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Considerations Regarding the Ethical Viability of Voluntary Active Euthanasia

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ABSTRACT: Issues regarding death are incredibly complicated and involve topics that are often difficult to discuss. In this essay, I will argue that active euthanasia is morally and ethically permissible in instances involving consenting terminally ill patients. Using an act-utilitarian approach, I contend that voluntary active euthanasia should be seen as a viable option due to its potential to reduce the total pain and suffering in an end-of-life scenario for both the patient and the patient's loved ones. Though passive euthanasia is widely considered to be morally superior to active euthanasia, I argue that voluntary active euthanasia has the potential to do more good than passive euthanasia can in certain scenarios and as such, each should have equal viability depending on the details of the case. Additionally, I discuss the ethical equivalency between voluntary active euthanasia and physician assisted suicide, a procedure that is beginning to gain credibility in some of the more liberal areas of the United States and Europe. Finally, in the event that a patient desires to end their life but cannot partake in physician assisted suicide, I contend that voluntary active euthanasia is likely the most ethical solution. Based on an act-utilitarian analysis of positive and negative consequences, I propose that voluntary active euthanasia be considered as a viable option for the treatment of terminally-ill patients.

Introduction

Bioethical issues that involve death are highly contentious due to their incredibly complex nature and because they force us to delve into an uncomfortable topic. However, these issues are numerous, widespread, and must be addressed if we hope to better our society. Euthanasia is an excellent example of one of these immensely complicated issues. In summary, euthanasia, literally translated to “dying well” (Campbell 2013, 106), entails bringing about the death of another person for that person's sake (Vaughn 2016, 626). Here I will only refer to the procedure taking place between a medical professional and their patient. Euthanasia can be bifurcated into two major subcategories: passive euthanasia, where life-saving measures are removed from a patient, and active euthanasia where an action is performed that directly causes a patient to die (Vaughn 2016, 627). For many, there is understood to be a moral discrepancy between active and passive euthanasia (Vaughn 2016, 626). As an example, there is a large constituency that may be open to the possibility of removing a patient from life-support, a form

of passive euthanasia. This same group however, may be much less supportive of doctors administering lethal injections to their patients, a form of active euthanasia (Vaughn 2016, 626). Further subdivision of euthanasia divides it into voluntary (in which the patient is killed with explicit consent), non-voluntary (in which the patient can neither give consent nor refuse the procedure), and involuntary (in which the patient is killed against explicit refusal) (Campbell 2013, 106-107). I will only discuss instances of voluntary euthanasia because involuntary euthanasia is murder and I believe non-voluntary euthanasia to be a much more elaborate ethical issue with a solution that would require its own essay to be addressed in any meaningful way. Euthanasia is also closely related to the concept of physician-assisted suicide, in which the physician provides the means for a patient to take their own life (Veatch 1997, 382). The primary difference between voluntary active euthanasia and physician-assisted suicide is who performs the action that kills the patient (Veatch 1997, 382). In this essay I will argue that, from an act-utilitarian perspective, voluntary active euthanasia not only morally permissible, but it could potentially be a morally superior option to passive euthanasia when a consenting patient is terminally ill. Additionally, I will address the moral equivalence between voluntary active euthanasia and physician-assisted suicide.

The main bioethical theory that I have used to construct my argument is act-utilitarianism. At the core of utilitarianism is “the view that right actions are those that result in the most beneficial balance of good over bad consequences for everyone involved” (Vaughn 2016, 36). Act-utilitarianism is one of the major subcategories within the larger concept of utilitarianism, and it is governed by the belief that “the rightness of actions depends solely on the relative good produced by *individual actions*”, referring to the specific action of voluntary active euthanasia (Vaughn 2016, 36). The primary focus of utilitarianism is to maximize the total

quantity of net positive consequences or net happiness, despite how these net goods are distributed (Vaughn 2016, 37). In situations regarding euthanasia, act-utilitarianism argues that the action of ending a patient's life would be permissible if, and only if, the positive outcomes of the situation outweigh the negative consequences.

Maximizing Net Good for the Patient

The most immediate instance in which happiness could be maximized is that in which the action appeals directly to the desires of the one who would be euthanized. This argument is rooted in respect for the patient's autonomy and their right to control their own life (Dilley 2015, 277). As a society, we generally claim to value a patient's self-determination. While we use patient well-being and autonomy as grounds to allow a patient to refuse life-sustaining treatment, it seems that we would also use patient self-determination to justify physician-assisted suicide or voluntary euthanasia in certain circumstances (Veatch 1997, 381). We place our trust in health care professionals to generally promote our welfare under all circumstances (Beauchamp and Childress 2016, 180). It then carries that if a patient desires to end their life, patients and families likely want the physicians to offer assistance in the darkest hour of their lives (Beauchamp and Childress 2016, 180). For an example of the importance of patient autonomy involving end-of-life issues, I turn to Timothy E. Quill's article *Death and Dignity: A Case of Individualized Decision Making*. The article discusses a patient named Diane with acute myelomonocytic leukemia (Median survival estimate of about 1.5 years) who desires to end her own life with the help of her physician (Quill 1991, 642). Though this is technically an instance of physician-assisted suicide, it is applicable to a case involving voluntary active euthanasia in that it conveys the importance of the patient's autonomy. Diane's primary motivation for wanting to end her life was the importance for her to have the ability to "maintain control of

herself and her own dignity during the time remaining to her” (Quill 1991, 643). Because she had made this decision herself in a sufficiently coherent mental state, it is reasonable to conclude that her choice to end her life accurately reflects her personal desires. As such, allowing her to take her own life through physician-assisted suicide, or through voluntary active euthanasia via her physician, would maximize the happiness of the patient. Considering the possibility of euthanasia allows Diane to find happiness in being able to die with the dignity that she wanted while ensuring that her life was taken with the precision of a trained professional. Though it can be argued that the euthanized patient may not benefit from this happiness after their death, it can also be concluded that the personal unhappiness that came as a consequence of remaining alive would be eliminated. Ultimately, a negative aspect of life would be removed, thus yielding a net positive outcome for the patient that wants their life to end.

In addition to fulfilling the patient’s expressed wishes, using active euthanasia would relieve the patient’s physical pain and suffering. Referring back to Diane’s case, throughout the course of her cancer she suffered from “bone pain, weakness, fatigue, and fevers [that] began to dominate her life,” with the clear knowledge that the end was not far off (Quill 1991, 644). In the near future, Diane’s life likely held “increasing discomfort, dependence, and hard choices between pain and sedation” (Quill 1991, 644). In Diane’s living state she dealt with constant pain and the knowledge that, despite her suffering, death would be in her near future. From a utilitarian perspective, allowing Diane to have the option to die through active euthanasia would provide her with a route to eliminate the pain that she constantly felt throughout the end of her life. By removing a persistent source of physical pain from Diane’s existence, ending her life through active euthanasia would produce a net positive consequence in regard to her physical well-being. As Quill emphasizes, Diane’s life with terminal cancer brought both emotional and

physical distress which would have been a continuous burden on her if she had not ended her life through physician-assisted suicide. Having the option to end her life through active euthanasia instead would have ensured that she have the option to relieve this distress quickly and effectively by providing her with direct help from a professional. By doing so, the physical and emotional pains that she felt in life would have been relieved and her death would have brought with it a net positive consequence by fulfilling her personal wishes and eliminating physical pain.

Physician-assisted suicide, like in Diane's case, has been made legal in some places like Oregon. Under Oregon's Death With Dignity Act, terminally ill adults may receive lethal drugs from their physicians as long as they are capable of making healthcare decisions and their prognosis is less than six months (Vaughn 2016, 632). However, the law also requires the patients to administer the drugs themselves (Vaughn 2016, 632). Because of this, patients who are quadriplegic or physically disabled in another way cannot partake in physician-assisted suicide. Similarly, if a patient has previously expressed a desire to take his own life if he ever developed dementia or lost his capabilities in some other way, the patient would not be able to fulfill the desire he had stated at a time when he was in a sound mind. These are just a few examples in which physician-assisted suicide is simply not possible due to legal restrictions. As such, voluntary active euthanasia is the only method by which patients like this could reach their desired outcome. As Dan Brock puts it, "denying this alternative to patients who want it has a cost that should not be borne lightly in a society that values self-determination highly in its moral, political, and legal traditions" (Veatch 1997, 383). If voluntary active euthanasia is considered to be a viable option when considering end-of-life issues, then there is an additional avenue for patients to receive the greatest amount of mental and physical good.

Maximizing Net Good for the Patient's Family

In addition to the positive outcomes that voluntary active-euthanasia could bring to a patient, actively ending their life could also result in a positive outcomes for the loved ones of the patient. Hardwig make several valid points in his article, *Dying at the Right Time: Reflections on (Un)Assisted Suicide*. One of which is that we “always have a responsibility not to make selfish or self-centered decisions about our lives. We should not do just what we want or just what is best for *us*,” but rather take others’ desires into consideration as well (Hardwig 2007, 685). This seems to especially hold true if you have a large number of close relationships that are directly affected by your decisions. Additionally, Hardwig mentions that sometimes “death comes too late” for both the person suffering and the suffering one’s family (Hardwig 2007, 682). If those who surround a sick patient are suffering because they are forced to watch their loved one spend their life in pain, act-utilitarianism demands that we make an effort to relieve the preventable suffering of the family. Though ending a patient’s life through active euthanasia may cause temporary grief due to the death of a loved one, the relief of the persistent suffering would result in a net positive long-term effect.

Potential Moral Inferiority of Passive Euthanasia

The concept of Double Effect is often used to warrant passive euthanasia to be morally superior to active euthanasia. Under this belief, passive euthanasia is acceptable because the intent is to relieve pain with the potential side-effect of death rather than deliberately ending life through active euthanasia (Campbell 2013, 107). Because active euthanasia involves a physician intentionally ending a life, Double Effect claims that it is never morally permissible. Despite this widely held belief, I argue that voluntary active euthanasia can actually be morally preferable to simply letting a patient die as a result of the development of their illness. Hardwig reminds us

that, “death due to untreated illness can be agonizingly slow, dehumanizing, painful, and very costly, both in financial and emotional terms” (Hardwig 2007, 684). Allowing a trained professional to actively end the life of a consenting terminal patient has the potential to greatly reduce the suffering felt by both the patient and those who have to watch them die. In the event that a self-determined death is the desired procedure and passive euthanasia would result in a slow and painful death as the sickness slowly kills a patient, a utilitarian argument demands that voluntary active euthanasia be facilitated instead in order to eliminate the pain throughout the dying process. Again, Dan Brock puts it best when he states that “it seems cruelly perverse to hold that if a life-sustaining treatment were in place we should honor the patient’s request to remove it and let him die, but that otherwise we cannot intervene and must leave him to suffer in pain until nature takes its course” (Veatch 1997, 382).

Moral Equivalence to Physician Assisted Suicide

There is a common notion that physician assisted suicide is more acceptable than euthanasia because the patient is the one performing the action on themselves. However, it is foolish to believe that either scenario exists in a vacuum in which the patient or physician is entirely isolated from the other. In both physician assisted suicide and voluntary active euthanasia, the patient and physician collaborate and determine a course of action that they are both partially responsible for (Veatch 1997, 382). In both scenarios, “the choice should rest fully with the patient, who can change his or her mind until the time the process is irreversible,” but aside from who performs the final action, physician assisted suicide and voluntary active euthanasia are essentially identical (Veatch 1997, 381). Because of the similarities between the two processes, it does not logically follow that one should be morally or ethically superior to the other. From a utilitarian perspective, both processes ultimately perform the same action with

consent by the same people and should therefore produce the same consequences. It is ethically inconsistent to declare that one of these actions is acceptable while the other is forbidden and it is simply unethical (according to act-utilitarianism) to deny a patient voluntary active euthanasia if it can provide them with a net positive outcome.

Opposition to Active Euthanasia

The most common opposition to the utilization of active euthanasia is a typical slippery slope argument (Veatch 1997, 383). It is believed that “allowing active euthanasia or physician-assisted suicide will inevitably lead to heinous extensions or perversions of the original practice” (Vaughn 2016, 633). Often these concerns involve the potential for a blanket normalization of euthanasia, resulting in a dangerous future in which doctors perform involuntary euthanasia on patients who do not want to die. Similarly, the atrocities of the Holocaust are frequently referenced as the real-world example of when euthanasia was used to kill unwilling recipients (Arras et al. 2015, 488). This is a valid moral concern because euthanizing a person who does not want to die is simply murder. Another similar criticism of active euthanasia is the belief that we will disproportionately euthanize people from oppressed groups such as the mentally ill, disabled individuals, or low socioeconomic classes (Vaughn 2016, 633). Again, this fear is often associated to the Nazis euthanizing people with disabilities, incurable diseases, and mental illnesses (Arras et al. 2015, 489). This too is a valid moral concern because disproportionate euthanasia within particular groups would facilitate deeper social issues. Acknowledging these two concerns, it is important to note that both of these dangerous scenarios involve instances of involuntary euthanasia. Again, I am supporting the ethical legitimacy of voluntary euthanasia. This slippery slope argument fails in that it assumes that by allowing voluntary euthanasia, our society will inevitably fall into practices that are as horrendous as genocide (Veatch 1997, 383-

384). This notion asserts that there will be such an erosion of moral restraints that we, as a society, will be unable to maintain any sort of legal or ethical distinctions in public policy, such as a clear separation between patient-requested death and murder through euthanasia (Beauchamp and Childress 2016, 180). We maintain legal distinctions and specifications across a variety of different areas. If we are able to maintain distinctions between what is legal or illegal in other fields, it logically follows that we would be able to establish legal safeguards to allow euthanasia only when there is explicit patient consent.

Even if we assume the plausibility of the slippery slope, it is also necessary to acknowledge that while euthanasia has been legal in the Netherlands since 2002, “Dutch authorities have reported that data gathered so far [albeit few] indicate that physician misconduct in euthanasia cases is extremely rare” (Vaughn 2016, 634). Additionally, a study led by the University of Utah “found that legalizing physician-assisted suicide in Oregon and the Netherlands did not result in a disproportionate number of deaths among the elderly, poor, women, minorities, uninsured, minors, chronically ill, less educated, or psychiatric patients” (Vaughn 2016, 638). Focusing on Oregon, “women, people with disabilities, and members of disadvantaged racial minorities have not sought assistance in dying in disproportionate numbers,” and most requesting physician assisted suicide are Caucasian with genders that represent that of the general population (Beauchamp and Childress 2016, 181). Finally the number of patients seeking physician assisted suicide under Oregon’s Death With Dignity Act has been low and stable (~60 per year) and “there is no evidence that any patient has died other than in accordance with his or her own wishes” (Beauchamp and Childress 2016, 181). Though these Oregon studies focused on physician-assisted suicide, it is likely that enabling doctors to perform voluntary active euthanasia would result in similar conclusions because the only

difference would be which person does the action. Despite this reassuring early data, it is fair to question whether the trends that are seen in the Netherlands and Oregon would translate well to other populations (Beauchamp and Childress 2016, 181). Additionally, this data is far from conclusive and we should be sure to consider all of the data that comes out of instances in which voluntary euthanasia or physician assisted suicide have been made legal.

Another major criticism of active euthanasia comes from a religious perspective. In Christianity, Islam, Judaism, and Sikhism (just to name a few), “life and death are in the hands of God, and so individuals have no right to arrange their death or to kill themselves” (Campbell 2013, 108). By killing a patient through active euthanasia, a doctor is breaking a fundamental tenet of several major religions. I counter this assertion by saying, one’s personal religion should not dictate the life of another in any legitimately free society. As such, the only religious beliefs that are relevant would be those of the patient and those of the physician. Because we are dealing with voluntary active euthanasia, the patient would be explicitly asking for this procedure, implying that they do not hold religious beliefs that oppose it. If the physician’s beliefs prohibit her involvement with euthanasia, she could abstain from the procedure with conscientious objection. This is common practice when a medical professional holds a belief that directly contradicts what they are being asked to do. Laws permitting physician-assisted death, just like in cases involving abortion, typically contain specific exemptions that allow the physician to conscientiously object to the procedure allowing them to abstain from their involvement in the procedure (Jonsen et al. 2015, 107). Because voluntary active euthanasia by definition has been approved by the patient and the physician also has the ability to abstain on religious grounds, the religious views of those who are involved would not include a belief that life and death are matters left to God.

Conclusion

In this essay I have argued that voluntary active euthanasia is a morally acceptable action on the grounds that it has the potential to relieve suffering for both the patient and their loved ones. From an act-utilitarian perspective, the primary goal is to perform the action that will maximize the positive consequences and minimize the negative consequences of any particular situation. Terminally ill patients often find themselves to be in a state of constant suffering which may only be relieved upon their eventual death. In instances where euthanasia is decided upon, passive euthanasia is currently seen as the only morally permissible option to end a patient's life. However, if active euthanasia provides an opportunity for a consenting patient to bypass the suffering that may occur while they wait to die naturally, act-utilitarianism claims that active euthanasia is the morally correct action to take. Allowing a patient to avoid the possibility of spending the remainder of their life in a state of suffering leads to the greatest positive consequence for the greatest number of people; the patient and their loved ones. Active euthanasia, of course, should not be the default solution to every difficult situation. However, the request by a patient must at the very least be considered as a viable option (Dilley 2015, 99). This multifaceted procedure requires careful deliberation and consideration of all pertinent aspects with priority given to the patient's consent. Each unique situation must be carefully analyzed to decide if active euthanasia is the correct medical procedure that will produce the most net positive consequences. Voluntary active euthanasia should be considered to be a credible procedure for a patient to utilize because it could, in many cases, provide an efficient and effective way to relieve an enormous amount of pain and suffering that may not be possible through passive euthanasia, physician-assisted suicide, standard medication, or typical treatment.

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