EUTHANASIA

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Literature

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In most Western societies, the Judeo-Christian religious tradition has given great importance to the sanctity of life. Modern medicine has also gained extraordinary new powers to prolong life. Within the last few decades, medical treatments such as kidney dialysis, cardiopulmonary resuscitation, organ transplantation, respirator support, and provision of food and water by artificial means have become common in hospitals. The ethics of euthanasia has been the subject of intense discussion throughout the world.

The term Euthanasia originated from the Greek language: «*eu*» means «good» and «*thanatos*» means «death». One meaning given to the word is «the intentional termination of life by another person at the explicit request of the person who dies».

It is common practice to differentiate some forms of euthanasia.

Passive euthanasia is usually defined as withdrawing medical treatment with the deliberate intention of causing the patient's death. For example: removing life support equipment (e.g. turning off a respirator) or stopping medical procedures, medications etc., or stopping food and water and allowing the person to dehydrate or starve to death. Not delivering CPR (cardio-pulmonary resuscitation) and allowing a person, whose heart has stopped, to die.

Active euthanasia occurs when one person performs the act of ending another person's life. An example of this may be a nurse injecting the lethal dose of a substance into a person's vein with the intention to end that person's life. So, the difference between «active» and «passive» is that in active euthanasia, something is done to end the patient's life; in passive euthanasia, something is not done that would have preserved the patient's life.

We may also classify euthanasia as:

— Voluntary euthanasia — it is when a clearly competent person makes a voluntary and enduring request to be helped to die.

— Non-voluntary euthanasia — instances of euthanasia where a person is either not competent to, or unable to express a wish about euthanasia and there is no one authorised to make a substituted judgment.

— Involuntary euthanasia, where a competent person's life is brought to an end despite an explicit expression of opposition to euthanasia, beyond saying that, no matter how honourable the perpetrator's motive is, such a death is, and ought to be, unlawful.

Besides these types we define «assisted suicide», a doctor provides a patient with the means to end his own life (e.g. a prescription for lethal dose of sleeping pills), but the doctor does not administer it.

Debate about the morality and legality of voluntary euthanasia has been, for the most part, a phenomenon of the second half of the twentieth century and the beginning of the twenty first century. Several factors have contributed to the increased interest to euthanasia. In 1988 there was an unsuccessful attempt to get the question of whether it should be made legally permissible on the ballot in

California. In addition to some cases of this kind, such as «It's Over, Debbie», described in the Journal of the American Medical Association, the «suicide machine» of Dr. Jack Kevorkian, and the cancer patient «Diane» of Dr. Timothy Quill, have captured wide public and professional attention.

The central ethical argument for euthanasia — the respect for persons demands respect for their autonomous choices as long as those choices do not result in harm to others — is directly connected with this issue of competence, because autonomy presupposes competence. People have interest in making important decisions about their lives in accordance with their own conception of how they want their lives to go. In exercising autonomy or self-determination, people take responsibility for their lives; since dying is a part of life, choices about the manner of their dying and the time of their death are, for many people, part of what is involved in taking responsibility for their lives. Many people are concerned about what the last phase of their lives will be like, not merely because of fears that their dying might involve them in great suffering, but also because of the desire to retain their dignity and as much control over their lives as possible during this phase.

The technological interventions of modern medicine have had the effect of stretching out the time it takes for many people to die. Sometimes the added life brings is an occasion for rejoicing; sometimes it drags out the period of significant physical and intellectual decline that a person undergoes in burdensome ways so that life becomes, to them, no longer worth living. It is the second argument which points up the importance of individuals being able to decide autonomously for themselves whether their own lives retain sufficient quality and dignity to make life worth living. One objection to euthanasia is that it involves killing, and all killing is morally wrong. This principle may be based on religious views (e.g., the sixth commandment) or maintained by purely secular grounds. Euthanasia violates some duty to God, or to ourselves, or to others.

The next group of argumentation supposes that there is always the possibility of an incorrect diagnosis or the discovery of a treatment that will permit

either survival or recovery. We can never be absolutely sure that we have voluntary and informed consent. If the request is made prior to patients' coming to be in a desperately bad way — say in the form of a living will — it cannot be considered binding because it is insufficiently informed. On the other hand, if the request is made when patients are in a bad way, then the pain and drugs prevent them from making a fully rational decision. In either case, it is not possible to secure a death-request which would justify it.

The chronically and terminally ill are often vulnerable and feel themselves to be (and often are) a burden to others. Many of the ill, however, are not tired of life and do not want to die. But if assisted suicide and active voluntary euthanasia were readily available, they might feel obligated to ask for death, and relatives or others in whose care they are, who often would just as soon get rid of the burden, may consciously or unconsciously exert pressures, in a way difficult to detect and avoid, to request assistance in committing suicide or active voluntary euthanasia.

Legalizing assisted suicide and active voluntary euthanasia today will lead to active non-voluntary euthanasia tomorrow, and that will lead to active involuntary euthanasia the day after: the antisocial, the ethnically unattractive, the politically deviant, the aged, etc., will all become potential victims. Thus if we do not draw the line where it is, we will not be able to prevent substantial harm to others. This is the famous slippery slope argument.

The medical profession exists to provide important professional services, and neither wants to be nor should be involved in the kind of bureaucratic activity involved in responsibly administering the delivery of assisted suicide and active voluntary euthanasia. The legalization of assisted suicide and active voluntary euthanasia will discourage the search for new cures and treatments for the terminally ill patient.

Patients who struggle to recover have better recovery rates than those who have given up hope. The availability of assisted suicide and active voluntary euthanasia will encourage patients to give up, and thus significantly decrease their chances for recovery.

The Netherlands has become the first country in the world to legalize euthanasia. In The Netherlands the Termination of Life on Request and Assisted Suicide Act, legalizes euthanasia and physician-assisted suicide in certain circumstances. In the Netherlands the guidelines were established to permit physicians to practise voluntary euthanasia in those instances in which a competent patient had made a voluntary and informed decision to die, the patient's suffering was unbearable, there was no way of making that suffering bearable that was acceptable to the patient, and the physician's judgments as to diagnosis and prognosis were confirmed after consultation with another physician.

Euthanasia was legalised in Australia's Northern Territory, by the Rights of the Terminally Ill Act 1995. However, this law was soon made ineffective by an amendment by the Commonwealth government to the Northern Territory (Self-Government) Act 1978. (The powers of the Northern Territory legislature, unlike those of the State legislatures, are not guaranteed by the Australian Constitution.)

After an extensive discussion the Belgian parliament legalised euthanasia in late September 2002. The new legislation, however, institutes a complicated process, which has been criticized as an attempt to establish a bureaucracy of death. Nevertheless, euthanasia is now legal and its proponents in the country hope that it will stop many illegal practiceces.

In Oregon in the United States, legislation was introduced in 1997 to permit physician-assisted suicide after a second referendum clearly endorsed the proposed legislation. Later in 1997, the Supreme Court of the United States ruled that there is no constitutional right to physician-assisted suicide; however, the Court did not preclude individual states from legislating in favor of physician-assisted suicide. The Oregon legislation has, in consequence, remained operative and has been successfully utilized by a number of people.