or others) whether they are chronically sick, terminally ill, severely physically disabled or not.

This means that our patient (if they were being treated in Britain) has every right to ask the doctor if they would consider death assistance because, under the terms of the GMC, the patient’s views, dignity and privacy must be respected, the patient must be treated politely and considerately (they must be listened to) and that the patient must be fully informed and involved in decisions about their care in a way they can understand.

In addition, the doctor (again in accordance with the GMC guidelines), must be honest and trustworthy and recognise the limits of their professional competence (no heroics and no lying and telling the patient that they will get better).

However, unless the doctor is willing to risk a prison sentence of up to 14 years (not to mention having their license to practice medicine revoked) there really is no point in the patient asking for euthanasia because, the chances are, it will not happen. This is why The Assisted Dying for the Terminally Ill Bill (2004) is currently being debated in the British Parliament by the governmental All-Party Parliamentary Group for Compassion in Dying. (I would like to see this bill extended to include the chronically sick and severely physically disabled – as I have maintained throughout this thesis, it is not just the terminally ill who are suffering and need help – however this is beside the point.)
Peter Singer (our utilitarian expert – see Part 3) is particularly admiring of The Netherlands and how, though open discussion, euthanasia has for some time, been tolerated under Dutch Law. On 1st April 2002, The Netherlands began implementing a new law (the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001) which exempted doctors from prosecution for euthanasia if there was unequivocal proof that the doctor had adhered to the following criteria:

- The Doctor was satisfied that the patient’s request is voluntary and well-considered. *(note: this means that the request must not be made owing to pressure from or influence by other people or as the result of a mental disorder. The patient must fully understand the nature of his condition, his prospects and the types of treatment available. He must also have repeatedly expressed the wish to die)*

- The Doctor was satisfied that the patient’s suffering was unbearable, and that there was no prospect of improvement

- The Doctor informed the patient about his situation and further prognosis

- The Doctor discussed the situation with the patient and came to the conclusion that there was no reasonable alternative

- The Doctor consulted at least one other physician with no connection to the case, who then visited the patient and stated in writing that the attending physician was satisfied with the due care criteria listed above

- The Doctor exercised due medical care and attention in terminating the patient’s life or assisting in his suicide.

*In addition, the Doctor must report the cause of death to the municipal coroner so that they can carry out their investigations to determine whether the Doctor got their facts right and prosecute if needs be. (Source: Pamphlet -The Termination of Life on Request and Assisted Suicide (Review Procedures) Act – Euthanasia, (Ministerie van Volksgezondheid, Welzijn en Sport – NL).*


‘In 2003, in the Netherlands, 1626 cases were officially reported of euthanasia in the sense of a physician causing death (1.2 % of all deaths). Usually the sedative sodium thiopental is intravenously administered to induce a coma, and after making sure the patient is in a deep coma, typically after some minutes, a muscle relaxant is administered to stop the breathing and cause death.
Officially reported were also 148 cases of PAS (0.1 % of all deaths), usually by drinking a strong barbiturate potion. The doctor is required to be present for two reasons:

1. To make sure the potion is not taken by a different person, by accident (or, theoretically, for "unauthorized" suicide or perhaps even murder)

2. To monitor the process and be available to apply the combined procedure mentioned below, if necessary.

Forty-one cases were reported to combine the two procedures: usually in these cases the patient drinks the potion, but this does not cause death. After a few hours, or earlier in the case of vomiting, the muscle relaxant is administered to cause death… In most cases the procedure was applied at home [where the patient would feel most comfortable].

It must be made absolutely clear that all forms of euthanasia still remains illegal under Dutch Law, however the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 allows an exemption from prosecution for doctors (and only doctors) if they follow, and can prove that they have followed, the strict rules as laid out by the legislation. This law is explained further in the following pamphlet issued jointly by the Dutch Ministry of Health, Welfare and Sport and the Ministry of Justice - The Termination of Life on Request and Assisted Suicide (Review Procedures) Act – Euthanasia, (Ministerie van Volksgezondheid, Welzijn en Sport – NL).

This law had the backing of a clear majority of Dutch people – although (as with all debates concerning medical ethics) there were objections on grounds of religion, criminality of killing and patient apathy (where the patient does not bother to up a fight believing that they will be euthanized whatever happens).

One other point that the patient must consider is that, if the Doctor does perform euthanasia this time, it would not be so hard for them to do it again for other patients requesting the same treatment – which may lead to a lowering of standards (the next patient may not be in quite the awful state that our patient is in and, in turn, to ‘the slippery slope’ which is how those against euthanasia argue the Nazi genocide programme (code-named the ‘T4’ operation) started during the Second World War.
According to researchers at the United States Holocaust Memorial Museum, the original victims of the secret T4 operation were meant to be adults and children with physical or mental disabilities, but towards the end of WW2, the range of people eligible for euthanasia under T4 grew to include Roma gypsies, homosexuals, political and religious dissidents, geriatric patients, bombing victims, people of Slavic extraction and foreign forced labourers - in other words people who were considered ‘undesirable’ by the Nazi regime - most of whom were not even ill!

No-one is denying that what happened during the Holocaust was a pure evil that should never be repeated, but a blanket ban on euthanasia for the sake of history is unfair, especially since those in favour of voluntary euthanasia are only advocating it for the chronically sick, terminally ill or severely physically disabled – i.e. those who have specifically ask to be released from their pain. However, the following extract from the Holocaust Encyclopaedia (www.ushmm.org) reveals something rather interesting:-

Hitler ordered a halt to the Euthanasia Program in late August 1941, in view of widespread public knowledge of the measure and in the wake of private and public protests concerning the killings, especially from members of the German clergy. However, this did not mean an end to the euthanasia killing operation. In August 1942, the killings resumed, albeit secretly. Victims were no longer murdered in centralized gassing installations, but instead killed by lethal injection or drug overdose at a number of clinics throughout Germany and Austria. Many of these institutions also systematically starved adult and child victims.

In other words, the unregulated killings went on in relative secrecy until the issue was forced out into public debate. Once all the fuss had died down, the killings resumed again on the quiet, just as unregulated and perhaps in more secrecy, as before. This proves my point in that if the whole issue of euthanasia is out in the open and publicly sanctioned for medical use only, and that proper, legally binding regulations are strictly adhered to, not only would patients get the protection that they need but the ‘slippery slope’ can be avoided.

The extract also proves that euthanasia can, and does, happen whether it is legal or not – and (as is also shown) where it is not legal is where the patient is at most risk. By legalising euthanasia and applying strict, legally binding regulations, these patients run a far lesser risk.

To prove this point further, The Remmelink Report into euthanasia and other end-of-life practices the Netherlands (conducted by a government-appointed committee lead by the Dutch former Attorney General Remmelink) revealed the following:-
Euthanasia and assisted suicide (where the patient themselves have specifically requested help to die in accordance with Dutch euthanasia guidelines)

<table>
<thead>
<tr>
<th>Year The Remmelink Report was carried out</th>
<th>1990</th>
<th>1995</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. physicians questioned</td>
<td>405</td>
<td>405</td>
<td>410</td>
</tr>
</tbody>
</table>

| Percentage of physicians who have at some time helped a patient die | 54% | 53% | 57% |
| Percentage of physicians who have helped a patient die within last 24 months | 24% | 29% | 30% |
| Percentage of physicians who have never helped a patient die but would be willing to do so under certain conditions | 34% | 35% | 32% |
| Percentage of physicians who would never help a patient die but would refer patient to another physician who may help | 8% | 9% | 10% |
| Would never do it nor refer patient | 4% | 3% | 1% |

Ending a life without patients explicit request

| Percentage of physicians who have at some time helped a patient die | 27% | 23% | 13% |
| Percentage of physicians who have helped a patient die within last 24 months | 10% | 11% | 5% |
| Percentage of physicians who have never helped a patient die but would be willing to do so under certain conditions | 32% | 32% | 16% |
| Would never do it nor refer patient | 41% | 45% | 71% |


The table above shows that, whilst the number of doctors willing to help patients die if they have specifically requested help in accordance with Dutch euthanasia guidelines has increased, those willing to end the life of an unwilling patient has significantly decreased. This means that whilst more Dutch patients who want help to die can receive that help (provided they have followed the guidelines); a significantly less number of Dutch patients who don’t want help to die are being killed. As Singer explains ‘That people are being killed [with consent] under these conditions would have no tendency to spread fear or insecurity, since we have no cause to be fearful of being killed with our own genuine consent. If we do not wish to be killed, we simply do not give our consent’ (Singer 194)
Euthanasia (and by extension assisted suicide) has for a very long time been an accepted part of Dutch medical practices without actually being legalised, much to the chagrin of pro-life campaigners who claim that these secretive practices put all patients' lives at risk and not just those of the chronically sick, terminally ill or severely physically disabled patient.

However, as one can see in the table, the slow increases shown by the Remmelink Report in the percentage of physicians who have helped a consenting patient die within last 24 months is indicating that a possible stabilisation of end-of-life practices is occurring though continual debate over what is and what is not acceptable. (Just for the record - the Remmelink Report is referred to in *Death and Dying, Life and Living* (Corr, Nabe, Corr, p503-4) - although not by name)

Because open discussions have led to more clarified euthanasia procedures, doctors are more confident in their diagnoses and there is less scope for error. Pro-life campaigners should be pleased that fewer patients were euthanatized without consent in 2001 than in 1990, and pro-euthanasia campaigners should be equally pleased that more people were consensually euthanized in 2001 than in 1990.

Also worth noting is the percentage of doctors who would never perform either kind of euthanasia nor refer patient to a physician who would. When it came to consensual euthanasia and assisted suicide, the percentage of unwilling doctors dropped between 1990 and 2001, whereas in cases where no consent is given – the percentage rose quite sharply. Both of these sets of statistics mean that those patients who are most vulnerable (i.e. those who cannot give their consent) are better protected in 2001 than in 1990.

And notice the dates - it is no coincidence that during the time that the Remmelink Reports were being compiled, the whole issue of euthanasia was being openly discussed everywhere, from the streets to the higher echelons of the Dutch parliament (a far cry from the secrecy surrounding the euthanasia programme in Nazi Germany).

In conclusion:- The patient does have a moral right to ask for euthanasia, but the patient must bear in mind that the final decision does not lie with them. It is up to the doctor to decide whether it is moral to kill that patient, irrespective of whether it is legal or not (although the question of the legality of the action may play a factor in the final decision if there is no exemption made).
2. The Nurse

Many of the arguments that I used in the previous discussion on doctors and euthanasia also apply to nurses and perhaps other non-medical personnel (e.g. physiotherapists). However, because nurses are very often the people with most contact with the patient (not counting the patient’s loved ones) it is easy for a bond to form between patient and nurse. The patient often feels that the nurse knows more about their medical condition than even the doctor simply because they are around more often and come across as friendlier and less authoritarian (which can be a problem with some doctors who have developed an unfortunate ‘I’m the one with the medical degree’ attitude).

It is hardly surprising that, in a time of great distress, patients would rather turn to someone they trust to help them end their lives (asking the nurse could also be seen as a back-up plan if the doctor refuses). The question is how does euthanasia sit with the role of the nurse? Just like doctors, nurses have to follow specific Codes of Conduct, such as the summarised version of one that I have copied below (published by the United Kingdom Nursing and Midwifery Council):

**Code of Professional Conduct [Summarised]**

As a registered nurse, midwife or health visitor, you are personally accountable for your practice. In caring for patients and clients, you must:

1. Respect the patient or client as an individual
2. Obtain consent before you give any treatment or care
3. Co-operate with others in your team
4. Maintain your professional knowledge and competence
5. Be trustworthy
6. Act to identify and minimise risk to patients and clients

Point 1 – *Respect the patient or client as an individual* - Respecting the patient means that the patient also has a say in how they are treated. The Nurse must respect the patient’s decisions with regards to their health and what they want to happen to them. Respecting patients as individuals signifies that no two patients are the same and all patients have differing needs. If a patient has a need to end their life, this must be respected and discussed in a serious manner and not dismissed as ‘crazy talk’.
Point 2 – *Obtain consent before you give any treatment or care* - The nurse cannot do or subject the patient to any form of treatment without the consent of the patient. It is unheard of for a nurse or other health professional to ask patients if they consent to enforced torture but it is more common for a patient to refuse to endure enforced torture (the fact that the patient wants to live is often taken for granted).

Point 3 – *Co-operate with others in your team* - If Point 1 is correct (i.e. that the patient has a say in how they are treated) then the patient is part of the care team as opposed to just the receiving instrument of care. Therefore the Nurse must co-operate with the patient as well as other members of the care team.

Point 4 - *Maintain your professional knowledge and competence* - As with doctors, nurses must recognise the limits of their professional competence (no heroics and no lying and telling the patient that they will get better). The Nurse must also perform their duty in the most competent manner possible – and their duty lies with the patient because as with the Doctor, the welfare of the patient must always come first.

Point 5 – *Be trustworthy* - Again as with doctors, nurses must be honest and trustworthy with the patient otherwise how will the patient feel that their opinions are being listened to and respected? It may compromise their health if the patient starts withholding information about their condition out of fear that they cannot confide in their nurse.

Point 6 - *Act to identify and minimise risk to patients and clients* - This is an interesting point! It all depends on what is considered to be a risk to a patient who wants to die. If the patient wants to die, giving them a lethal dose of opiates (a favoured method of euthanasia used by the nurses in the survey mentioned a little later in this section) would in essence be of no risk, as this would help them in the direction that they want to take with their life.

However, by not euthanizing the patient, nurses run the greater risk that the patient (if desperate enough) may ask someone else entirely who may have neither the expertise nor means to kill them in a clean, swift way (the patient may even try to do it themselves) – thus causing the patient to be at even more risk of harm and pain than before.
As mentioned with doctors, there are nurses who do engage in euthanasia under certain circumstances, even though it is illegal. In an anonymous survey of 852 nurses in America who practiced exclusively in adult intensive care units, 141 reported that they had received requests from patients or family members to perform euthanasia or assist in suicide; 129 reported that they had honoured such requests outright and an additional 35 reported that they had hastened a patient's death by only pretending to provide life-sustaining treatment ordered by a physician (covert euthanasia).

Of the 129 nurses who had perform euthanasia or assist in suicide, 65 percent reported doing so 3 or fewer times compared to only 5 percent reported doing so more than 20 times. 40 nurses performed euthanasia at the request of the patient themselves (10 of the 129 nurses did so at the request of another nurse who for whatever reason, were unable to do the deed themselves.) In the year prior to the survey, 62 nurses reported a total of 124 instances of euthanasia or assisted suicide - which works out as roughly 2 deaths per nurse per year.


As the survey asks - Why were so many nurses willing to perform euthanasia or assisted suicide? The list of reasons is a long one, including an overwhelming sense of responsibility for the patient’s wellbeing, protecting the patient’s dignity or relieving suffering – but the vast majority of reasons stem from the nurses bond and familiarity with the patient.

Nurses are continually warned not to get too attached to their patients, but it can be difficult to care for someone and not feel some kind of emotional contact with them – especially if the patient is spending what is likely to be their last hours being in physical and emotional turmoil and is reaching out to them for support.

In conclusion:- Because the welfare of the patient must be the priority of all healthcare professionals, there is a duty for the Nurse to at the very least respect a decision for euthanasia. It may be both morally correct and easier for the patient to ask the nurse for help to die but as with the doctor, the patient must bear in mind that the final decision lays with the nurse and not with them. Euthanasia may not be legal and the nurse runs the risk of being sentenced to 14 years in prison if they do it, but it is up to the nurse to decide whether it is moral for them to break their code and kill that patient, irrespective of whether it is legal or not.
3. The “Person of the Cloth” (Priest, Nun, Holy Person etc.)

Because life and death are an intrinsic part of spiritual life, many patients on the verge of death turn away from medical world altogether in favour of the spiritual world of religion. In some cases it could be because the patient is devoutly religious and needs guidance in preparing to meek their Maker, in other cases, patients may feel that medicine has failed them in some way and that they are better off looking towards religion in reconciling their lives.

More still may have a distrusted in all other people and feel that, because the “Person of the Cloth” is accountable to the Ultimate Boss, they are more trustworthy that anyone else and can therefore be trusted with the one most precious gift that the patient still possesses – their life.

I have already mentioned how euthanasia is viewed within the realms of Christianity and Hinduism, but, as you probably are already aware of, there is a myriad of other religions and what may be considered ‘independent religious beliefs’ (strongly held beliefs which may not necessarily form part of any organised religion) circulating the world today. Differing belief systems have differing views on euthanasia, and there are different ways that both the patient and the Person of the Cloth have of interpreting those views.

First off in this section, I will give a very brief summery of how some of the other major world religions view euthanasia:-

**Judaism** – Jewish teaching asserts the belief that, because God created the patient, God also owns the body and life-force of the patient and that the patient is only ‘borrowing God’s property’.

Put it this way – think of your body as a lawnmower which you have borrowed from you neighbour. Now, having been loaned the lawnmower in good faith, would it not be immoral for you to destroy your neighbour’s property (the lawnmower) by ripping out the fully functioning motor without the consent of the owner just because you could – and then giving it back minus the motor?
Without the motor to power the lawnmower - the lawnmower will not work, and similarly, without the life-force to power the body - the patient’s body will not work. However if your neighbour took out the motor from their own lawnmower – there is no problem. Similarly, if God took the life-force from His property (the patient), there is no problem.

When you add the fact that, in Jewish tradition (rather like Kantianism) the life of the patient is valuable in itself, regardless of any property, status, action or any other quality, one comes to the conclusion that the entertaining of any thoughts of euthanasia is not welcome within Judaism.

‘However, many Reform Jews…hold that autonomy and self-determination are also values of primary importance. On this basis, these Jews often assert that it is the individuals who have ultimate control of their bodies,’ (Corr, Nabe, Corr, 499). This passage indicates that there is a certain amount of room for manoeuvre for the rabbi to at least think about the request.

In thinking over a request for euthanasia, the rabbi would most likely consult the Talmud, which is a documented record of Jewish law, ethics, customs, and case histories. According to the Talmud, a ‘gosses’ (that is a person who is close to death and will probably be dead within three days) is still considered to be a living person and it goes against Jewish teaching to hasten their death (equates to murder, whether the patient asked for euthanasia or not).

However, the Talmud also commands that one should ‘Choose for [the patient] a pleasant death’ (www.jewishvirtuallibrary.org/jsource/Judaism/euth.html). If it is clear that all courses of action to cure the patient have been taken but have not worked, subjecting the patient to life-prolonging treatment against their will could be seen as hindering the patient’s soul from departing. If this is the case, it is then permissible to remove the hindrance.

This is why, although active euthanasia is itself ruled out, passive euthanasia and the Principle of Double Effect can still be used to end the Jewish patient’s suffering. Passive euthanasia removes the hindrance and (as explained in Part 1 of this thesis) the primary purpose of the Principle of Double Effect is to give what is essentially an overdose of painkillers to induce a state of pleasantness – free from pain - for the patient and not to actually kill the patient, although the patient’s death will happen anyway as a ‘side effect’ of the drugs.
Islam – According to *Death and Dying, Life and Living* (Corr, Nabe. Corr, 500-1), the word ‘Islam’ means submission (to the will of Allah – the Islamic God).

In Islam, as with Judaism, the belief is that because Allah created the patient, Allah also owns the body and life-force of the patient and that the patient is only ‘borrowing Allah’s property’.

There is an added dimension to the discussion of Islam and euthanasia – in certain circles, suffering is viewed as a means of atonement for misdeeds and as such, is a way of coming closer to the Almighty. Ergo, to interfere with a person’s suffering is to interfere with the spiritual link between the Muslim patient and Allah. Although euthanasia is not explicitly referred to under Sharia (Islamic) law, it is generally understood to be taboo.

However (again in common with Judaism) if it is clear that all life-enhancing treatment has proved futile, the physician may perform euthanasia using the Principle of Double Effect in order to spare the patient and their loved ones from further torment. Note that any reference to the patient being in pain plays no role prior to exhausting all avenues of treatment within Islamic teaching.

There is a debate going on within Islamic circles over whether medical treatment itself should be viewed as obligatory at all (looking after Allah’s property) when some argue that, by suffering and enduring the pain that Allah has deemed fit to inflict the patient with, this would bring the patient closer to Allah. This is what must be decided between the Muslim patient and the Imam.

Buddhism – Unlike Christianity, Judaism or Islam, there is no actual God-like creator of Man within Buddhist teaching. What really matters here is the state of mind that the patient is in when death claims them from this mortal world.

According to Stevenson, Buddhists, like the Hindus discussed in Part 3 of this thesis, believe in karma – the belief that the actions taken in one life has an effect on the next life. This is linked to the Buddhist belief of re-incarnation and the ‘circle of life’. (According to Stevenson (98) both religions are based on the Vedas - which could be loosely described as the eastern version of the Torah/Bible/Koran.)
Mortal life (as Buddhists know it) is filled with a lot of stress and suffering, and in order to escape the circle of reincarnation and achieve the state of nirvana (everlasting bliss); one must lead a virtuous life. If one leads a reprehensible life, one is doomed to be re-born and go through more rounds of stress and suffering until one has got it right.

Within Buddhist teaching, stress and suffering is linked to our desires (be they physical or psychological). These desires can cause us to commit reprehensible acts in order to satisfy them. By not desiring that which is beyond the necessary, one is free of the stress and suffering linked to that desire and there is less temptation to act in a culpable manner. The result is a much calmer person, who is in a better position to achieve nirvana (or at least get a better stab at the next life).

With regards to euthanasia - it is understood that the mental state of the patient at the moment of death plays a major role in how the next life turns out. If the patient desires euthanasia, the request indicates that they are suffering mentally – which is not at all good for the transition to the next life (it is bad for the patient’s karma). Ideally the patient would be in a calm, almost serene state of acceptance at the moment of death and in neither emotional nor physical distress.

However, administering a dose of morphine reduces the amount of pain that the patient is suffering, making them much calmer and more serene for their journey into the next life. (Morphine – as mentioned in Part 1 of this thesis – causes the patient to comatose, a state which could be described as serene).

It is within the realms of possibility to use the previously mentioned standby of the Principle of Double Effect in order to perform euthanasia without actually intending to kill the patient (the motive of all concerned is important – if the death of the patient is not the main intention (which in this case it is not - pain relief is) – the patient’s karma is not affected.)

There is one other point that the Buddhist patient must take into consideration when asking for euthanasia – because of the Buddhist belief of ahimsa (non-violence towards all living things) not only will intentional killing (which is essentially what euthanasia is when you remove the good intentions behind it) be detrimental to the patient’s karma, the intentional taking of life will also affect the karma of the Buddhist monk.
Quick re-cap on the views of Christian and Hindu Holy people and euthanasia

Referring back to the Christianity section of Chapter 3 – The Christian Holy person must decide if they are willing to endure the wrath of God by going against (amongst other rules) the 6th Commandment (Thou shalt not kill) in order to follow the example of Jesus in ‘…reducing the suffering of others’ (Corr, Nabe, Corr, 500).

Referring back to the Hinduism section of Chapter 3 – The Hindu Holy person must decide (amongst other considerations) whether the ahimsa principle of non-violence means that they should not kill the patient or if the same principle means that they must end the violence within the patient’s body (Corr, Nabe, Corr, 500).

Having had a very brief tour through five of the world’s biggest religions, we can now reflect on how the patient asking for euthanasia from a Person of the Cloth may affect said Holy Person.

Just as with the Doctor and the Nurse previously, the Person of the Cloth has their own Codes of Conduct that they must adhere to – except in their case, it is not just their job that may be in jeopardy, their spirituality is also at stake.

No matter how strict the religion, it is often a source of comfort to those who have lost hope. The Person of the Cloth must be able to reflect this and show some measure of compassion towards the patient and their plight. If the notion of euthanasia is to be entertained in any way, the Person of the Cloth (whatever their religion) must be the kind of person who is willing to see past the obvious rules surrounding their particular belief and see what the patient is going through.

This is a lot to ask of someone who, as part of their life of service, is dedicated to helping to administer to the sick and needy – asking them to kill the sick patient (even if it happens to be the patient themselves doing the asking). This person must have an extremely strong sense of character for the patient to even consider asking, because it is not just asking the Holy Person to go against their beliefs, it is asking them to go against the Almighty Himself.
4. The Friend or Relative

As I have already discussed in previous sections – the legal price for euthanizing the patient can be very high indeed, but (especially in the case of the friend or relative) it is not just prison sentences that the patient should be thinking about – the chosen agent will also be subjected to phenomenal amounts of emotional and psychological pressure from all quarters.

The cold reality is that if the chosen agent is a friend or relative, they will be killing the much-loved patient – forcibly taking their life. This is not an easy burden to bear. Although I have repeatedly shown throughout this thesis that there are ways to interpret and circumvent traditional thinking, it is still generally accepted that killing another human being goes against almost all cultural and society codes of conduct. The agent will have to run the gauntlet of trials, not only by judge and jury in the legal courts, but also by people acting as if they are judge, jury and executioner. Whoever the patient asks for help to die must be mentally strong enough to defend their actions, both to the outside world and to themselves.

There are three good reasons for the patient asking a friend or relative to perform euthanasia – the first is that the patient is less likely to be turn down by a friend or relative – their loyalty and love for the patient may convince them that this is the best course of action.

The second is that the friend or relative would be acting out of compassion for the patient, which is far preferable than just a clinical respect for the patient’s autonomy. If the love felt by the friend or relative is genuine and strong enough, that alone will ensure that the patient and the patient’s interests (i.e. their dignity) are protected at all costs. Death is never just a clinical act, it also involves a lot of emotion from all sides, and sometimes, we humans do the most inexplicable acts for no other reason than the love felt for our fellow beings.

The third and more compelling of the two is that the patient’s request for euthanasia may not actually be a request for help to die, but instead be a result of temporary despair or just an extreme cry for help. A stranger may not know that the patient, when giving their final consent to the procedure, may be having second thoughts (perhaps the patient feels that having persisted in their request, they are now obliged to go through with it and save face in front of the helpful stranger, even though they have changed their mind and want to live) – whereas someone who is very close personally to the patient might have a better idea of what the patient is thinking.
The patient is likely to be more honest with the loved one than with the unknown person, because the fear of letting down a stranger is greater than letting down a loved one who will probably be grateful for a reprise.

There are four downsides to asking a friend or relative to act as agent in killing the patient –

   a. The agent risks a prison sentence and the wrath of disapproving family and society members

   b. The agent may have their own, unscrupulous motives for killing the patient (perhaps they are mentioned in the patient’s last Will and Testament or maybe they want to get their hands on the family fortune) so even if the patient had a last minute change of heart, the unscrupulous agent may ignore it and kill them anyway.

   c. As mentioned above with regards to nursing, the friend or relative may not have access to the drugs, equipment or skills that would enable them to kill the patient in a clean, swift way – thus causing the patient to be at even more risk of harm and pain than before.

   d. If the euthanasia attempt fails or if the potential agent is offended by the request – the close relationship between the patient and the agent could be over – a major psychological blow for both parties.

If the patient can find such a person amongst their friends and relations who is willing to risk far more than just a prison sentence to end their suffering, then perhaps asking them would be the moral thing to do – but the patient must be aware that this is more than just a life and death question – and they are risking more that just continuing their torturous life.

5. A Euthanasia machine

The obvious question to ask at the start of this section is – just what is a euthanasia machine? I could tell you that it is a contraption that allows the chronically sick, terminally ill or severely physically disabled patient to be able to take their own lives without the assistance of any potential agent – thus sparing everyone the nightmare of the agent being charged with the patient’s murder, but to be honest, I think that the best way to describe euthanasia machines is to show you some pictures of three of the best known machines and describe what they do:-
**Machine 1 – The Mercitron (Inventor – Dr. Jack Kevorkian)**

The Mercitron consists of three bottles suspended from a metal frame, about six inches wide by 18 inches high. Each bottle has a syringe that connects to a single intra venous (IV) line in the person's arm. The first bottle contains ordinary saline, or salt water. Another contains sleep-inducing barbiturates, and the third contains a lethal mixture containing potassium chloride, a chemical which immediately paralyses the heart, and a muscle relaxant to prevent spasms during the dying process – thus ensuring that the patient dies a peaceful, pain-free death.

The Mercitron works like this:-

1. Kevorkian or an assistant starts the saline solution flow.

2. When ready, the patient themselves deliver the sleep-inducing barbiturates by throwing a switch or pulling a string.

3. After that, either a timer or a mechanical device triggered by the person's falling arm as the drugs take effect starts the lethal drug flowing. The idea is for the deadly chemicals to enter the bloodstream only after the person is asleep. Death usually occurs within two minutes.

**Machine 2 - The Carbon Monoxide Device (Inventor – Dr. Jack Kevorkian)**

The Carbon Monoxide consists of a cylinder of deadly carbon monoxide gas which is connected by a tube to a breathing mask fitted over the patient's nose and mouth.

The Carbon Monoxide device works like this:-

In order for the gas to start flowing, a valve must be released to start. Depending on the patient's disability, a makeshift handle may be attached to the valve to make it easier to turn, or, with the valve in the "open" position, a clip or clothespin may be clamped on the tubing. Pulling it off allows the gas to flow.

By Kevorkian's estimates, this method may take 10 minutes or longer. Sometimes, he encourages people to take sedatives or muscle relaxants to keep them calm as they breathe deeply of the gas.

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The source information for the Mercitron and the Carbon Monoxide devices are courtesy of www.fansoffieger.com/mercitron
Because he believed passionately that sick and dying patients should have the autonomous right to choose if and when to have an early death, Dr. Jack Kevorkian (a retired pathologist) began using these machines to help patients requesting euthanasia in the 1990’s. The machines were used to provide the attending physician (which on occasions was Kevorkian himself) with some measure of protection against prosecution for murder. As I will explain later, the attending physician cannot be charged with the patient’s murder if they did not directly inject the fatal drug into the patient’s bloodstream.

However, in 1998, Kevorkian publicly admitted to directly injecting a patient suffering from advanced amyotrophic lateral sclerosis (commonly known as Lou Gehig’s disease) with two chemicals that caused the patient’s death. For this the doctor was initially charged with first degree murder and criminal assisted suicide. After the case went to trial in 1999, Kevorkian was eventually sentenced to 10 - 25 years for second degree murder plus 3 -7 years for delivery of a controlled substance (to run concurrently). He is currently serving his sentence at the Thumb Correctional Facility in Michigan, and may be eligible for parole in 2007.

**Machine 3 - Self-Deliverance – computerised assisted suicide system**
(Inventor - Dr. Philip Nitschke)
The third euthanasia invention (shown on the previous page) comes by way of the Australian physician Dr Philip Nitschke, who created a euthanasia program called Self-Deliverance to be used by the patient, with the aid of a computer, to trigger the delivery of a fatal dose of Nembutal (sodium pentobarbital – used mainly by veterinarians to euthanize animals and a drug which is no longer available for human use in Australia) in order to cause the patient to go into a coma within minutes and death in hours. (Incidentally, Nembutal is one of the drugs used by physicians practicing euthanasia in Oregon – the only state in the USA to legalise euthanasia (physician-assisted suicide only).

The Self-Deliverance computer program was used in the world’s first legalised euthanasia (assisted suicide) death, which took place at the patient’s home in the Northern Territory of Australia in September 1996, during the brief six month period before the Rights of the Terminally Ill Act 1995 (NT) was overturned.

Dr Nitschke inserted an IV line into the arm of the patient, which was connected to the computer and a bottle of Nembutal. On the left hand side of this page are the series of screens that the patient saw with the instructions clearly displayed. Within five minutes of answering ‘yes’ on Screen 3, the patient had died peacefully.

During an interview for the Australian newspaper The Canberra Times (published: Monday, 27 May 2002), Dr Nitschke (dubbed the Australian ‘Dr. Death’ and a finalist in the Australian of the Year 2005), revealed that the utilitarian philosopher (and fellow Australian) Peter Singer had influenced his views on euthanasia. Singer’s views on euthanasia (you may recall) are discussed in Part 3 of this thesis. (Information courtesy of Deliverance spokesperson – via e-mail dated 10th March 2005)

So, now that we know what a euthanasia machine is, why should our patient consider using one to end their life? There are several reasons why a euthanasia machine may be preferable to a euthanizing human:-

1. **The patient themselves decide if and when to administer the deadly dose** – allowing the patient to change their mind at any time. The patient is in control

2. **The patient knows that the machine is not going to back out at the last minute** – the machine has no feelings, no conscious and no way of acting on them. The machine does what the patient tells it to do
3. **The machine cannot be punished** – because it, in itself, does not earn anything, and because the machine has no will of its own, it has to do what the patient and the supplier instructs it to do.

4. **The machine cannot try to talk the patient out of their decision** – it has no thought or morals of its own – it just does what the patient and the supplier instructs it to do.

There are also several reasons why a euthanasia machine may not be preferable to a euthanizing human:

1. **The machine may fail due to technical error** – viruses could be introduced to the computer program, there could be a power-cut at the crucial moment, there could be a blockage in the tubes…as the oft quoted Murphy’s Law says ‘If anything can go wrong – it will! Any problems with the equipment is liable to cause the patient more distress and subsequently prolonging their suffering and pain

2. **Supplying the machine makes the supplier liable for sentencing** – It is an offence to assist in a suicide, and by supplying the machine and connecting the patient to it, the supplier (who knows full well what the patient intends to do with it and what the outcome is likely to be) is assisting can be charged with manslaughter (some countries – like Sweden - do take the circumstances surrounding the death of the patient into consideration when sentencing, however in the UK the same act carries a sentence of to up to 14 years imprisonment)

3. **The supplier could back out at the last minute** – well, when faced with possible consequences such as those mentioned above, is it surprising that the supplier may have last-minute second thoughts?

4. **The person setting up the equipment fails to do it properly (deliberately or accidentally)** – Perhaps the instructions are too complicated to understand, the person setting up the equipment is inexperienced or maybe the person setting up the equipment does not want the patient to die (for whatever reason) and is only pretending to set up the equipment to spare feelings. As with point 1 - any problems with the equipment, or people, is liable to cause the patient more distress and subsequently prolonging their suffering and pain

5. **The machine cannot interpret any signs of the patients change of mind other than the ‘off switch’** – so if for whatever reason the patient decides not to die but cannot ‘flick the off switch’ due to some kind of disability, the patient is in serious trouble
6. The equipment is liable to tampering to make it either bypass safety measures and deliver the fatal dose without warning the patient, or to stop the machine from killing the patient - maybe someone either does not want the patient to die or (the more sinister) wants to make sure the patient does not have a chance to change their mind, for whatever reason. Either way – the patient’s choice as to whether they should die or not has been taken away from them.

7. There are not that many euthanasia machines around – and there is not much point in thinking about this question if the patient cannot get hold of one (although it is not that difficult to make something similar to Kevorkian’s Carbon Monoxide device if one has access to the correct components).

There is also one more reason for the patient not to consider using a euthanasia machine – even though technically speaking it would make no difference to our patient whatsoever:

8. Using a machine to kill oneself de-humanises death – physically looking into the face of death really brings home the fact that life is a part of being human and death is a permanent end to that person’s life. By using a machine to take the life of the patient, other concerned parties may come to feel that taking a life is not such a big deal – which in turn could lead to more deaths and the start of the ‘slippery slope’ mentioned earlier in this part. As the article ‘Do Artefacts have Politics?’ states:

‘What matters is not technology itself, but the social or economic system in which it is embedded….Those who have not recognised the ways in which technologies are shaped by social and economic forces have not gotten very far’ (Technology, Information and Ethics (Compendium 1) Autumn 2004, pages 20-1)

For instance, the Northern Territory of Australia (where Nitschke’s computing program was used) is a huge area which has very little in the way of hospices and other state-provided palliative care. Some anti-euthanasia campaigners suggest that the Northern Territory only sanctioned euthanasia as a way to cut the territory’s healthcare budget (if there are less terminally ill people (neither the chronically sick, nor the severely physically disabled were included in the Bill) then the territory will not need to spend so much money on caring for them).
However, even the very existence of these machines in society suggests that the very value of life in general is being cheapened by not having a human carry out the deed. Even, Deliverance (the pro-euthanasia group founded by Dr. Nitschke) have only used a euthanasia machine because doctors fear prosecution if they directly kill the patient (Dr. Kevorkian has also cited this excuse). Using the machine affords the doctor a certain amount of protection because, as it is the patient themselves who orders the computer to trigger the deadly drug flow, the patient is actually killing themselves, and it is nigh-on impossible to prosecute someone who is already dead.

Most euthanasia patients would rather not have their lives ended ‘by cold, hard steel’ but by a warm, caring individual – however they have little choice. If the life of the patient (or of all other people for that matter) is to be respected, it is humans who have to do the deed – otherwise it is all too easy to carry on letting technology do the dirty work.
Chapter 5. Conclusion

1. It is ethical for a patient to even be thinking about euthanasia?

No matter how many times, or in how graphic the detail, the patient explains their plight, no-one will never know just how much that patient is suffering. The language and actions may be colourful or expressive, but everyone has differing pain thresholds and differing degrees of dignity. Contrary to popular opinion, no other body knows the patient better that the patient themselves.

As I said in the Introduction, those of us who are relatively unaffected by illness or disability have a choice in how and when we end our lives. We can decide to wait until our life ends naturally, or we can speed up the process by committing suicide in whatever manner we choose. But, because of their illness or disability, the patients discussed in this thesis have had their right to decide these matters for themselves taken away from them by people who believe that they know better than the patient what is best for them.

For someone to resort to asking another person to help them die – they must be in a very dire state indeed. Kant believed that because our natural instinct is to stay alive, we have a duty to desire to continue living under every and all circumstances. However, having suffered the pain and indignity that their unwanted and unasked-for illness or disability has inflicted on their lives - these patients no longer have a desire to continue living.

A patient who is chronically sick, terminally ill or suffering with a severe disability has lots of time to think seriously about matters of life and death – more so that those of us who are relatively fit and healthy (there is not much else one can do when confined to bed for hours on end) and as long as their mental faculties are fully functioning, they can come to a perfectly logical decision without any direct or indirect interference from anyone else.

Some would say that euthanizing one consenting patient will start a trend for Nazi-like mass-murdering of everyone who does not fit the model of perfect health – but as I have repeatedly shown throughout this thesis, open discussion and strict legislation can prevent such horror stories from ever becoming reality again.
So in conclusion – the patient has every moral right to consider euthanasia – which society must recognise in order to stop violating the rights of the most vulnerable members of our society.

2. Who is (ethically) the best person to ask to kill the patient?

As I said in the Introduction to this Thesis, current rules against the deliberate taking of human life are frightening patients who have no other hope of ending their suffering. If no-one is willing to help them, are we not condemning these patients to live a life of pain and misery? Would we not be forcing these patients to endure what amounts to constant physical and mental torture, against their will? Doesn’t torturing people go against all manner of moral codes, not just legal, moral, religious or cultural?

And even if the patient does find someone willing to take the risk in order to help them, doesn’t the worry of what might happen to the helper after their death, just add to the patient’s worry and suffering?

Within the medical profession, there is a duty to respect the dignity and privacy of the patient and be honest with them, whatever their state of health. They also have a duty to protect their patients from harm. By not at the very least considering the patient’s plea for help – they are breaking their own rules and inflicting more harm on their patient. This means that our patient has every right to ask for euthanasia from a member of the medical profession because the patient’s views must be heard and treated with politeness and consideration – even if they are going to get a negative answer.

The same can be said of anyone else whom the patient is considering asking. If they are true friends, the patient’s relatives and friends (including their choice in Holy Person) would do their best to protect the patient from harm, and will likely remain loyal to the patient. True friends too have a duty to listen to the patient and treat them with politeness and consideration – even if they are going to get a negative answer.

It only takes one person to take the life of a willing patient. If the patient can find someone who is willing to risk a substantial prison sentence, the wrath of society and even possible eternal damnation, then the patient should at least ask – the worst that the potential agent can say is no.
As to who that person is – everyone is different, and as I have shown, different people can interpret the same varying rules of morality in widely differing ways. It really is up to the patient to find someone suitable – someone with whom they can trust with their most important possession – their life.

The End

A thesis focusing on Euthanasia and The Patient
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