

Ethical and Legislative Aspects on The Legalisation Of Euthanasia From The Patient Rights Perspective

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Abstract:

Interest in euthanasia, also called “dignified death” or “death humanization” is relevant from the ethical and moral points of view, especially if it is oriented toward the detection of the motivations and conceptions of life subject to such practices. The movement of opinion in favour of euthanasia, currently active, has characteristic connotations and motivations, aimed at demanding legalization. Legalizing euthanasia will bring about profound changes in social attitudes toward illness, disability, death, old age and the role of the medical profession. Once euthanasia is legalized, it will increasingly become a ‘treatment option’, alongside regular medical or surgical treatments.

Keywords: *patient rights, legalization, euthanasia, bioethics, medical assisted suicide, palliative therapies, legislative reform*

1. Introduction

Human life has an intrinsic value. Judaeo-Christian tradition teaches that man was created in the image of God and therefore human life has dignity, sanctity and is inviolable. In that tradition, the principle that one should not kill is based on this dignity and sanctity.

Euthanasia, once legalized, would result in the killing of patients who did not want to die. The experience of the Netherlands shows that euthanasia, once legalized, cannot be effectively controlled.

Euthanasia, initially intended for certain well-defined groups, such as patients with terminal diseases, will be performed on other patient groups, including the elderly, the disabled, people with emotional disorders, the invalid and even children and infants with disabilities who cannot ask for euthanasia. From the experience of the Netherlands, at least one thousand patients, including children and new-born, are killed every year without expressed consent and / or against their will.

Patient autonomy will decrease once euthanasia has been legalized. Despite all the claims related to 'patient autonomy' formulated by proponents of euthanasia, eventually one or more doctors will have to make a decision that should not make, as to whether a patient's life is worth or not to be maintained or shortened.

If euthanasia became legal, the decision to preserve or to shorten the patient's life or to assist the patient with PAS will be a characteristic of the medical profession. Legalizing euthanasia will increase the power doctors have over their patients and WILL considerably decrease patient autonomy.

2. Theory

Law historians agree in finding that the penetration of Christianity in the Western world was, in this field, a turning point in terms of habits and thinking. Current opinions in favour of euthanasia are not identical to those advocating death from a sense of pity, characteristic to other historical periods. The current movement is not limited to the humanitarian understanding of the fact, where intervenes, as I said, the 'sympathy factor', but it targets legalization.

A connection is frequently and spontaneously made with the movement of ideas which in many countries has led to the legalization of voluntary abortion; actually it is not difficult to understand the common cultural background of the two requests to legitimize the "imposed death", which means knowing the value of the person; of course, the strategy adopted by the supporters of the two theories of death is the same: it begins with raising public awareness on "cases that arouse pity", the exaltation of the not too severe sentences of the tribunals, which have established criminal processes, to finally arrive at the request of legitimisation by law, of course, after the public opinion has been sensitised by the media and in public debates [1].

In the campaign in support of legitimizing euthanasia there is a new, characteristic, even terrible aspect, namely the social and personal attracting potential, which is much wider than what could appear, at least in the immediate

sense, in the legalization of abortion. An abortion can only be performed on certain people, whereas death is the destiny of all.

In the Marcozzi's definition [2] there are also other lawyers and moralists of recognized competence; thus euthanasia means "the painless of out of pity suppression of the suffering or of that who is deemed to be suffering who may suffer unbearably in the future." [3]

To complete the table of definitions, we must add that today is spoken of euthanasia not only in relation to the gravely and terminally ill patient, but also in other situations: in the case of the new-born with serious defects (*wrongful life*), in which case some suggest abandonment by elimination of food to avoid the suffering of the subject - they say - and the burden that they would represent to society; in this case we speak of the "euthanasia of the new-born." Another acceptation of the term 'euthanasia' is foreseen, that of 'social' euthanasia, which is presented as a choice made not by an individual, but society, as a result of the fact that the healthcare budget could no longer bear the financial burden represented by the assistance given to patients affected by long-term disease, in terms of both prognosis and costs. In this way, economic resources could be saved for patients who will return after healing to a productive and active life. This is one of the threats of an economy that would take into account only the cost-benefit criterion.

"Euthanasia is linked to the process of secularization of thought and life which is permeating our society and which is expressed mostly as the supreme form to claim the independence of man from - or especially - before God and, therefore, deems suffering unnecessary and refuses the religious symbolism of death "[4].

Euthanasia and suicide are the sign of man's claim of the right to dispose of itself, of its own life and death. Secularization is enhanced in the industrial era by productivist utilitarianism and, therefore, by the hedonist ethics, for which death and pain are elements of extreme disorder. For this type of culture, pain and suffering take on a load of non-value and determine refusal.

This is where the 'taboo' of death with all its procession is born, this is where the social demand of a kind of medicine to ensure "full physical, mental and social wellbeing" and a painless death is born. Death has become a 'taboo', a word that should not be pronounced and, as it was once the case with sex, it should not be uttered in public. [5]

The beginning of this type of ideology favourable to euthanasia is represented by the well-known *A Plea for Beneficent Euthanasia*, published in "The Humanist" (July 1974), signed by approximately 40 personalities, including Nobel Prize laureates, Monod, Pauling and Thomson.

3. Results and Discussions

Medical advances have aggravated the problem of euthanasia or, we could say, have revealed more the problem of 'worthy death'. This has happened in two directions: towards the technological progress of assistance to the dying and towards the already mentioned direction of the socialization of medicine.

Technological effort in the resuscitation rooms is often accompanied by the isolation and seclusion of the patient, its separation from its relatives even at death, by loneliness despite the existence of the medical staff operating the devices.

These extreme situations raise ethical problems on the permissiveness and compulsoriness of certain technical resuscitation interventions beyond a certain point and raise the ethical issue of the compulsoriness of human, psychological help for this kind of dying.

The foundation of ethics is the respect for human truth, the respect of the person as it is: another real foundation cannot be conferred to ethics; ethics is directing the man from 'being' to 'must be'; the other criteria consist of the usefulness of one over another, of the power of some over others, of the efficacy of this power, which is increasingly higher for some and oppressive to others. [6]

The exigency of the health condition, supported by the need for individual and social welfare, causes the congestion of hospitals and, consequently, a

depersonalization of healthcare, leading to the isolation of the dying in wards; all these are real challenges for the healthcare staff in switching from mere technical assistance to human assistance.

Morality cannot ignore this issue and the commitment to make death worthy of man and of the faithful: the phrase “dignified death”, when it does not refer to veiled forms of euthanasia, contains an acceptable and necessary indication from an ethical standpoint. It is true that many people die serene and we should not only think of extreme cases. It is very important today that at the time of death human dignity and the Christian beliefs on life be protected against a technicality likely to become abusive. In fact, some people talk about *the right to die*, expression which does not denote man’s right to cause its own death or to require death to be caused onto them as desired, but the “right to die with total serenity, with human and Christian dignity” [7].

Until the Declaration on Euthanasia of the Congregation for the Doctrine of the Faith, one spoke of ‘ordinary’ and ‘extraordinary’ therapeutic means, with this indication: it is compulsory to use ordinary means to support the dying, but it is allowed to renounce, with the consent of the patient or at their request, to the extraordinary means, even if this renouncement determines the anticipation of death. The ‘extraordinary’ character was defined in relation to the worsening of the suffering that such means could have caused, by their cost or by the difficulty of access for those who could not ask for them. Medical advances have made this distinction difficult because many means that until recently were considered extraordinary, have become commonplace and then, as noted by important people in hospitals and intensive care, the use of intensive care has saved many lives. [8]

Therefore it was necessary to find another reference criteria which no longer relies on the ‘therapeutic means’ but rather on the ‘therapeutic outcome’ that is expected of it; wherefrom some prefer to speak of *proportional* means and *disproportional* means.

In any case, the means could be well assessed, taking into account the type of therapy, the degree of difficulty and risk that would be entailed, the expenditure required and the application possibilities with the result that could be expected, given the conditions of the patient and its physical and moral strength.

When from the therapeutic point of view it is no longer really possible to stop the disease or its regression, medicine still has resources to use and therefore there is the obligation to resort to them whenever possible, not as an act aimed at healing and extending life, but out of respect for the patient and for its quality of life. These resources are the ordinary treatments and palliative treatments. The two concepts are not automatically equivalent.

Ordinary treatments consist of nutrition and hydration (artificial or otherwise), the aspiration of bronchial secretions, the cleaning of ulcerated bedsores.

In recent years, controversy arose regarding ordinary treatments, particularly in the US, as some centres tend to consider artificial hydration and nutrition as therapeutic interventions, even more, as having extraordinary character and therefore their application to patients is not a duty. In reality, this aid can help in many cases not so much to extend life, not being torture, but at making death less painful; it is also stated that nutrition and hydration cannot be a medical act, but an ordinary treatment, even though the means of administration is artificial. Of course, if the body is no longer able to receive it and use it, the treatment is no longer considered care and the obligation to administer it is extinguished.

Palliative treatments have a wider acceptance than normal treatments because they are used to relieve symptoms, primarily pain (but not only pain) to which we will refer further.

By palliative treatments we generally understand that care offered to patients with incurable diseases, more oriented towards symptom control than towards the basic pathology, by applying the procedures by which to allow the patient a better quality of life.

Palliative treatments consist in, for example: “*oncological palliative therapy* (surgery, radiotherapy, chemotherapy) applied to patients seeking treatment of symptoms” [10]; *support treatments*, which include: *non causal analgesics therapies* aimed at reducing or eliminating the perception of pain; *nutritional assessment and hydro-electronic regulation*; *the treatment of opportunistic infections*; *physiotherapy rehabilitation procedures*; *psychological support*, which has a very important role in supporting the patient and family; *the psychological surveillance of the healthcare team*, whose emotional performances are essential for the therapeutic optimization at this delicate stage of the chronic disease.

This strategy has resulted in the emergence of experiences such as ‘*Hospices*’ and home treatments.

Several initiatives to legalize euthanasia adopted in different countries constitute incentives for legalization of euthanasia.

In the US that *Natural Death Act* (the law on natural death), document issued by the state of California and spread to other US states in equivalent terms, dates from 1976. Specifically, the act recognizes the right of every adult to dispose of the non-application and interruption of the “life support therapies” when found “at the extreme limit of essential conditions”.

This provision (living Will) must be signed by the beneficiary in the presence of two witnesses, who are not connected to them by family ties or affinity, or recipients of its assets, not the treating physician or a subordinate thereof or of the treating institution. The provision, established in writing on a very precise form, provides its non-application if the patient is pregnant, and is valid for five years.

The *external existential conditions* refer to the terminal phase in which the use of therapies would delay death, but would not lead to the recovery of life. *Life support therapies* refer to any medical means or intervention which, by means of mechanical or artificial devices supports, restores or replaces a natural and vital function only leading to the delay of death. The patient must have a terminal diagnosis made by two doctors.

'United States Catholic Health Association' distributed in 1974 a document (*Christian Affirmation of Life*) which states: "I ask, if possible, to be consulted on the medical procedures that could be used to prolong my life when approaching death. If I am unable to make decisions about my future and if there is no hope of recovery for my physical and mental disability, I am asking that extraordinary means to prolong my life not be used." Other such initiatives have subsequently appeared, such as the "will of life" proposed by the Episcopal Committee for the Protection of Life attached to the Spanish Episcopal Conference [13].

However, there are significant doubts regarding the *living will* procedure [14], especially on legal and moral validity of a testamentary will expressed beforehand, in lack of the concrete conditions of the disease, over an asset which is life and not a thing. There also remains the background confusion on the interpretation in the specific case of what is called means of maintaining life and determining the conditions of irreversibility.

After the famous case of Nancy B. Cruzan, the US adopted in 1990 a law on self-determination of the patient (*Patient Self Determination Act*) which favours the patient's role in making decisions concerning its life, especially in the final stage of the disease [15]. A 'referendum' of 1991 in Washington (DC) state, while with a slight rejection, it ruled, however, in favour of those who reject euthanasia.

In Canada, the regulations called the *do not resuscitate policy*, declared ethical by the General Council of the Canadian Medical Association in 1974, goes beyond the limits set by *living will*.

Practically, this regulation consists in the refusal or failure to apply reanimation techniques to patients for whom it would be pointless and costly, even if this would cause an early death.

The practical application is varied, there are hospitals which require the opinion of the ethical committee, there are doctors who come to an agreement with the patient, explaining earnestly beforehand the condition and the prognosis

of the disease; there are doctors who claim themselves the right to evaluate the appropriateness of using resuscitation techniques.

It is clear that in the absence of objective criteria of instrumental and physical confrontation and given the existence of a variety of cases which cannot be generalized, this procedure presents more serious ethical issues. Then, the subjectivity of patients or doctors both in evaluating the lethal diagnosis and in the application of the rule has a wider and almost indefinite scope.

We shall also refer to the “Netherlands case” and to the regulations approved by the Dutch parliament. As is known, some research has highlighted the fact that in this country the medical practice of euthanasia was widespread [16] so that the law sought to be responsive to a practice like this, as if the task of the law were to legalize what was happening in practice, instead of the practice to comply with the provisions of the law. This law does not actually legalize euthanasia, but it dis-penalizes it; it does not act on the physician who, observing some well-defined points, interrupts the patient’s life. Also, it does not change the essence of a conduct which is seriously condemned from the ethical standpoint, and opens the way to other forms of euthanasia, even involuntary.

The legislative issue of euthanasia and assisted suicide laws was enriched in recent years with various initiatives and standpoints. Besides the Dutch law commented above, is known the law approved by the Parliament of the ‘Northern Territory’ of Australia in May 1995. With the tile ‘*Rights of the Terminally Ill Act*’, the law, which came into force on 1 July 1996, was the first in the world today, which approved euthanasia, considering it a right of citizen under certain conditions. The fierce debate that began in Australia on this law resulted in the approval of a federal law which abolished that of the Northern Territory (voted by the Federal Senate on 24 March 1997).

On June 26, 1997 the Supreme Court of the United States ruled on two decisions which nullified laws prohibiting assisted suicide in Washington and New York states. The Supreme Court overturned those rulings, saying that this alleged right cannot be included among the rights recognized by the American

Constitution and, therefore, states have the legal authority to regulate this situation. The motivation of the sentence states: "The State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's"[17].

Currently, more than 30 federal states consider assisting suicide as a criminal offense [18]. There have been numerous attempts to change this situation by various groups and associations favourable to euthanasia. After several failed attempts in some states, in 1994 it obtained approval of the law in Oregon, which approved assisted suicide for the terminally ill, under very restrictive conditions (prohibiting, for instance, that the patient be helped to die by injection, although it is known that the prospected pill method is ineffective in many cases).

The Constitutional Court of Colombia, a Latin American country, by the decision of 20 May 1997, approved euthanasia for terminally ill persons provided they give their consent [19].

The ethical question remains - can it ever be right to kill, even with the intention to alleviate suffering? In most countries the law is very clear. Killing a patient, even to relieve their suffering, it is considered homicide. This is why euthanasia is illegal in Canada and in most countries. Currently, euthanasia has been legalized only by the Netherlands and Belgium. Medically assisted suicide is also legal in the Netherlands and in Oregon, USA. Switzerland has legalized assisted suicide, even by a person who does not belong to the medical personnel.

The Hippocratic Oath states the same principle: "*To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion*". Hippocrates lived in the 5th century BC, thus the principle of the sanctity of life predates Christian teaching. The Declaration of Geneva of the World Medical Association in 1948 states: "I will

maintain the utmost respect for human life from its beginning.” The right to life has been included in the Canadian Charter of Rights and Freedoms. The same principle was implemented in the European Convention of Human Rights, which states: “Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally...”

Euthanasia, initially intended for certain well-defined groups, such as patients with terminal diseases, will be performed on other patient groups, including the elderly, the disabled, people with emotional disorders, the invalid and even children and infants with disabilities. A change in legislation will lead to a disregard of human life, especially of the vulnerable members of society. “Euthanasia, once accepted, is uncontrollable for philosophical, rational and practical reasons. Patients will die without and against their will if such legislation were introduced.” [20].

In 2001, a report made by Danish researchers shows that in the Netherlands, where euthanasia was legalized, a thousand deaths were recorded (0.7% of total) against the wishes or without the free consent of the persons [21].

Euthanasia does not stop with adults in the Netherlands. Nine percent of all deaths in new-borns in the Netherlands occurred due to the administration of medicines with the explicit purpose of hastening death. This was noted in two surveys of 1995 and 2001. At least 2.7% of deaths of children between the ages of 1 and 17 in the Netherlands were due to euthanasia. [22].

In Flanders and Belgium, more than half of the deaths of new-borns were due to doctors making life-ending decisions, usually by stopping the prescribed treatment. However, 7% of all neonatal deaths were caused by an injection of a lethal dose of medication. Most of the children had birth defects and / or were born prematurely. Three paediatricians out of every four were prepared to engage in the euthanasia of new-borns [23].

In 2002, Belgium legalized euthanasia for adults who suffer from physical or psychological permanent and unbearable conditions, and who are sufficiently conscious to make the request to die. Killing children is a crime in Belgium.

Legalizing euthanasia would put pressure on the ill and on those who feel that due to illness, disability or due to expensive treatment, they have become a burden to society and especially to their relatives.

With the increase of the acceptance of euthanasia, anyone with medical trianing - not necessarily completed – will consider euthanasia as a method of treatment. Euthanasia will become accepted for conditions such as depression, stress, loneliness, fear of disease or fear of decline, but also for children or adults with disabilities. Euthanasia would become part of the armamentarium of medical treatment alongside conventional medical treatments such as pain treatment, antidepressant medication, radiotherapy and chemotherapy.

Legalizing euthanasia, societies will bring a fundamental change in the doctor-patient relationship, when patients will ask themselves if the doctor entering the room “is wearing the white coat of a healer or the black clothes of an executioner” [26]. The legalization of euthanasia will ultimately undermine medical care, especially palliative care, and will seriously undermine the doctor-patient relationship.

4. Conclusions

While euthanasia and assisted suicide (PAS) may appear attractive, on the surface, they have profound adverse effects in shaping society, in our attitude towards death and illness and in our attitude towards the sick or disabled.

Euthanasia, once legalized, could not be effectively controlled. The Dutch experience shows that around 1,000 patients are killed by doctors each year against their will or their consent. Euthanasia, initially intended for a specific group, for example patients with terminal illnesses, has also been applied to other groups, those who are sick or just consider themselves sick, and even on new-born babies with disabilities.

Legalizing euthanasia would put immense pressure on the elderly or ill and on those who feel that due to illness, disability or due to expensive

treatment, they have become a burden to society and especially to their relatives. 'The right to die' will soon become 'the duty to die.'

With the increasing acceptance of euthanasia or assisted suicide, there will be a change in the perception of illness, death and medical treatment. The example of legalized abortion shows what happens. Every pregnant woman must now decide whether to continue with the pregnancy or abort. Similarly, euthanasia, once legalized, will become a 'treatment' option for those who are diagnosed with a disease, not necessarily incurable, and who consider themselves ill.

It is always cheaper (and quicker) to kill than to treat. The legalization of euthanasia would undermine medical care and especially palliative care. Where euthanasia was legalized (for example in the Netherlands or in Oregon) the provision of palliative care appears simple and inadequate.

The legalization of euthanasia will adversely affect the doctor-patient relationship. Despite all possible precautions, patients will be wondering if the doctor is wearing the white coat of the healer or the black coat of the executioner.

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