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Is Euthanasia Compatible with Palliative Care?

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ABSTRACT

There has been a gradual shift in the attitude of the medical community as well as the lay public towards greater acceptance of euthanasia as an option for care of the terminally ill and dying. There have also been calls by certain groups to actually legalise voluntary euthanasia and physician-assisted suicide for patients who meet certain conditions, some of which are as follows: that the patient be of a sound mind, suffering from an incurable or terminal illness, experiencing unbearable suffering and uncontrollable pain. The rationale for legalising euthanasia is based on the principle of the patient's right of self-determination and the duty of doctors to relieve pain and suffering at all times. A few within the medical community quickly saw certain similarities in terms of goals and aims between euthanasia and palliative care and, thus, proposed that euthanasia be an option or choice for difficult palliative care cases. Some even went as far as to suggest that euthanasia and palliative care be part of the continuum of care for terminally ill patients. When palliative medicine fails to fully control pain and suffering for the patient, euthanasia can be the logical next step in the continuum of care. This article seeks to discuss why the rationale for legalising euthanasia is flawed, why euthanasia goes against the fundamental principles of Medicine in general and why it is incompatible with the practice of palliative medicine.

Keywords: end-of-life, terminally ill, dying, physician-assisted suicide

INTRODUCTION

Euthanasia is defined by Hunt as the deliberate action to terminate life by someone other than, and at the request of, the patient[1] while Roy et al simply defined it as the administration of death to the dying or assisting the dying to administer death to themselves[2].

The subject of euthanasia arouses different reactions in different people depending on which side of the divide they stand. It is murder or killing to some while to others it is 'aid-in-dying' or 'death with dignity'. The practice of euthanasia and physician-assisted suicide is currently banned in most countries. However in the last decade or so there has been a slow, gradual and yet definite paradigm shift in the attitudes of the medical community and the lay public towards greater acceptance of this practice. This is evidenced by the various attempts at legalising and decriminalising it in the US, Netherlands and the Northern Territory of Australia[3-5]. On 25 May 1995, the Parliament of Australia's Northern Territory (NT), through its Rights of the Terminally Ill Act, became the first ever legislative assembly in the world to legalise euthanasia[6,7]. This marked a significant milestone for the euthanasia lobby and bore grave implications for those in the medical community. Two years later, however, on 25 March 1997, this Act was repealed by the Australian National Senate when it passed the Euthanasia Laws Bill by a narrow margin of 38 to 34. This Bill prohibits any of Australia's three territories from passing laws legalising euthanasia[8] The demise of the Rights of the Terminally Ill Act did not put to rest the issue of euthanasia. Instead, it highlighted the fact that there was a large and significant number of individuals within the lay public as well as the medical community who supported its legalisation.

As a result of these recent developments, Medicine is confronted with two very important issues. The first is whether euthanasia can ever be ethically acceptable or tolerable within the practice of Medicine and the second is whether the former should be legalised or decriminalised and be accepted into the practice of mainstream medicine[2].

The euthanasia debate also saw certain segments of the healthcare community identifying similarities between the practice of euthanasia and palliative medicine. These elements, some of whom were palliative care physicians themselves, went even further as to suggest that euthanasia was compatible with the practice of palliative care and should be regarded as part of the continuum of accepted practice in the care of the terminally ill patient[9]. In the ensuing sections the authors hope to address the following:

1. The case for legalising euthanasia
2. Problems and issues related to the legalisation of euthanasia
3. The conflicts between euthanasia and palliative care

The case for legalising euthanasia

Doctors have the duty to relieve suffering at all times. Callahan pointed out that, "no moral impulse seems more deeply embedded than the need to relieve human suffering. It has become a foundation stone for the practice of medicine and it is at the core of the social and welfare programs of all civilised nations[10]".

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Unfortunately, inspite of all the technology that medical science possess, the complete alleviation of pain and suffering can never always be achieved. And when this occurs, some patients have the right to request that they be relieved of their suffering by the act of euthanasia and because it is the duty of the doctor to relieve pain and suffering at all times, it becomes incumbent upon him to act according to the wishes of the patient. This would seem the most merciful course of action to take.

The individual's right of self-determination must be respected always. Each person is responsible for his own life. He has moral authority over his own life and the decisions he makes. The Supreme Court of the US made a landmark ruling just before the turn of the century that recognised this fundamental right. It held in the Union Pacific v Botsford Case that "no right is more sacred, or is more carefully guarded by the common law than the right of the individual to the possession and control of his own person"[11]. Hence, every individual has the absolute right of total control over his life and that includes the right to request for assistance in terminating his or her own life.

Dying is difficult in this day and age. It cannot be accepted as a natural process of life. Medicine fails when patients die. Advances in medical technology have increased our capacity to prolong life and, ironically, to prolong the process of dying as well. There is a 'technological imperative' to use whatever means we have to prolong life and, in the process, cause unacceptable suffering to the dying patient. This form of treatment can be unnecessarily burdensome, may diminish the person's quality of life and personal dignity, and cause the person to undergo prolonged agony, a sense of utter futility and pointless suffering [10,12]. Who then can deny a person from avoiding this kind of death by seeking the peaceful, quick and painless death that is promised by euthanasia?

Euthanasia can help safe-guard the strained health care resources of a country. This is especially so in this era of technology-based medicine where our utmost is done, at times, to fight the course of nature, to deny death to the dying and plodding on in the face of futility. To financial planners, it makes sense to 'euthanise' patients who exert a burden on the state finances especially since they are not expected to contribute much to society and country. The Court of Appeal in its decision to strike down the New York State ban on euthanasia stated, "surely the state's interest (in the individual) lessens as the potential for life diminishes"[2]. There are many who also feel that when a hospital or health-care budget is slashed, the first service to be slashed should be the palliative care service, a non-essential service. And the alternative would then be euthanasia.

There are arguments that withholding or withdrawing treatment that is futile, overly burdensome and of no benefit to the patient (which is ethically permissible) is morally no different to euthanasia. The principle of 'double effect' which is used occasionally in palliative care is, likewise, not dissimilar to euthanasia[9]. In other words, euthanasia is already being practised though in a different guise. In fact, the practice of euthanasia is already taking place in many countries including the US, the Netherlands and Australia. Nearly 30% of Australian doctors have 'taken steps to bring about death' when requested to do so by a patient[7] while in the US, 16% of doctors admitted to writing at least one prescription to be used to hasten death[13]. Even if euthanasia is not legalised, it will be practised anyway albeit in a clandestine manner without proper supervision and control and this would make it vulnerable to abuse.

The current care delivery system with regards to the dying is grossly deficient in many areas. Expertise in pain management is often not available to patients. Comprehensive and enduring care is the exception[14]. The call for legalising euthanasia is actually a call for better management of the terminally ill and dying. It is a call for better and more widely available palliative care services, so that our patients may die "gently, with ease and dignity". However, even with adequate palliative care, there are occasions when pain and suffering cannot be fully controlled. In this instance, euthanasia may be the logical next option[9].

Problems and issues related to the legislation of euthanasia

The legalisation of euthanasia carries with it grave implications, not only for the terminally ill, the elderly, the disabled and the mentally incompetent, but also for humanity as a whole. Some of the issues and foreseeable problems will be discussed now.

- Self-determination is important but never absolute

  Self-determination or autonomy is important but it must be exercised within certain limits and in conjunction with our responsibilities towards others, if we are to be truly free. No one ends his life without affecting those around him: friends, relatives, loved ones and the healthcare staff. Self-determination can never be absolute. John Stuart Mill, commenting on slavery, wrote in his classic essay *On Liberty*, 'The principle of freedom cannot require that he should be free not to be free. It is not freedom to be allowed to alienate his freedom'[10]. Thus, civilised societies do not legally permit individuals the right to sell themselves into slavery even though that denial is a limitation on self-determination.

  Callahan points out that when a patient requests for euthanasia, he or she, in effect, relinquishes his or her sovereign self or autonomy and puts it in the hands of another. He wrote, "To allow another person to kill us is the most radical form of relinquishment of sovereignity or autonomy ever imaginable"[10]. Freedom, self-determination and autonomy become meaningless if life ceases to be. Hence, it appears rather odd that euthanasia seeks to protect the rights and the autonomy of the patient by rendering it meaningless to him (when he is dead).

- Does the general duty of the physician to relieve pain and suffering encompass the right to kill a patient on request?

  Callahan wrote in his book, *The Troubled Dream of Life*, that "A physician faced with suffering has to bear two burdens. The first is to act and try to relieve the suffering as best as he can. The second is to know when suffering cannot be wholly overcome and where it has to be accepted ... for just those reasons it cannot be fully correct to say that our highest moral duty to one another is the relief of suffering. If we make the relief of suffering the highest goal, we run the risk of sacrificing or minimising, other human purposes. Life would then be focused on avoiding pain, minimising risk, and craftily eyeing all possible life projects and goals with a view toward their likelihood of producing suffering"[10]. Pain and suffering is a natural part of our human condition. At times it works to our advantage. One need only look at sufferers of Hansens disease to appreciate the importance of feeling pain at times. Our job, as doctors, is to try to relieve pain and suffering as best as we can and know our limitations so that when these become uncontrollable, we would be able to accept and not feel the duty to end it at all cost, even at the expense of the patient's life. When pain and suffering become uncontrollable, the doctor's duty would be to comfort the patient with his presence, to suffer with the patient and to be a companion to the patient along his final journey.

  The danger of euthanasia is that it encourages society not only to cease bearing one another's suffering but to seek a cheap and easy solution to this by eliminating the sufferer altogether.

- Assault on the integrity and ethics of the medical profession

  The legalising of euthanasia would herald a major change in the ethos of medicine. The complicity of doctors in the death of patients would undermine the doctor-patient relationship based on trust, confidence and mutual respect[12]. The Supreme Court of the US has maintained that assisted suicide and euthanasia are incompatible with the healing role of physicians and that practice would undermine the physician-patient relationship[15].

  A decision for euthanasia is not a medical decision but a moral one. It must be the doctor's moral reason to act, not the patient's. Therefore, if a doctor believes that the life of a suffering but incompetent patient is not worth living, can the former deny the latter the same relief as a mentally competent patient? What began as a right to kill under specified conditions will soon become a duty to kill[10].

  The business of killing does not require medical skills. Since time immemorial, it has been the duty of the doctor to dispense treatment, not poison[16]. Perhaps it would be appropriate to restate here an excerpt from Hippocrates Oath, which reminds us of the duty a doctor undertakes towards his patient: 'I will give no deadly medicine to anyone if asked, nor suggest such counsel...'.

- The Law and euthanasia

  A popular argument against legalising euthanasia is that the Law is a blunt instrument that lacks the finesse, sensitivity and compassion to deal with the dying[12]. The dying experience is a very personal, subjective and unique experience to the individual. There are just too many variables associated with the process of dying that a 'blanket' law cannot hope to address each and every single situation and to cover every imaginable loophole.

  The Dutch experience has shown us that it is eminently difficult if not impossible, to regulate and control euthanasia. Studies in the Netherlands has shown that 2% to 7% of patients who died there did so from active voluntary euthanasia while a small but significant number died without prior consent (involuntary euthanasia)[17,18]. The deaths from euthanasia usually occurred in the privacy of the home with the agreement being made privately between the patient and the doctor and no other person need know about this. Thus, it is not surprising that most of these 'private killings' went unreported, despite the law requiring otherwise. It is evident that the Dutch are inexorably sliding down the slippery slope where euthanasia is increasingly being carried out involuntarily and without the knowledge of the Law. Lord Walton, the Chairman of the Select Committee on Medical Ethics set up by the House of Lords in the UK, had this to say, "We conclude that it was virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law in the UK could not be abused. We are also concerned that vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to request early death"[19].

- The slippery slope

  "The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived. This attitude, in its early stages, concerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans" – this description by Loo Alexander, a psychiatrist working for the War Crimes Office at Nuremberg, was about where the gas chambers of Aushwitz, Belsen and Treblinka had their humble beginnings in the 1930s – the nursing homes, the geriatric institutions and psychiatric hospitals all over Germany[19]. Indeed, the Nazi Holocaust acts as a grim reminder of an euthanasia law gone awry and the Dutch experience of euthanasia, it is feared, may cause history to repeat itself.

Mitchell et al warned that legalising euthanasia would 'condition' society to its presence. When this happens, it transforms the moral fibre and ethos of a whole generation for whom it becomes acceptable to take the lives of the terminally ill. They also warned that, "once we legalise intentional killing of patients by their physicians, then we will inevitably change society's perception of the sick, the elderly, the disabled and ultimately our very understanding of life and the process of dying ... step by step cogent reasons may be advanced to justify broadening the circumstances in which euthanasia may occur ... and finally the process of dying may be substituted by the 'act' of euthanasia[12].

The conditions are now ripe for history to repeat itself except that it is in a more subtle form: a favourable public opinion, a handful of willing doctors, economic pressures and a law allowing it[29].

- <u>The relief of suffering and patient self-determination – what if one occurred without the other</u>

The two most important points for euthanasia are patient self-determination and the need to relieve suffering. These two points are always spliced together and presented as if they were a single unified contention where one cannot occur without the other[29]. The NT law, for example, specified, among other things, that the patient must be of a sound mind and must be suffering a terminal illness and experiencing pain, suffering and/or distress that is severe and unacceptable[7]. Now, what if one were to 'divorce' the two conditions and approach them separately? What if a patient who was competent but not suffering requested for euthanasia, would it be denying him or her the right of self-determination if the latter was refused? Conversely, if a mentally incompetent patient was suffering, should we deny him the benefits of euthanasia as well? Are the mentally incompetent less entitled to relief from suffering than the competent[10]? The implications and permutations would be countless if one were to take into consideration the other conditions required for euthanasia to take place. Indeed, it would be exceedingly easy to expand the scope for euthanasia.

- <u>Voluntary euthanasia is not always voluntary</u>

The decision to undergo euthanasia can never always be voluntarily made. External as well as internal pressures may come to bear upon the patient. Patients may be subjected to external pressures from healthcare providers, insurers and relatives seeking to minimise costs while internal pressures may originate from within the patients themselves, who may perceive themselves to be less valued and may wish to spare their loved ones the financial and emotional burdens. One may be compelled to choose to be killed because of society's expectations too[12]. While careful regulation of assisted suicide could minimise the undue influence of others, it cannot fully protect vulnerable individuals from their own perceptions and fears[15]. A form of subtle coercion occurs when option becomes expectation or even obligation.

The real wishes, needs and fears of the dying are often elusive and poorly expressed because of their condition and the effect of medications[12]. In addition, studies have shown that most suicidal cancer patients have clinical depression (up to 60%) or other treatable conditions such as pain, which when treated, might effectively reduce the suicidal intent. Suicidal ideation among cancer patients range from 3% – 20% in certain studies[14,16]. Many patients may broach the subject of euthanasia to gauge how much others are concerned and value their well-being. This acts as an indirect evaluation of their self-worth.

- <u>Implications for medical practice</u>

At the turn of the century, man was busily fighting the ravages of infectious diseases which brought death more often than not. Through the means of intensive and rigorous research, many new advances were made, one of them being the discovery of antibiotics. Advances in medical science is the result of our quest for new cures for diseases and symptoms. If the early medical pioneers had taken the easy way out by killing those who were hopelessly ill, then medicine would not have progressed this far. Euthanasia not only kills patients but also kills research in medicine.

Medicine can never be practised in black and white. The physician, a human being, is fallible. Time and again the diagnosis of cancer has been proven subsequently to be wrong with the patient-outliving his or her life expectancy. If these patients had requested and duly received their request for euthanasia, nothing in this world could have brought them back to life. Euthanasia administers death which is final and irreversible. To quote Callahan again, "When euthanasia is requested, the doctor is being asked to act upon someone else's subjective suffering, variable from person to person, externally unverifiable, and almost always reversible – but to respond with an action that will be objective and irreversible"[10].

In our work with dying patients, it is undeniable that we do encounter patients with uncontrollable pain and other symptoms. This, however, is rather uncommon. If euthanasia were to be legalised, it must be said that it is done so for the sake of a few who are in the minority. The legalisation of euthanasia can only be based then on 'hard cases'[20]. Allowing difficult-to-treat 'hard cases' to create a precedent for legalised killing is the wrong response to take[19].

Callahan theorised that when a dying person suffers, he does so at two levels. The first level is related to the psychological reaction in coping with the illness and the second is related to existential questions such as what is the meaning and purpose of suffering or end of human existence. The physician can, and in

fact, should try with all that is within his means to relieve suffering at the first level through comfort, counselling, symptom control, etc. but, he should never overstep his boundary and try to solve suffering at the second level. The purpose of medicine is not to relieve all the problems of human mortality, about why we have to die at all or die in ways that seem pointless to us. Medicine has no competence to manage the meaning of life and death. The duty of the physician is therefore, only to relieve the problems of illness and not the problem of life itself[10].

Palliative care vs euthanasia

In 1826, Dr Carl Friedrich Marx wrote a treatise on medical euthanasia describing it as that science 'which checks oppressing features of illness, relieves pain and renders the supreme and inescapable hour a peaceful one ... how can it be permitted that he who is by law required to preserve life be the originator of, or partner in its destruction?'[2]. What Dr Marx calls euthanasia then, we would call palliative care today. The euthanasia that we know today means exactly what Marx excluded from the use of the term.

There are some elements even within the palliative care community who have come to view euthanasia as part of the continuum of palliative care[9]. In other words, euthanasia is a form of palliative care – the final act of palliation, so to speak. When palliative care physicians fail to control unbearable pain and suffering, it becomes incumbent upon the practitioners of euthanasia to assume this role. They will provide what palliative care could not – a peaceful, painless and 'easy' death.

So, it would seem that euthanasia and palliative care share similar goals. After all, do they not both stress on the importance of patient autonomy, or aim to relieve pain and suffering or to provide 'death with dignity'?

- Killing goes against the most fundamental principle of palliative care

  'Palliative care affirms life and regards dying as a natural process of life ... it neither hastens nor postpones death...'[21] Palliative care is the opposite of euthanasia. Through the clever play of words, the proponents of euthanasia are leading us to believe that the two are one and the same. In the Orwellian logic of equating opposites, where war is peace and ignorance is strength, the euthanasia lobby is proposing that euthanasia is palliative care and palliative care is euthanasia[22]. The principles of palliative care are the principles of medicine at large. Doctors have the dual responsibility to preserve life and relief suffering. The principles of beneficience (to do good) and non-maleficience (do no harm) apply equally to palliative care as well as to Medicine. Killing a patient is not beneficience, it is maleficience.

- The degradation and affirmation of life

  Euthanasia degrades life. It makes the patient doubt his or her self-worth. He is made to feel like a burden to his family, the health service and society. Palliative care affirms the person's worth and intrinsic goodness. It seeks to make the patient feel valued and loved. This is reflected in the following words, 'You matter because you are you, and you matter until the last moment of your life. We will do all we can, not only to help you die peacefully but also to live until you die'[23].

- Euthanasia denies the person the final stage of growth

  Dying is a period of reflection and a time for growth. It is a time for reconciliation and the mending of broken relationships, a time for rediscovery of mutual love and responsibility. It is a time when loving words are exchanged between loved ones and strength imparted to help sustain those left behind through the years ahead. It is truly the final chapter in a person's life story. Losing this opportunity of caring for the dying denies us an essential part of our humanity. Voluntary euthanasia artificially shortens and denies us this final phase of our growth[19]. Palliative care on the other hand accepts death as a normal process and tries to support the patient and his family through this final phase even if the patient experiences severe pain and suffering. It cannot promise to take away all pain but it can promise to stand by the patient and bear part of the suffering right to the end.

- The doctrine of double effect and the withholding and withdrawing of treatment do not constitute euthanasia

  The doctrine of double effect states that, so long as the intention is to do good and not harm the patient, it is ethical to perform a medical intervention which carries with it the risk of hastening death. The emphasis here is on the intended effect. In euthanasia, the intended effect of the treatment is death whereas in palliative care, where the use of morphine in controlling pain is the usual example taken, the intended effect is to alleviate pain at the small risk of hastening death. One seeks death while the other risks death. In euthanasia, death is the intention and death will be the outcome.

  In using the doctrine of double effect to justify our use of certain treatment, we must intend only the good and not the evil effect (death)[12]. Returning to the issue of morphine use, it is claimed that the use of this drug to cause 'pharmacological oblivion', which purportedly hastens death, is morally and ethically not different to euthanasia. Here, once again the advocates of euthanasia are attempting to confuse the issue by claiming that morally there is no difference between euthanasia and palliative care. But if one were to judge the issue according to the effect intended, the immorality of euthanasia is self-evident. It is important to note that morphine, with careful titration and monitoring, very rarely hastens death; contrary to what many who have never had the experience of using this drug, would have us believe.

Withholding and withdrawing treatment when the latter is futile and when the burdens outweigh the benefits is morally and ethically justifiable. It is not euthanasia. Making a person die and allowing a person to die are different morally and ethically. The five stages of disease as proposed by Haines et al recognises a stage when cure-orientated treatment is no longer appropriate and can be withdrawn, where the next stage is to treat the patient symptomatically and to relief distress[24].

CONCLUSION

From the above discussion, it is clear that the legalising of euthanasia and physician-assisted suicide goes against the most fundamental principles of Medicine. Legalising or decriminalising it would cause numerous legal, ethical and moral problems. The whole practice of medicine and the doctor-patient relationship based on trust, mutual respect and openness would be severely undermined. Despite what the euthanasia lobby would have us believe, euthanasia is fundamentally incompatible with palliative care. The palliative care movement must not allow itself to be 'hijacked' by the euthanasia lobby.

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