Saving Life vs. Permitting Death: 

The Ethic of Euthanasia

Euthanasia can be considered one of the most prevalent problems when dealing with the ethics of patient treatment. Should people have the right to end their own lives when prolonging it will only cause them more pain? Should families who love someone so much, that they don't want to lose them, cause them more pain by keeping them alive. What makes that more ethically correct then letting them die? The more you look into this issue the more you see how contradictory people are when it comes to making these decisions. In this paper, I will start with defining the key terms, legal background, then give more detailed analysis on both sides of the euthanasia (people against or for it) and explains briefly my standpoint on the subject. Introduction A. Examples showing why euthanasia is receiving national attention. B. Legal state of euthanasia in United States and other countries. C. A summary of reasons offered by those opposed to euthanasia is given. D. A summary of reasons offered by those in favor of euthanasia is given. E. Transition into my argument as pharmacist.

In 1987 Dr. Jack Kevorkian started advertising in Detroit papers as a physician consultant for "death counseling". Between 1990 and 1998, he assisted in the deaths of 130 people. A Michigan court sentenced him to 10-25 years in prison for the videotaped lethal injection of Thomas Youk. In a 1989 issue of the New England Journal of Medicine, ten doctors associated with the nation's hospitals and medical schools declare their belief that “it is not immoral for a physician to assist in the rational suicide of a terminally ill person”. In 1998, the New England Journal of Medicine published a National Survey of Physician Assisted Suicide and Euthanasia in the United States that showed 320 out of 1902 physicians reported having received a request from a patient for assistance with suicide and 59 of them said that they had administered at least one lethal injection. In the 2006 New England Journal of Medicine, two Dutch physicians announce that euthanasia of newborn babies is a regular occurrence in the Netherlands. Each of these events has served to provoke emotive response. For this reason, this issue will continue to be debated at all levels of society.

Euthanasia is not a new topic that has just recently been brought up. Debate about the moral dilemmas of euthanasia dates back to ancient times. Many of the historical arguments used for and against the practice still remain valid today. From the Hippocratic Oath (350 B.C.) “… I will neither give a deadly drug to anyone if asked for it, nor will I make a suggestion to this effect…” to the Oregon “Death with Dignity Act” which legalized physician-assisted suicide (1997), euthanasia will continues to be a subject of major controversy in society. First of all, the act of euthanasia itself is illegal (except Oregon) in U.S. Secondly, medical advances have made it possible to artificially prolong the life of an increasing number of patients far beyond what was possible only a few years ago. However, we have become a very busy, utilitarian society that no longer has the time to care for our elderly and
disabled members. Furthermore, financial constraints are an important consideration in modern health care provision. There is now a tremendous emphasis on reducing the cost of healthcare; end of life care is expensive, but the pills for assisted suicide cost only about $40. Finally, there is an ethical difficulty in interpreting the concept of a patient’s right, or autonomy versus the rights and duty of a health care provider. But, if we exam the important ethical, professional and legal aspect of euthanasia, we will find out that euthanasia, regardless of voluntary or involuntary and active or passive, would create major problems in medicine and in public.

If we are to effectively understand the debate about the right to die, it is important to have some basic definitions clarified and understood. The first and most essential term is euthanasia. According to The Webster’s New World Medical Dictionary, the word “euthanasia” comes straight out of the Greek -- "eu", goodly or well, "thanatos", death, the whole word means the good death -- and for 18th-century writers in England that was what euthanasia meant, a "good" death, a welcome way to depart quietly and well from life. The most commonly understood meaning of euthanasia today is more than the old dictionary definition of dying well -- a good and easy death. It refers to take a direct and specific action to intentionally end another person’s life. For example, a doctor induces the death with a lethal injection to a patient who is suffering unbelievably and has persistently requested the doctor to do so. Suicide, whether irrational or rational, for unrelated reasons is not euthanasia. Nor is the forced killing of another person.

The term of euthanasia can be further divided into voluntary / involuntary and active / passive.

The voluntary euthanasia is said to occur if the person who dies makes an informed consent for a life-terminating event performed by another person. [3] This consent may be in writing as in the case of a living will or advance directive; involuntary euthanasia is used when a death performed by another without the patient’s informed and specific consent. Basically, the action happens without the knowledge or consent of the patient. Involuntary euthanasia is the main arguments against legalization.

Euthanasia is frequently separated into active and passive form. Active euthanasia occurs when the medical professionals, or another person, deliberately do something that causes the patient to die, typically by injecting lethal injection. In practice, this is usually an overdose of painkillers or sleeping pills. On the other hand, passive euthanasia occurs when the patient dies because the medical professionals either don’t do something necessary to keep the patient alive, or when they stop doing something that is keeping the patient alive, such as switching off life-support machines, disconnecting a feeding tube or stopping giving life-extending drugs. For example, if a patient requires kidney dialysis to survive, and the doctors disconnect the dialysis machine, the patient will presumably die fairly soon. In other words, 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. Therefore, an important moral dilemma behind this distinction is about “to kill and allow to die”, which is also thought to be crucial for medical ethics. Some people think that it is acceptable to withhold treatment and allow a patient to die, but that it is never acceptable to kill a patient by
a deliberate act. The idea is that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient. This doctrine seems to be accepted by most doctors, and the House of Delegates of the American Medical Association endorses it into a statement on December 4, 1973:

The intentional termination of the life of one human being by another - mercy killing - is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family.

Some medical people like this idea of passive euthanasia. They think it allows them to provide a patient with the death they want without having to deal with the difficult moral problems they would face if they deliberately killed that person. Contrary, others even say that active euthanasia is morally better because it can be quicker and cleaner, and it may be less painful for the patient.

With the knowledge of the important terms that will be involved in my discussion, it is important to discuss the legal state of euthanasia in the United States and in other countries.

Euthanasia reemerged in the 1970's, when in 1976 California was the first state to legalize a patient's right to refuse life-prolonged treatment. The Legislature passed the Natural Death Act, which allows for living wills, an advance directive to a doctor requesting the withholding or withdrawing of life sustaining treatment. Today, all states have some form of living will legislation. In addition, the individual who wishes to have such a will, may also designate a family member or friend as a proxy to make the decisions for him or her, should he or she be unable to make the decisions himself or herself. Some states also require the individual to sign a power of attorney to do so.

In 1976, the New Jersey Supreme Court decided the parents of Karen Ann Quinlan won the right to remove her from a ventilator because she was in a persistent vegetative state. The justices unanimously ruled that this act was necessary to respect Quinlan's right to privacy. Some medical ethicists warned then that the ruling was the beginning of a trend--the slippery slope--that could lead to decisions to end a person's life being made by third parties not only on the basis of medical condition but also on such considerations as age, economic status, or even ethnicity.

In 1990, the Supreme Court case, Cruzan v. Missouri, recognized the principle that a person has a constitutionally protected right to refuse unwanted medical treatment. In 1983, Nancy Beth Cruzan lapsed into an irreversible coma from an auto accident. Before the accident, she had said several times that if she were faced with life as a "vegetable," she would not want to live. Her parents went to court in 1987 to
force the hospital to remove the tube by which she was being given nutrition and water. The Missouri Supreme Court refused to allow the life support to be withdrawn, saying there was no "clear and convincing" evidence Nancy Cruzan wanted that done. The U.S. Supreme Court agreed, but it also held that a person whose wishes were clearly known had a constitutional right to refuse life-sustaining medical treatment. After further proof and witness testimony, a probate court judge in Jasper County, Mo., ruled Dec. 14, 1990, that Cruzan's parents had the right to remove their daughter's feeding tube, which they immediately proceeded to do. Nancy Cruzan died Dec. 26, 1990.

November 1997, The Oregon “Death with Dignity Act” becomes law. After a legal declaration (both orally and in writing) that they want to die, a patient’s could prescribe a lethal dose of medication that the patients could take themselves. Only people with less than six months to live, who are suffering unbearably and deemed to be of sound mind and not depressed would be able to end their life under this law. But the federal Drug Enforcement Agency quickly announced that regardless of Oregon law, doctors and pharmacists still had to be licensed by the DEA, and the DEA would revoke the license of anyone who violated federal laws. The Controlled Substances Act, passed by Congress to fight drug abuse, says that certain drugs can only be prescribed for “legitimate medical purposes”, and killing someone is not a “legitimate medical purpose”. But then-Attorney General Janet Reno overruled the DEA. Ballot initiatives similar to Oregon’s have failed in the states of Washington, California, Michigan and Maine. 2001, The Alaska State Supreme Court rules that there is no constitutional right to assisted suicide. May 2005, 38 states have statues prohibiting assisted suicide and 6 states prohibit it by common law. Only 5 states other than Oregon do not have laws criminalizing assisted suicide: North Carolina, Utah, Wyoming, Ohio and Virginia. So far, physician-assisted suicide being legal is only in Oregon in the United States. There are total of 246 assisted suicide death reported since 1998 in Oregon.

Although not technically legalized until 2002, euthanasia has been permitted in the Netherlands since 1973 when a Dutch Physician was given only a suspended sentence for assisting in the death of her terminally ill mother. 1991, a confidential survey of Dutch physicians reported that 11,800 doctor-assisted deaths occurred in Holland in 1990 (9% of total death); 50% of these were involuntary (without the consent of the patient or family), 60% of assisted deaths were not reported. No Dutch physician has ever served a prison term for assisting suicide or performing euthanasia.

There are many questions that must be considered when euthanasia is involved. For example: Whose right is it anyway? Do physicians have the right to perform assisted suicide? Is it morally right? When is "competent" not competent enough? It is understandable that some patients suffering from a terminal, painful, debilitating illness may come to decide that death is preferable to life. However, legalize euthanasia would ultimately cause more harm than good. Medical professionals assist most people who want to die. Should those people who save lives as occupation end them? No, euthanasia is fundamentally incompatible with the health care provider’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.
First of all, euthanasia weakens the society’s respect for the sanctity of life and devalues lives. By becoming commonplace and used in medical practice along with more traditional methods of healing, society becomes desensitized toward death to the point where life is no longer valuable. Some people fear that allowing euthanasia sends the message, "it’s better to be dead than sick or disabled". This put the weakest and most vulnerable members at risk. In a society that devalues life, people see life with a disability as a disaster, filled with suffering and frustration. It will surprise some people that the state of Oregon reported that among terminally ill people who want to die, the most common reasons given for wanting to die are the loss of autonomy or the perceived eventual loss of autonomy and fear of being a burden to family, friends, or caregivers, not physical pain as we always thought. This truth proves that request of life is about much more than just being free from pain. Therefore, if physician-assisted suicide is legally sanctioned, the practice is likely to get out of hand. Severely incapacitated patients might feel emotional or financial pressure from relatives, or insurers, to end their lives. The American Journal of Medicine surveyed 1,664 critically ill patients, on how many of them would want CPR if their hearts stopped. 72 percent of the patients wanted to be brought back, 27 percent would rather be in a coma than have died, and 42 percent were willing to stay on respirators for the rest of their lives. [8] If euthanasia were to become legalized, what will happen to those people who unable to make decisions for themselves, such as babies/infants, the mentally disabled, the mentally unstable, and patients in a coma or continual vegetable state?

Once assisted suicide is legalized, there is no way to protect the vulnerable and mentally ill from abusive situations. Oregon's most recently publicized assisted suicide case invites questions as to the effectiveness of so-called "safeguards" to protect vulnerable terminally ill patients from abusive situations.

According to an October 17, 1999 Oregonian article, 85-year-old Kate Cheney, a terminally ill cancer patient with Kaiser Permanente, made a request for assisted suicide. Her first psychiatric evaluation revealed the patient did not have "the very high level of capacity required to weigh options about assisted suicide." Signs of dementia by the patient, combined with exhibited pressure by the patient's daughter to obtain the assisted suicide drugs made the psychiatrist wonder whose agenda the request for lethal drugs really was. He refused the assisted suicide request. Refusing to accept the first psychiatrist's evaluation, the daughter sought and found a psychologist who agreed to the suicide request, although she also noted that the patient's "choices may be influenced by her family's wishes and her daughter, Erika may be somewhat coercive." The final decision for the drug prescription rested with Dr. Robert Richardson, director of Kaiser Permanente Northwest Ethics Service. On August 29, Kate Cheney, an 85-year old woman with growing dementia killed herself with an overdose of barbiturates. [9] No system of safeguards could ever be foolproof, so in practice legalizing 'voluntary euthanasia' would result in legalizing involuntary euthanasia. This case highlights the ineffective "safeguards" in Oregon's law.

The legalization of euthanasia would create major problems in medicine and nursing. The physician's only role is to save lives and relieve symptoms. Permitting doctors to assist suicides would compromise their role and undermine trust in the medical profession. Let look at what is happened in Holland where euthanasia has been permitted since 1973. This is the only hard "data" on the long-term
consequences of legalization: Euthanasia for the terminally ill leads to euthanasia for the chronically ill and the disabled; euthanasia for physical suffering leads to euthanasia for psychological suffering; euthanasia for adults lead to euthanasia for adolescents, children even newborns. It is now known from official sources that in Holland, the authorities have no control over the euthanasia, and it is indeed associated with many abuses, including the frequent killing of persons without their consent.

Medical literature reveals that a rising number of health care providers are insisting that when they believe a patient's life is not worth living because of the person's disabilities or poor "quality of life," this means they should be able to deny lifesaving treatment, even if the patient and patient's family disagree: In January 1991 a Minnesota hospital went to court to try to cut off medical treatment for Helga Wanglie, an 87-year-old patient with brain damage. Prior to her incapacity, she had many times made it clear that she would want lifesaving medical treatment, food, and fluids if she became disabled. Her family unanimously supported her. The hospital eventually lost the court battle.

Another controversial case related this issue is that a doctor and two nurses are accused to intentionally killed patients with injections before the hospital was evacuated in the wake of Hurricane Katrina. Despite horrific medical conditions including triple-digit temperatures, no electricity and useless lifesaving equipment, ethicists and even some doctors caught in Hurricane Katrina's aftermath say there's no way to justify killing a sick or dying patient. We must look at what they did, which was the unlawful killing of a human being. They neither have the patient's permission nor the family's permission to act in the ways in which they did. Overdosing someone against his or her consent is homicide, not euthanasia. That is simply the law. No one in the medical field should ever presume to judge what quality of life should be for someone else. It depends upon the person's belief system and their desires. Whether the doctors or any of you feel they should die, it's not your place to make that decision for someone else without consent or legal means. The doctors' oath is to do no harm, and American Medical Association ethics say mercy killings or euthanasia are "incompatible with the physician's role as a healer." [10]

The proper role of a physician includes diagnosis, making judgments about the probable effect of providing alternative medical treatments, and administering medical treatment. It does not include judging that a life that can be preserved is not worth preserving, overriding the opinion of the person whose life it is. Doctors must aid their patients, fight for their survival, but they should kill neither for love nor for money.

Euthanasia may not be in the best interests of the patients. A serious problem for supporters of euthanasia are the number of cases in which a patient may ask for euthanasia, or feel obliged to ask for it, when it isn't in their best interest. [11] A group of researchers have studied the medical histories of a sampling of the people who died with the assistance of Mr. Kevorkian. Among their findings: only 25% were terminally ill, and 7% showed no signs of physical illness at all. 13% had symptoms of clinical depression, and a disproportionate number were divorced, widowed, or never married. Most of the people who came to Mr. Kevorkian were not terminally ill. It is likely that most were not suffering from unusual physical pain. For most, their
problem was that they were old or handicapped, and they were feeling useless, a burden on their family and friends and society in general. Did these people really want to die? Or were their attempted suicides a cry for help? If we make euthanasia legal, it will push these poor people to the edge. They will think that they have become such a burden on their family and society, and maybe everyone would be so much better off if they'd just kill themselves and get out of the way. This is sad.

Proper palliative care makes euthanasia unnecessary. I think our society should pay more attention to think about how to provide better options for suffering patients, instead of "mercy killing" them. Palliative care is physical, emotional and spiritual care for a dying person when cure is not possible. It includes compassion and support for family and friends.

Competent palliative care may well be enough to prevent a person feeling any need to contemplate euthanasia. Take additional steps to improve patients' comfort and quality of life, rather than helping them to die. Many hospital patients endure needless pain. If patient care were improved and additional measures taken to reduce pain and suffering, fewer patients would want to hasten their deaths. Moreover, expand palliative care in medical facilities. Even acute care facilities should be able to provide as much comfort and pain relief as possible. Doctors need more training, time, and compensation for care of the dying. All medical schools, pharmacy schools and nursing schools should include palliative care as part of their training. All hospitals should have palliative care and pain management programs. Improve training so medical professionals are able to provide relief from pain, and also the emotional support people need as they near death. For example, clinical training, pain management and public information programs are the fundamentals of a new collaborative initiative to address end-of-life issues in Michigan. Besides, expand hospice care, both facilities designed specifically for this purpose and in-home hospice care. Remove barriers to effective pain management, such as overly restrictive regulation of narcotics. We also need pay more attention to provide mental health care for terminally ill patients, who are prone to suffering and depression. Since many suicidal people are not terminally ill, they are depressed. They need treatment for depression, not assistance in dying. If medical professionals consistently honored the right to refuse treatment, which is already recognized, there would be less demand for physician-assisted suicide.

The last reason that I am against euthanasia is that there is always the possibility of a mistaken diagnosis. Sometimes patients experience a complete remission from their illness. Sometimes, doctors may misjudge patients' end-of-life decisions. American doctors frequently misjudge the wishes of seriously ill heart patients about their desire to be resuscitated in the event of a cardiac arrest, a report says. The study, published in Circulation: Journal of the American Heart Association, says about one in four doctors of patients with advanced congestive heart failure got it wrong. The authors of the study say patients sometimes change their minds about whether they want their doctors to "pull the plug". In the study's survey of do-not-resuscitate preferences among 936 individuals hospitalized for severe heart failure, nearly one-quarter said they did not wish to receive artificial respiration. However, physicians misjudged their patients' preferences for 24% of the individuals. [12]
There is also the possibility of a new cure being discovered. Who can predict the development of medication? Take a look at the development of curing cancer in the past ten years. For example, over the last 10 to 15 years, more women have begun to live beyond breast cancer. And there is a 24% increase in survival rates from 1990.

People who support euthanasia believe that terminally ill patients have the right to die with respect and dignity. They contend that the individual has certain rights guaranteed under the law and the Constitution that allows them chooses when they can die. And individual liberty is a fundamental constitutional guarantee. Although death is unavoidable for human beings, suffering before death is unbearable not only for terminal patients but for the family members and friends. Euthanasia for the patients would provide freedom from the guilt of being a burden to caregivers. From the caregivers perspective it is also the only humane choice. Terri Schiavo, the brain-damaged woman who became a symbol of the right-to-die debate, have finally been laid to rest over a year. Against Terri Schiavo’s parents’ wishes, Mr. Schiavo fought a lengthy legal battle to have his wife's feeding tube removed, insisting that she had asked him to do so in the event of any incident that left her brain-damaged. This case was run for years and last seven days Terry had the least miserable time after her brain damage. She died after a week of starvation and relieved from excruciating pain. Thus euthanasia helps the terminally ill people to get rid of the unbearable pain, and so some people believe that euthanasia, right-to-die, should be legalized.

In the term of financial concerns, the last few months of a patient’s life are often the most expensive in terms of medical and other cares. A 1998 study found that doctors who are cost-conscious and ‘practice resource-conserving medicine’ are significantly more likely to write a lethal prescription for terminally ill patients \[13\] this suggests that medical costs do influence doctors' opinions in this area of medical ethics. Supports of euthanasia might think that shortening this period through euthanasia could be seen as a way of relieving pressure on scarce medical resources, or family finances. It's worth noting that cost of the lethal medication required for euthanasia is less than $40, which is much cheaper than continuing treatment for many medical conditions. But if this nation support's these views, we are a nation with out a heart.

As a student pharmacist, I’d like talk about how euthanasia will affect on us. What is the “choice” for pharmacists? Pharmacists are in a critical position when pharmaceutical agents are prescribed for the purpose of euthanasia and they may need to decide whether dispensing a lethal dose of a medication is ethically and morally acceptable for a patient. Who prevails when the needs of patients and the morals of providers collide? Pharmacists must now decide where they stand when asked to terminate a life. My answer will be “NO”.

First of all, pharmacists, as member of professionals, can exercise independent judgment to decide “provide” or “refuse’. They complete a graduate program to gain expertise, obtain a state license to practice, and follow its own code of ethics. Society
relies on pharmacists to instruct patients on the appropriate use of medications and to ensure the safety of drugs prescribed in combination. Courts have held that pharmacists, like other professionals, owe their customers a duty of care. Pharmacists are not automatons completing tasks; they are integral members of the health care team. Thus, pharmacists have right to exercise personal judgment in refusing to fill certain prescriptions.

Secondly, I believe euthanasia to be morally and ethically indefensible and incompatible with the professional pharmacy oath. Pharmacists have a special responsibility to protect patients who are contemplating end-of-life decisions. Pharmaceutical care ("Responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life") requires that the pharmacist not only understands the medications but also the individual patient and the complexities of their lives and suffering. [14] Only in this way can pharmacists provide safe and effective use of medications for the patients they serve.

More generally, the right to refuse to participate in acts that conflict with personal ethical, moral, or religious convictions is accepted as an essential element of a democratic society. Indeed, Oregon acknowledged this freedom in its Death with Dignity Act, which allows health care providers, including pharmacists, who are disquieted by physician-assisted suicide.

In conclusion, from what I have discussed above, I believe that euthanasia should not be legalized in any state. Although it is legalized in Oregon it is not wise for any other state to follow that example. Euthanasia is a violation of medical ethics. The role of our physician should be a healer, not a killer. Euthanasia goes against the natural law inclination to survive, and each human life has a special value that must be respected. It is immoral to intentionally end a life.


References

10. Lindsey Tanner Ethicists: No way to justify mercy deaths