EUTHANASIA AND ALLOWING TO DIE*

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The views of people concerning euthanasia are influenced by their fears of enduring intolerable pain, of being trapped by machines beyond their control and of losing bodily integrity and personal dignity in the final stages of their lives. A multitude of achievements in modern medicine and information provided by the mass media serve to reinforce and even provoke a person’s fear of being kept biologically alive in the terminal phase of his or her illness, without any hope for recovery.

Needlessly and senselessly prolonged pain and suffering understandably contributes to a patient’s fears, as does the patient’s loss of autonomy while being subjected to artificial life support against his or her will.

For these reasons people are earnestly considering the aspects and ramifications of accepting help to die. An important question should be asked: does the progress of medical knowledge and technology influence attitudes as to whether or not euthanasia should be accepted as part of medical practice?

1. Euthanasia – What Is It?

The word *euthanasia* is derived from two Greek roots, “eu” (good) and “thanatos” (death), transliterating to “good death”, or “happy death”. Circa 300 B.C., it is believed that the term euthanasia was used for the first time by Posidip. Later Philo, with Sveton, used it as a designation of a relatively easy or painless death. Thomas More understood the word euthanasia as the assistance given by a priest or physician to a person trying to achieve an uncomplicated or “smooth” death. More’s meaning of euthanasia included the person’s refusing meals and, at least in some cases, the providing to that person of a drink containing a strong sleeping agent.

And in historical medical terminology, euthanasia has always expressed an altruistic and kind assistance given by the physician to the dying patient in order to diminish pain and alleviate the patient’s suffering.

* This paper is dedicated to the 80th anniversary of the birth of prof. E. Pellegrino of Georgetown University, Washington D. C., USA.
It is only in the course of the twentieth century that the neutral (or even positive) word “euthanasia” (“good death”) has taken on the negative connotation of the direct killing of a patient who, lacking the prospect of recovering health, might want this kind of immediate death.

An explicit and current definition of euthanasia can be found in Webster’s New International Dictionary as follows: “the act or practice of killing individuals that are hopelessly sick or injured for reasons of mercy”. Some opponents of euthanasia ignore the word “euthanasia” itself, preferring instead the term “mercy killing”, for the reason that the act of euthanasia is considered by them to be priorly a “killing” with a motive claimed to be that of “mercy”.

The Declaration on Euthanasia of the Congregation for the Doctrine of the Faith, (May 5th, 1980), describes euthanasia as “an action or an omission, which of itself or by intention causes death in order that all suffering may in this way be eliminated”.

2. Arguments against Euthanasia – Are there Categories of Distinction?

The noun “euthanasia”, in the literature is very often modified by an adjective so as to draw a distinction between different types or categories of euthanasia. Unfortunately, this often leads to confusion as the modifiers seem to assign a quality or judgement. Further confusion is introduced because the same act or same omission, for example, is described by different authors using different adjectives. These different sets or pairs of adjectives, in effect, act as synonyms.

The most common terminology used by authors to distinguish categories of euthanasia are:

- Direct Euthanasia and Indirect Euthanasia
- Active Euthanasia and Passive Euthanasia
- Positive Euthanasia and Negative Euthanasia

1 The cited definition was introduced in the first edition of Webster’s New Collegiate Dictionary. It seems to be even more appropriate then the definition used in the fifth edition of the same dictionary that is as follows: euthanasia is “a mode or act of introducing death painlessly as a relief from pain”.

2 “Until now deliberate killing has been regarded as something abhorrent in Western society. If we begin to accept killing as a good thing in order to solve one kind of problem, then we will soon find reasons to use killing in order to solve other kinds of problems. And history provides many examples of the kind of society we get, if killing is regarded as good”. N. M. DE S. CAMERON, Death without Dignity. Euthanasia in Perspective. Edinburgh 1990, p. 5.

3 “By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia’s terms of reference, therefore, are to be found in the intention of the will and in the methods used”. SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, “Declaration on Euthanasia”, May 5th, 1980, in: L’Osservatore Romano, June 30th, 1980.
Direct, active, positive euthanasia is considered by virtually all authors to be a positive act, an act of commission, inducing death.

Indirect, passive, negative euthanasia is usually considered to be the withholding of treatment, an act of omission.

But is there any need to distinguish categories of euthanasia? It would seem to be morally and practically dangerous to stress a difference between active and passive euthanasia. For example, many people – even ethicists – are inclined to pronounce that active euthanasia is forbidden while passive euthanasia is acceptable. However, recently the term “passive euthanasia” has been often used (or misused) for the withholding of treatment in an overly general sense. Few would claim that not administering chemotherapy to a comatose, vegetative patient, who also had cancer, would be passive euthanasia, but is it not, in some sense, the withholding of treatment? Therefore, it is more accurate to speak only about “euthanasia” where there is an intent to cause the death of a person in order to end suffering.

Also supporting this position is the recent statement of the Catholic Church (see 3) which emphasizes that euthanasia may result from an act, as from an omission of an act. Therefore, there is no need to distinguish between active and passive euthanasia from this particular moral point of view. In contradiction to past writings of the Catholic Church, new ecclesiastic documents do not speak about active and passive euthanasia, and thus the risk of misunderstanding is minimized.

Some authors distinguish between voluntary (autonomous) and involuntary (heteronomous) euthanasia. However, there is no good reason for introducing such terminology. Euthanasia can be only voluntary. In fact, an accurate and well-established term for the result of “involuntary euthanasia” is “homicide”, or “murder”. Recalling Hitler and the thousands of handicapped persons executed by the Nazis is quite appropriate in this connection.

There is also no need to distinguish between euthanasia performed by a physician and euthanasia performed by relatives, friends or other persons. In fact, by definition there can be no human euthanasia without a physician’s assistance.

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6 “Involuntary” Euthanasia is the killing of someone who could consent but does not. Such an action is indistinguishable from criminal homicide and the claim that the motive for the killing is “the best interests” of the victim is irrelevant-Euthanasia. Report of the Working Party to Review the British Medical Association’s Guidance on Euthanasia. London, May 1988 (para. 2–5.3).
3. Historical Roots

The claim for a “need” for euthanasia is frequently asserted because of the extensive progress of modern medicine. At first glance, this seems plausible. Nevertheless, we can find indications that the dilemma of “euthanasia” today was topical long before the era of modern medicine began. In the Hippocratic Oath one can read this promise: “I will neither give a deadly drug to anybody if asked for it, nor I will make a suggestion to this effect”. Obviously, the authors of this text, written circa 400 B.C., explicitly prohibit the act of mercy killing. It is reasonable to presume that euthanasia must have been accepted by at least some segments of that “pre-modern medicine” society because it would have been senseless to speak of that problem if public opinion and law excluded such an action in an outright way. Therefore, medical progress and technological advances cannot be used as a sole or even primary justification for euthanasia. Other factors, such as changes in ethical visions, growing relativism and expanding utilitarianism play a much larger role in any effort to justify euthanasia.

The idea of killing a patient is an ancient idea, indeed. Baby killing for eugenic reasons was common in Sparta, and Plato defended euthanasia in his Politeia. Deliberate termination of life, connected with relief of suffering, was acceptable for Stoa, as well as for Epicurus. Tacitus described in detail an act of euthanasia in the time of ancient Rome in his Annales. Philosopher and poet Seneca decided to end his own life as a means of dealing with his persecution by the emperor, Nero. It was typically during a time of decline when a person’s life was considered as not worth living.

Later on and for centuries, (with the exception of utopians Francis Bacon and Thomas More), a human life was deemed to have a limitless value and no reason would have justified killing an ill person by a physician. This supreme respect conferred to human life is expressed by one of Europe’s most famous nineteenth century medics, German physician Christopher Hufeland. In his “Macrobiotics or the Art of Human Life Prolongation,” he wrote, “The physician has a duty and is obliged to do nothing else than to preserve life regardless whether it is a good or bad existence, and whether it has worth or is worthless. It is not for the physician to decide.”

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7 “Bleeding was going too slowly and dying extended for a long time. Therefore Seneca asked his faithful friend and physician Statius Annaeus to bring him a foresightedly prepared poison used in Athenes when somebody was sentenced by the state law-court”. Tacitus, Annales.

8 “Der Arzt soll und darf nichts anderes tun als Leben erhalten, ob es ein Glück oder Unglück sei, ob es Wert habe oder nicht. Dies geht ihn nichts an. Und maßt er sich einmal an, diese Rücksicht mit in sein Geschäft aufzunehmen, so sind die Folgen unabwehbar und der Arzt wird der gefährlichste Mensch im Staat. Denn ist einmal diese Linie überschritten, glaubt sich der Arzt einmal berechtigt, über die Notwendigkeit eines Lebens zu entscheiden, so braucht es nur stufenweiser Progressionen, um den Unwert und folglich die Unnützigkeit eines Menschenlebens auch auf andere Fälle anzuwenden”. Ch. W. Hufeland, Macrobiotik oder die Kunst, das menschlichen Leben zu verlängern, 1836.
Toward the end of the nineteenth century, social Darwinism and racism tried to justify prescribed death and euthanasia, mainly in Germany (“das Recht auf den Tod”). Ernst Haeckel recommended the killing of physically crippled and mentally ill persons by means of morphine and cyanide. Early in the twentieth century, the first euthanasia societies were established. The “Voluntary Euthanasia Legalization Society” was formed in the United Kingdom in 1935 and the “Euthanasia Society” (later “Hemlock Society”) in the USA in 1938.

The danger of the slippery slope to a society embracing euthanasia was emphatically demonstrated in Germany at the time of the Second World War. In Nazi Germany, euthanasia was formally and openly practiced in the years 1940 and 1941. By August 24th, 1941, when sanctioned euthanasia was stopped as a result of international protest, 70,000 people (mainly Germans) had been killed. Euthanasia continued informally, of course. Hundreds of thousands of mentally or physically handicapped people were killed, and it should be noted that many of them were made available for “medical” experiments before their death. This horrific experience with euthanasia in the Nazi time is probably the main reason for the rigorous restrictions against euthanasia in Germany today.

Since the beginning of the 1960’s, new appeals for legalization of euthanasia and assisted suicide have found voice in the USA. Joseph Fletcher, a Protestant moralist, justified mercy killing as being an act of compassion. Daniel Marguire, a Catholic theologian, suggested that the circumstances under which the patient’s life was terminated determine the morality or immorality of such an act. Euthanasia Societies such as the Hemlock Society began to be more active. In 1976, California enacted “the living will law” which enabled people to determine (while still perfectly lucid and legally competent) what medical procedures would be used to “artificially prolong” their lives, or not, and under what circumstances. Most other states enacted similar laws. The movement known as the “Right-to-die” had started.

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9 The only “legal” basis for starting killing “incurable patients” was Hitler’s circular dated September 1st, 1939 (but written probably later): “Reichsleiter Bouhler und Dr. med. Brandt sind unter Verantwortung beauftragt, die Befugnisse namentlich zu bestimmender Ärzte so zu erweitern, daß nach menschlichem Ermessen unheilbar Kranken bei kritischster Beurteilung ihres Krankheitsszustandes der Gnadentod gewährt werden kann”.


12 See J. Fletcher, Morals and Medicine, 1954.

4. Recent Developments

**USA**

Even though efforts to legalize euthanasia and physician assisted suicide has been growing stronger in some states of the USA during the last twenty years, the American Medical Association House delegates have rejected euthanasia absolutely. Other influential groups have spoken out in a similar way. In 1994, Daniel Callahan, a prominent bioethicist and co-founder of the Hastings Center for the Study of Bioethics, declared that euthanasia is incompatible with the goal of medicine and with the competence of the physician. As a matter of law, euthanasia is illegal in the whole of the USA at this time.

**The Netherlands**

The Netherlands is the first country (excluding Nazi Germany) where euthanasia has been widely practiced. In 1984, the Dutch Supreme Court decided that a doctor who intentionally killed a patient may successfully invoke the defence of necessity if he had been faced with a “conflict of duties”, that being to protect life and to relieve the suffering of the patient.

The act of killing patients without their request has been confirmed by a commission appointed by the Dutch government in 1990. This commission, under the chairmanship of the Attorney General, Professor Remmelink, entrusted P.J. van der Maas, Professor of Public Health and Social Medicine at Erasmus University, with the task of carrying out a survey on the practice of euthanasia in the Netherlands. The published results are startling.

In 1990 there were approximately 129,000 deaths in the Netherlands of which 49,000 were in some way involved in “Medical Decisions Concerning the End of Life”, i.e. 38 %.

- 1,8 % Direct euthanasia (“terminating life at the patient’s request”);
- 0,3 % Assisted suicide;
- 0,8 % Life-terminating act without explicit request;
- 17,5 % Alleviation of pain and symptoms with opioids in such dosages that the patient’s life might have been shortened;

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17.5% Withholding or withdrawal of treatment, *without* explicit request, in situations where the administration of treatment would probably have prolonged life.

In 187 cases of direct termination of life at the patient’s request, ("i" above), the stated reasons were as follows:
- 57% i) loss of dignity;
- 46% ii) pain;
- 46% iii) “unworthy dying”;
- 33% iv) undesired dependence on others;
- 23% v) “tired of life”.

It is significant that the stated reason of “pain”, *as a single reason*, was present in merely 10 of the 187 total cases. Life was shortened in these 187 cases by at least one week in 70% and by more than 6 months in 8%.

In 22,500 deaths of “alleviation of pain and symptoms”, (“iv” above), there were 1,350 cases with the “explicit purpose of shortening life”, (450 of which were *without explicit request of the patient*), and 6,750 cases “partly with the purpose” of shortening life (5058 of which also were *without explicit request*).

In 25,000 cases of withdrawal or withholding of treatment without explicit request, (“v” above), there were 4,000 cases with “explicit purpose” of shortening life and 4,750 cases “partly with the purpose of shortening life”.

Lethal doses of drugs *without* a patient’s explicit request for life termination, (“iii” above), were administered in 1000 cases, i.e., in 0.8% of all deaths in 1990 involving “medical decisions”.

Summarizing the published data, John Keown concludes that there were 26,350 acts or omissions with intent to shorten life in the Netherlands in 1990.17

Euthanasia and “medical decisions concerning the end of life” became accepted by a large part of the Dutch public18. In 1995, five years later, there were approximately 135,000 deaths in the Netherlands of which 58,000 were in some way involved in “Medical Decisions Concerning the End of Life”, i.e. 43%.18

- 2.4% Direct euthanasia (“terminating life at the patient’s request”);
- 0.3% Assisted suicide;
- 0.7% Life-terminating act *without* explicit request;
- 19.1% Alleviation of pain and symptoms with opioids in such dosages that the patient’s life might have been shortened;
- 20.0% Withholding or withdrawal of treatment, *without* explicit request, in situations where the administration of treatment would probably have prolonged life.

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And in 1995, the Court of Alkmaar was the first to consider a case of an intentional killing of a handicapped newborn. The physician was exempted from punishment.

Though the practice of euthanasia is statutorily illegal in the Netherlands, the law established conditions, in 1993, under which providing euthanasia is tolerated and the physician is not punished. These required conditions are:

1) Euthanasia is requested voluntarily, explicitly and repeatedly by a fully informed patient;
2) The patient is experiencing intolerable (but not necessarily physical) suffering;
3) There is no other alternative to alleviate the patient’s condition;
4) The case is consulted with another physician experienced in the relevant medical specialty;
5) Euthanasia is performed by a physician, only;
6) The physician provides information via a questionnaire and reports the case to the local coroner.

The Remmelink Report and the van der Maas Survey clearly documented that a significant number of lives are terminated by physicians in the Netherlands, without a patient’s request. And thus, the Dutch practice of euthanasia has proven to be a real (not theoretical) slippery slope.

It should be noted that a large number of Dutch physicians disagree with euthanasia as practiced in their country. It seems that the benevolent attitude towards euthanasia has much to do with the generally liberal inclination of ethical issues in the Netherlands.18, 19

**Australia**

The only region where euthanasia has been formally legalized is the Northern Territory of Australia, in July 1996. However, the Australian parliament abolished the euthanasia law in March 1997.

5. **Assisted Suicide**

The differences between euthanasia and assisted suicide are mainly technical ones. In direct euthanasia the physician administers the means by which the death is caused, usually a lethal injection. In assisted suicide, the patient, himself or herself, administers the injection or drinks the lethal solution.

The differences from a moral point of view are less obvious. The main objections against assisted suicide are nearly the same as those against euthana-

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Euthanasia and Allowing to Die

A human life has an absolute (not relative) secular value; the task of the physician is to protect a life, not to extinguish it; and contemporary medicine should be and is able to relieve suffering of a terminally ill patient. Legalization of assisted suicide would likely open the way to pressing indigent patients to choose death instead of expensive care. The danger that social and economic pressures would motivate patients to choose death is one of the most important reasons why euthanasia is not allowed in nearly all the countries at this time.

The attitude toward assisted suicide is more liberal than toward euthanasia because it seems that a patient has a greater autonomy and is more protected from external pressures if it is he or she who must perform the final act. But, in fact, the patient has more a decisive role only during the time between the insertion of the needle and the depression of the plunger. That the patient would change his or her mind in these last seconds is not probable.

The proposition that there is only a minor responsibility on the part of a physician assisting a suicide, as contrasted with performing euthanasia, is not justified. The participation of a physician is a necessary condition for the realization of an assisted suicide. Therefore, if killing a person is wrong, then helping to kill is also wrong. The legalization of assisted suicide should be seen as the first step toward legalization of euthanasia.

In 1994, assisted suicide was legalized for the first time, in Oregon, USA. Eleven other states later liberalized their laws to some degree. American physician Jack Kevorkian declared that he had assisted at 130 suicides by the end of 1998. He advertised the use of his “suicide machine” in the newspaper for the first time in 1989. In 1990, Janet Atkins was the first person to die with his help.

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20 Nicolas Dixon summarizes the meanings of authors opposing euthanasia but defending assisted suicide: “...the health care system in the United States – in particular, the lack of universal access and the absence of close physicians-patient relationships – create a real danger that active euthanasia would be overused were we to legalize it in this country. Social and economic pressures, and not an authentic desire to die, may motivate patient’s request for active euthanasia. In contrast, the argument continues, we may safely legalize physician-assisted suicide because of the crucial difference that it places control firmly in the hands of the patient who wants to die. When patients themselves are the ones who perform the final act to end their lives, their actions are more likely to be autonomous and not unduly influenced by external pressures. Autonomous decisions by patients are intrinsically desirable and are less susceptible to abuse.” Then he explains: “The only moment when the patient has more control over her destiny in physician-assisted suicide than in active euthanasia is split second between the insertion of the needle and the depression of the plunger. … However, the chance of such last-second change of heart seems too remote to count as significant reason for preferring physician-assisted suicide to active euthanasia.” N. DIXON, “On the Difference between Physicians-Assisted Suicide and Active Euthanasia”, in: The Hastings Centre report 28, 1998, No. 5, pp. 25–29.


Dr. Kevorkian publicised most of his assisted suicide events, and his efforts soon became a cause celebre.

Kevorkian had been prosecuted four times in the 1990’s, specifically for the charge of violating laws against assisted suicide. Those prosecutions resulted in three acquittals and one mistrial. Then, in September 1998, he recorded an assisted suicide on videotape to again challenge the law. In this event, however, Dr. Kevorkian, himself, administered the lethal injection. And in the resulting trial, in which he was charged with murder, he was convicted, and received a sentence of 10 to 25 years, of which he must serve 6 before being eligible for parole.

It is interesting to note that at Kevorkian’s sentencing, the judge in the trial proclaimed to him, “This trial was not about the political or moral correctness of euthanasia. It was about you, sir. It was about lawlessness. When you purposely inject another human being with what you know is a lethal dose, that, sir, is murder.”

6. Right to Die

It is a duty of medicine and physicians to protect human life and to care for people’s health. That should not require, however, that life must be prolonged by any and all means and in any event. The means of prolonging a life may be withheld or withdrawn if those means do not or would not effectively help a person strive for the spiritual purpose of life, or if they impose a grave burden on the person in regard to striving for the purpose of life.23

Traditionally it is taught that there is a duty to use ordinary means of treatment while extraordinary means can be forgone. Paul Ramsey24 has offered a clear distinction between ordinary and extraordinary means that is currently accepted. Medicines, treatments and operations offering a reasonable hope of benefit for the patient are ordinary means if they can be obtained and used without excessive expense, pain and other inconveniences. If any of these features are absent, the means employed are extraordinary means.

The central role in decisions of this nature falls to the patient and therefore it is impossible to compile specific lists of ordinary and extraordinary means,

23 “It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected or a desire not to impose excessive expense on the family or the community.” SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH, Declaration on Euthanasia, 1980.
respectively. A treatment that is ordinary for one patient can be extraordinary for another. And the same treatment can be ordinary or extraordinary to the same patient in different circumstances.25

Hydration and nutrition pose particularly difficult and complex problems when considered in this medical setting. It is ironic that in this era of such technologically advanced medical procedures we find the most basic of human needs to be so controversial. Certainly food and water offer a “reasonable hope of benefit for the patient”. But what about a stomach tube? Is that “excessive pain and inconvenience?”

Some in the medical community consider food and water taken orally to be natural hydration and nutrition, and therefore ordinary means, while I.V. fluids are considered artificial, and therefore extraordinary. But how is a stomach tube more natural than a needle? And how is intravenously dripped dextrose, a carbohydrate from a bottle, less natural than stomach-tubed, pureed carbohydrates from a blender?

Reasonable, well-intentioned people can conclude that food and water administered to a comatose and vegetative patient by stomach tube is extraordinary means, offering no hope of recovery, and that the food and water may be ethically withdrawn. But if withdrawn, the patient faces a slow death by starvation and dehydration, which seems less kind than would be a bullet.

Perhaps some guidance can be found by considering what is being administered rather than why it is being administered. If the nutrition and hydration were to be considered a meal, then it would be unthinkable to withhold food and water, irrespective of what method was used to administer it. On the other hand, if the nutrition and hydration were to be considered medicine, then as an extraordinary means it would seem feasible to withhold it in particular situations. There are no easy answers and such decisions must be made on a case by case basis.

The Declaration on Euthanasia of the Congregation for the Doctrine of the Faith, (May 5th, 1980), acknowledges that the terms “ordinary” and “extraordinary” are less clear today and prefers the terms “proportionate” and “disproportionate”. When unreasonable procedures are necessary to keep someone alive, there is no obligation to apply them. Medical procedures should be proportionate to the results that can be expected.

If there is no real hope for a significant improvement of health and the only result would be just prolonging biological life, the use of disproportionate techniques can be withheld or withdrawn. However, withdrawing or withholding such should not be confused with euthanasia. A right to refuse treatment and a right to die cannot be confused with a right to be killed.

7. Conclusions

The precise definition is a necessary precondition for avoiding confusion. The word euthanasia should be perceived as an intentional killing of a patient at his or her request by a physician, in order to relieve the patient's suffering, by a positive action (inducing death) or by an omission (withholding treatment) of ordinary (proportionate) means.

The duty of a physician is to help the patient and to protect life and nothing can justify killing of a person. Causing a human death can never be considered help. Usually, a patient speaking about euthanasia is really asking for care (help) that is more humane and not for death.