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Eduardo Rodriguez

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The Arguments for Euthanasia and Physician-Assisted Suicide: Catholic Response

by

The Rev. Eduardo Rodriguez, Ph.D., M.D.

*The author is Professor of Medical Ethics at the Medical School
of the Catholic Pontifical University of Santiago*

Introduction

Over the last several years there has been a significant debate about the ethics of making active voluntary euthanasia and physician-assisted suicide available for terminally ill patients, including arguments for their moral adequacy. There is an increasing tendency to write in favor of accepting the morality of euthanasia in an effort to fit into public consensus. By "physician-assisted suicide" it is meant that the physician provides the means for a patient to end his or her life. By "active euthanasia" it is meant that the physician personally administers a lethal drug. Death will be caused to end a life of suffering, either because the patient does not want to continue living or because life has deteriorated to such a condition that it no longer can be considered dignified.

Advancements in medicine have led to examination of the obligation to consider the use of all possible means of keeping a person alive, or if we are to do this when there is little chance of success. The issue has arisen of the question of a right to die with dignity.

For some, this means to die without pain, through medical intervention or assisted suicide. Any death that is accompanied by suffering is considered undignified in today's mentality. Death can be caused by administration of a drug with the intention of ending life as well as ending suffering. Such active interventions are chosen when there is no

possibility of a cure and when the patient has expressed his desire not to continue living.

For many others, the right to die with dignity implies the removal of life support systems or the withdrawal of treatment from terminally ill patients in order to allow the patient to succumb to the underlying disease. This frees the person from the slavery of aggressive medical treatment, which prolongs suffering.

There has been a debate over the reach of the term "euthanasia". In the past, that term has been divided into active and passive. Passive euthanasia means to hasten the death of a patient by removing life support equipment or stopping medical procedures or treatment. Active euthanasia means to immediately cause death by the application of a lethal agent. From the point of view of professional ethics, it is irrelevant whether the life of the patient was taken by an active intervention or by omission of a necessary treatment. Through both, death is brought about intentionally.

The definition of euthanasia must be understood as, by action or omission, the deliberate ending of the life of a patient who is suffering or has an incurable disease, and this has been requested by either the patient or the family.¹ Here, omission is understood to be the privation of a medical intervention that is considered valid and necessary for the patient to live.

On the other hand, there is no euthanasia in the removal of unnecessary life support, or in death caused by the "double effect" of drugs that are given to relieve suffering but may also shorten life, or refraining from medically futile treatment. There is no obligation to undergo or prolong a treatment that is considered futile by the medical profession. The practice of allowing death with palliative care interventions to relieve the terminally ill patient's pain, suffering and other symptoms is accepted as ethical and legal, provided the intention of the physician is to relieve pain and other symptoms, and not to hasten death.²

Physicians are considered the logical candidates from whom to seek help in dying since many of the terminally ill see help in dying as an extension of relief from suffering and as a form of caring, consistent with the profession.³ Furthermore, it is already being done in countries like Holland. In addition, according to anonymous polls, 13 to 19% of physicians in the United States have participated in physician-assisted suicide.⁴ Oregon has been the first state to legalize physician-assisted suicide.

In the present reflection I am going to analyze the arguments in favor of euthanasia and physician-assisted suicide and consider a critical response from the Catholic Christian perspective for each of them, taking into account as well that there is also a rationale for the secular mind.

Reasons Given in Favor of Euthanasia and Physician-Assisted Suicide and Catholic Response

1. Poor quality of life. Those who advocate euthanasia and physician-assisted suicide argue that in some circumstances living is worse than dying, that the pain and suffering caused by a terminal disease may make life so agonizing and unbearable that death may seem "an act of humanity" and physician-assisted suicide a way to die with dignity.⁵ The physician would act under the principle of beneficence to relieve the pain and suffering of terminally ill patients. For the dying patient, suffering may go far beyond pain. This includes: progressive loss of activity, mobility and freedom associated with increasing helplessness and dependence on others; physical discomforts such as nausea, vomiting, inability to swallow or to talk, incontinence and weakness; fear of dying, loss of dignity; and dementia.⁶ Life loses all quality and meaning so that death is preferable.

Critical response: Quality of life issues are confused here with the value that the quality of life has. Human life has an intrinsic value.⁷ Good health cannot give dignity to human life, since health does not have life in itself, rather it participates in life. Health is a good that one can enjoy and care for, but it is not an absolute good to which everything else must be subordinated. Health is for the human being, but the human being is not for health. The dignity of the person cannot be erased by illness. Rather, loss of dignity is imputed to the patient by reactions of caregivers and family to the patient's plight or appearance. Furthermore, quality of life issues have a strong subjective component. Very easily the health care professional will substitute his or her quality of life standard for that of the patient.

Dying with dignity must not be understood as a right to active euthanasia or physician-assisted suicide when one is enduring a poor quality of life due to pain and suffering, rather it is a right to die in a dignified environment, receiving care and affection from persons to whom one is close, and the right not to prolong suffering with futile treatments. Suffering is not only caused by pain, there are many circumstances that cause suffering. The values, fears, and anxieties of the person must be attended to when death is near.

2. Respect for the patient's autonomy. According to the defenders of euthanasia, respect for autonomous persons demands recognition of their right to decide how they will live their lives. This includes the dying process. It is proposed that we have the right to avoid intolerable suffering by exerting control over the way we die; we are free to take responsibility for our own life, including our death. Every person has an individual level of tolerance for suffering and therefore there is no objective measure of when life is unbearable that can apply to everyone. This is why it is

necessary that the patient exercise his/her autonomy. Some authors believe that there is a right to commit suicide and to have no unreasonable restrictions placed on the means by which one can exercise this right to suicide.⁸ States would not have the right to prevent a patient from the freedom to take his/her life. Battin has argued that there is an unequally distributed but fundamental right to suicide, which we have because it can be constitutive of human dignity, at least in a negative sense, when life becomes unbearable.⁹ This is even more relevant if we consider that, with adequate palliative care, there are cases in which it is not possible to avoid the suffering.¹⁰ The patient's right to self-determination has been a most central argument in favor of physician-assisted suicide.¹¹ Often it is assumed, without argument, that this implies a patient's right to request another agent to intervene so as to bring about his or her death.¹² A person who is terminally ill may not be able to exercise the option of suicide because of mental or physical limitations. In a way, they are being discriminated against because of their disability, since able-bodied people can exercise the option. It is also argued that future patients would be less anxious if they know of the possibility of physician-assisted suicide.

Critical response: The terminally ill patient is in an extremely vulnerable position, suffering from depression, anxiety, fear, dejection, guilt, and diminished autonomy. Under these conditions, it is very difficult to have a clear mind to make decisions and the patient may almost blindly follow the suggestions of the physician. Asking for death does not necessarily reflect an enduring, voluntary wish, properly reflected upon. The patient may wish death because of deficiencies in medical attention, such as not being able to alleviate pain, not because of a free decision. Further, it is not the same to commit suicide as to aid in a suicide. The latter is a form of homicide, even if the underlying reason is compassion. The autonomy of the patient cannot override the physician's autonomy.¹³ The patient has no right to ask another person to help in suicide.

3. The principle of beneficence. The principle of beneficence, or compassion for the suffering has been used as an argument in favor of euthanasia.¹⁴ In this way, euthanasia has been considered a virtuous act. Nonabandonment of the patient has been part of the traditional care by physicians. Physician-assisted suicide must be judged under this ethical principle.¹⁵ Today, many terminally ill patients consider physicians the logical ones to help them in dying since, for these patients, assisting death is considered an extension of alleviating suffering and exercise of care, consistent with the profession.¹⁶

Critical response: The compassion talked about by the proponents of euthanasia reflects a distorted view. True compassion does not eliminate the sufferer, but seeks to relieve the cause of the suffering.¹⁷ Otherwise, the

life of the patient is devalued. Besides, compassion is a spiritual quality, which means "suffering with," to be present to the sufferer, it is not a principle or self-justifying reason. Choosing assisted suicide eliminates all possible bonding with those who accompany one in the difficult moments of death. Further, to bring about death by euthanasia is not within the competence of the medical profession. Physician-assisted suicide is not consistent with the doctor's pledge to heal and treat, is against the traditional ethical codes (Hippocratic, World Health Association, AMA). It will lead to a distrust in physicians. Accepting assisted suicide will diminish the peoples' trust in physicians. Moreover, the health professional also has an autonomy that must be respected and he/she cannot be pressed to act against his/her professional values.

4. The positive experience of acceptance of euthanasia in Holland. The experiment of euthanasia in Holland is regarded as successful by the general public and the medical profession in that country, so that no physician who follows the given guidelines can be penalized. These guidelines are: the patient must be competent and ask voluntarily for death after having been counseled, his/her suffering must be unbearable not possible to ameliorate, the judgment of the physician with respect to diagnosis and prognosis must be confirmed by another physician.

Critical response: The experience in the Netherlands has shown the reality of the slippery slope. There have been successive steps in relaxation of criteria: euthanasia has been extended to non-terminal patients, minors, Down Syndrome, patients with mental suffering, severe depression, dementia, incompetence "under certain conditions, and non-terminal AIDS patients."¹⁸ This evil reality exceeds the positive effect that could be claimed for legalized euthanasia.¹⁹

5. Diminishing of the public stigma against suicide. The public stigma against suicide is decreasing. In most jurisdictions, suicide is a legal act and has been so for decades. Most suicides are seen as resulting from temporary mental illness, usually depression,²⁰ but the reason why terminally ill patients desire to shorten the process of dying is to terminate their suffering. This raises the concept of rational suicide.

Critical response: Suicide is still considered an evil in today's society and when it is known that someone is attempting suicide, measures are taken to prevent it. Data suggest that the interest of patients in euthanasia in the majority of cases is due to depression or psychological distress, rather than pain. This suggests that much of the debate about euthanasia is misplaced, since it focuses on pain and using euthanasia for pain relief when, in fact, pain does not seem to be the primary motive.²¹ Suffering of psychological origin can be relieved with adequate counseling

and psychiatric intervention. With proper support, including pain relief, psychological and spiritual therapy, and friendship, the patient can die in a dignified way as a member of the human family, without any euthanasia. No present legislation allows help in committing suicide for a person who is going through a period of depression. Rather, his/her depression would be treated. To legalize physician-assisted suicide would contribute to desensitization toward killing throughout society. Though attempting suicide has lately been decriminalized, the state's interest in preventing it, including the penalization of those who aid the attempt, has not wavered. No matter how ill a person, he is still among the living and therefore has the right to live.²² Moreover, because life does not belong completely to us, we simply do not have a right to commit suicide. No one can say that he/she has given life to himself/herself. Not all ultimate choices about one's life qualify as protected rights.

6. The similarity between killing and letting die. The distinction between "passive" and "active" euthanasia has been criticized for depending on problematic conceptions of causation and on the belief that the sheer difference between killing and letting die is morally irrelevant. Discontinuing life support measures and active voluntary euthanasia are similar from the patient's point of view in that the fundamental desire is for an earlier and more comfortable death. They are similar morally in that both are done with the intent of ending life.²³ It is argued that the intention is morally irrelevant in the evaluation of the morality of the action. For example, in the case of stopping feeding artificially a patient in coma, clearly the intention is to end life, since the person would die of hunger. In the case of discontinuing supportive measures and allowing the patient to die after days or weeks of extreme discomfort, active euthanasia is sometimes deemed morally preferable.²⁴ For some, discontinuing a ventilator cannot be considered a refusal of treatment, rather it is a request to be killed.²⁵ For Patrick Hopkins,²⁶ there is no metaphysical, essential and intrinsic moral difference between machines and body organs so that omitting treatment is a form of killing in which we deprive the person of an organ that can only function with the aid of a machine or technology. He feels that we need to set aside our prejudices against the artificial and extend the option of good killing (active euthanasia) to those who are trapped by nature. If our society recognizes that life can be sufficiently burdensome while on life-sustaining treatments, such as a respirator or dialysis machine, and further that these interventions can be withdrawn or withheld (what some call passive euthanasia), then it can be sufficiently burdensome to justify active euthanasia.

Critical response: There is a special relationship between the physician and the patient. An omission to act, if it results in harm, may

bring legal liability. If a competent patient refuses to consent to treatment or to continue treatment, the legal effect is that the physician is absolved of his or her duty by the patient. Although the physician terminates treatment, the subsequent death is caused by the underlying disease, which the physician no longer has authority to treat. The physician is not killing the patient but allowing him to die. Ordinarily no one is under any duty to help a neighbor, such that omissions to act bring no liability.²⁷ Voluntary acceptance of a death that medical intervention can only postpone cannot be forbidden.

What is forbidden is unlawful killing. Often in the dialogue, there is confusion between passive euthanasia and euthanasia by omission. The latter brings legal liability but the former does not since natural deaths are not killing. Thus, they are neither illegal nor immoral, and do not confer responsibility. It will prove helpful to avoid the term passive euthanasia, while we can retain the idea of euthanasia by omission, which implies a negligent act.

A conclusion about causation simply reflects a judgment about the right place to assign responsibility. When a person turns off a life-supporting respirator without authorization, it is clear that he/she is causing the patient's death and is subject to liability, but when a physician follows the patient's directions to disconnect a respirator, he has not acted wrongfully. He has no duty to continue treatment against the patient's wishes, even though his action is causally related to the patient's death. Furthermore, the right to avoid treatment is based on the right to resist physical invasions that are not proportionate to the cost to the patient, not in the right to accelerate death, which does not exist.

Withdrawal or withholding treatment is accepted in such cases as: continuation of mechanical ventilation after whole brain death, therapy in cases of irreversible coma (except ordinary care), life support mechanisms in cases of terminally ill patients, resuscitating techniques in cases considered futile by the medical profession, medically futile therapies that increase pain, and therapies clearly disproportionate in relation to human costs and utility for the patient.²⁸

An illustration that intention has its place in moral life is that when the person does not die after removal of the treatment, the person is left alive. This is not satisfied by assisted suicide. It is one thing to desire death and actively bring this about and another thing to desire death and allow it to occur. It is one thing to respect the will of the patient to reject treatment and another to take his life. It is not just a psychological difference, but also a moral one. To kill is always a lesion of the principle of non-maleficence, but to allow death is not, under certain conditions. To allow someone to die of a disease for which we are not responsible and cannot cure is to allow the disease to be the cause of the death.²⁹ The intention of

allowing to die is compassion, not death, while the intention of active euthanasia is death as a means for compassion.³⁰ It does not maintain the dignity of the patient to continue futile treatments when there are no possibilities of cure. A futile treatment does not produce a benefit to the patient, but a harm.³¹ It is not the same to maintain life in someone who is living as it is to as to prevent death in someone who is dying.

A treatment is considered futile if it does no more than maintain unconsciousness or if it does not permit an end to dependency on the intensive care unit. Quantitatively, a physician can consider a treatment futile when empirical data demonstrate less than 1% probability of benefit to the patient.³² Life and death issues cannot be decided with absolute certainty, simply because there is no strict and specific relation between the etiology and the disease. Our knowledge of an empirical reality is always approximate, probable. We cannot ask the physician for absolute certitude in his/her decisions. Therefore, it is necessary to establish a prudent limit of error for life and death decisions. Since there is no absolute certainty, it is the decision of the patient to continue with a futile treatment. For an act of omission to be euthanasia, the treatment omitted or withdrawn must be a useful one, not a futile one.

7. The principle of double effect is a form of active euthanasia.

Physicians are allowed to give increasing doses of narcotics when there is severe pain. It is presumed they do this with the knowledge that these drugs depress respiration and could hasten death.³³ It is argued that if the death of the person who wishes to die is not an evil for himself/herself, then the doctrine of double effect does not have relevance in allowing voluntary euthanasia.

Critical response: Optimal palliative care could provide adequate pain relief for most terminally ill patients.³⁴ Inpatient hospice units provide an example of providing supportive measures at the end of life, with comfort care directed to the person as a whole. Legalizing physician-assisted suicide would divert attention from pain relief and palliative care. The easy road for the health care professional is to be free from the frustration, hostility and anguish that cause the "hopeless" cases. The issue of hastening death with palliative care interventions for terminally ill patients is accepted as ethical and legal provided the intention of the physician is to relieve pain and other symptoms and not to hasten death.³⁵ Physicians, though, must be careful not to introduce narcotics in a big dosage all at once, without giving the patient time to develop tolerance. A disproportionate sedation can cause interruption of feeding and hydration of the patient, who can die of hunger or thirst while unconscious or even of an overdose. In such cases, euthanasia can be concealed. Ethically, the

physician must look for the pain relief that will offer less risk to shorten life and still relieve the patient from unnecessary suffering.

8. The duty of not imposing heavy burdens on those close to us. John Hardwig has argued that when modern medicine allows us to survive far longer than we can take care of ourselves, there is a duty or responsibility to die, out of consideration for our loved ones not to impose crushing burdens on them.³⁶ In a time when medical funding is restricted, it may not be ethical to engage in extremely expensive treatment of terminally ill people. David Thomasma argues that it could be ethical to ask for physician-assisted suicide or active euthanasia because of love for close relatives, considering that in Christian doctrine there are instances in which killing is justified and also considering that such a request could be considered acceptance of the cross, or the acceptance of death as the martyrs had done, since having been able to avoid death, they accepted it instead, donating their lives for others.³⁷

Critical response: To allow physician-assisted suicide would have an impact on other sufferers who are ill, aged, or weak. This will devalue their lives and they may undergo assisted suicide under pressure. Further pressure is exerted by economic constraints, but mentioning this to the patient undermines the call to generosity of those who surround the patient, who is suffering enough already with the disease. Terminally ill patients would lose the bonds with those who accompany them in the last moments of life, they would have to justify their decision to keep on living. To help discover, through suffering, the meaning of the entirety of life can liberate the patient from feelings of abandonment and desperation when facing death.

Furthermore, the voluntary acceptance of death by Christ and the martyrs can not be interpreted as equivalent to suicide.³⁸ As has been pointed out by Engelhardt,³⁹ Christ has taught us that life has as a goal union with God and His cross is a way to offer His life to God. Suicide, instead, is an act in which the person turns against himself/herself, wishing death without pursuing union. The martyrs never accepted death under the premise of refusing to be a burden to themselves or their loved ones. To the contrary, they accepted with humility the indignity and suffering of death because of a superior cause, the union with God. This has nothing to do with active euthanasia or assisted suicide.

Ethical Reflection

Practically all religious traditions, including groups such as Christians, Muslims, and Jews, consider life as a gift from God, to be given and taken at the time of His choosing; suicide can never be an option. Aristotle

affirmed⁴⁰ that suicide is an unjust act and cannot be allowed, not because it goes against the individual, but because it goes against the community. Human life has value and dignity in itself because it is the life of a person. Physical life is constitutive of the person and a condition for its existence, is the fundamental value of the person and therefore cannot be valued, taking as criteria minor and relative values, nor can be declared to the disposition of others. Besides, Christians believe that God supports people in suffering and therefore to actively end one's life would represent a lack of trust in God's promise.⁴¹ Taking life usurps the prerogative that God has over each one of our lives. Also, as Christians, we have an obligation to support those who are suffering and to maintain our belief that suffering brings us closer to Christ, identifying us with His cross and participating in redemption.

Part of the problem with much of the present debate on euthanasia is that no value is given to suffering, although it could be an occasion for a person to look deeply into his/her own existence, to look for reconciliation and find a transcendental meaning to life. Nowadays people have very little tolerance for pain, we are afraid of it. This fear is due to an excessive preoccupation with the body and to technical progress. In these, thanks to alleviation of pain by drugs and anesthesia, we are today much less familiar with pain than our predecessors were. It has gotten to the point that death is accepted more than pain. This rejection of suffering has led to the social acceptance of euthanasia.

But suffering can lead to a spiritual experience and it is possible to find meaning in life when there is no hope of cure.⁴² Spirituality can fortify a person who suffers and help him accept his condition. Finding meaning to suffering gives sense to a suffering life that has little capacity for relationships. Even considering that life can become unbearable, the final matter is that life cannot be taken because suicide is not ethical.

The question can be raised as to whether believers have the right to take these beliefs and impose them on the entire populations, including secularists, atheists, and agnostics. I will argue that they do in this case, since it is possible to find a rational solution. Both believers and non-believers agree with the common conception that life and death are given to us. The only difference is that believers attribute this gift of life to God. Not everything, then, is autonomous in the human being. We do not give life to ourselves, we have received it from our parents. Therefore, we do not have absolute dominion over our own lives and cannot take them.

This argument reinforces all the critical arguments against euthanasia, since the quality of life cannot have greater value than life itself. The autonomy of the person cannot be absolute, true compassion cannot consist in eliminating the sufferer, suffering cannot be enough argument to accept suicide, to allow to die is in the context of accepting death as a part of life, and to alleviate pain and suffering is to help life. To treat the body as if it

were an object that could be freely destroyed violates the intrinsic dignity of the person. We have the responsibility and the duty to take care of each other until the natural end of our lives. We have received our lives, they are not objects that we possess. Rather, we are responsible for what we do with them. We are able to exercise options and it is this that makes us responsible for our lives.

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37. D.C. Thomasma, "Assisted Death and Martyrdom," *Christian Bioethics* (1998) 4: 122-142.
38. "One must clearly distinguish suicide from that sacrifice of one's life whereby for a higher cause, such as God's glory, the salvation of souls or the service of one's brethren, a person offers his or her own life or puts it in danger," Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, 1980.
39. H.T. Engelhardt, Jr., "Physician-Assisted Death: Doctrinal Death: Doctrinal Development vs. Christian Tradition," *Christian Bioethics* (1998) 4: 115-121.
40. *Ethics to Nicomachus*, V, 11: 1138a 12-15.
41. The Magisterium has evaluated euthanasia as "a grave violation of the Law of God, since a deliberate killing is morally unacceptable for the human person," *Evangelium Vitae*, n. 65.
42. "Suffering is a call to manifest the moral grandiosity of the human being, his spiritual maturity," John Paul II, Apostolic Letter *Salvifici Doloris* VI, 28.