Euthanasia in West and Western Countries

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ABSTRACT

The word "euthanasia" was first used in a medical context by Francis Bacon in the 17th century, to refer to an easy, painless, happy death, during which it was a "physician's responsibility to alleviate the 'physical sufferings' of the body." In current usage, euthanasia has been defined as the "painless inducement of a quick death". However, it is argued that this approach fails to properly define euthanasia, as it leaves open a number of possible actions which would meet the requirements of the definition, but would not be seen as euthanasia. In particular, these include situations where a person kills another, painlessly, but for no reason beyond that of personal gain; or accidental deaths that are quick and painless, but not intentional. The British House of Lords Select Committee on Medical Ethics defines euthanasia as "a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering". In the Netherlands and Flanders, euthanasia is understood as "termination of life by a doctor at the request of a patient". Euthanasia is categorized in different ways, which include voluntary, non-voluntary, or involuntary. Voluntary euthanasia is legal in some countries, U.S. states, and Canadian Provinces. Non-voluntary euthanasia is illegal in all countries. Involuntary euthanasia is usually considered murder. As of 2006, euthanasia is the most active area of research in contemporary bioethics. In some countries there is a divisive public controversy over the moral, ethical, and legal issues of euthanasia. Those who are against euthanasia may argue for the sanctity of life, while proponents of euthanasia rights emphasize alleviating suffering, bodily integrity, self-determination, and personal autonomy. During doing the project shown through this paper, the subject case will be studied in view of west.

Keywords: Euthanasia, Death, Europe, World, West.

1. INTRODUCTION

There are 6 definitions about the subject on some minds: Person A committed an act of euthanasia if and only if (1) A killed B or let her die; (2) A intended to kill B; (3) the intention specified in (2) was at least partial cause of the action specified in (1); (4) the causal journey from the intention specified in (2) to the action specified in (1) is more or less in accordance with A's plan of action; (5) A's killing of B is a voluntary action; (6) the motive for the action specified in (1), the motive standing behind the intention specified in (2), is the good of the person killed. The first apparent usage of the term "euthanasia" belongs to the historian Suetonius who described how the Emperor Augustus, "dying quickly and without suffering in the arms of his wife, Livia, experienced the 'euthanasia' he had wished for." The word "euthanasia" was first used in a medical context by Francis Bacon in the 17th century, to refer to an easy, painless, happy death, during which it was a "physician's responsibility to alleviate the 'physical sufferings' of the body." Bacon referred to an "outward euthanasia"—
the term "outward" he used to distinguish from a spiritual concept—the euthanasia "which regards the preparation of the soul." In current usage, one approach to defining euthanasia has been to mirror Suetonius, regarding it as the "painless inducement of a quick death". However, it is argued that this approach fails to properly define euthanasia, as it leaves open a number of possible actions which would meet the requirements of the definition, but would not be seen as euthanasia. In particular, these include situations where a person kills another, painlessly, but for no reason beyond that of personal gain; or accidental deaths which are quick and painless, but not intentional. Thus another approach is to incorporate the notion of suffering into the definition. The definition offered by the Oxford English Dictionary incorporates suffering as a necessary condition, with "the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma", and this approach can be seen as a part of other works, such as Marvin Khol and Paul Kurtz's "a mode or act of inducing or permitting death painlessly as a relief from suffering". However, focusing on this approach to defining euthanasia may also lead to counterexamples: such definitions may encompass killing a person suffering from an incurable disease for personal gain (such as to claim an inheritance), and commentators such as Tom Beauchamp & Arnold Davidson have argued that doing such would constitute "murder simpliciter" rather than euthanasia.

The third element incorporated into many definitions is that of intentionality – the death must be intended, rather than being accidental, and the intent of the action must be a "merciful death". Michael Wreen argued that "the principal thing that distinguishes euthanasia from intentional killing simpliciter is the agent’s motive: it must be a good motive insofar as the good of the person killed is concerned", a view mirrored by Heather Draper, who also spoke to the importance of motive, arguing that "the motive forms a crucial part of arguments for euthanasia, because it must be in the best interests of the person on the receiving end." Definitions such as that offered by the House of Lords Select Committee on Medical Ethics take this path, where euthanasia is defined as "a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering." Beauchamp & Davidson also highlight Baruch Brody's "an act of euthanasia is one in which one person ... (A) kills another person (B) for the benefit of the second person, who actually does benefit from being killed". Draper argued that any definition of euthanasia must incorporate four elements: an agent and a subject; an intention; a causal proximity, such that the actions of the agent lead to the outcome; and an outcome. Based on this, she offered a definition incorporating those elements, stating that euthanasia "must be defined as death that results from the intention of one person to kill another person, using the most gentle and painless means possible, that is motivated solely by the best interests of the person who dies." Prior to Draper, Beauchamp & Davidson had also offered a definition which includes these elements, although they offered a somewhat longer account, and one that specifically discounts fetuses in order to distinguish between abortions and euthanasia:

"In summary, we have argued ... that the death of a human being, A, is an instance of euthanasia if and only if (1) A's death is intended by at least one other human being, B, where B is either the cause of death or a causally relevant feature of the event resulting in death (whether by action or by omission); (2) there is either sufficient current evidence for B to believe that A is acutely suffering or irreversibly comatose, or there is sufficient current evidence related to A's present condition such that one or more known causal laws supports B's belief that A will be in a condition of acute suffering or irreversible comatoseness; (3) (a) B's primary reason for intending A's death is cessation of A's (actual or predicted future) suffering or irreversible comatoseness, where B does not intend A's death for a different primary reason, though there may be other relevant reasons, and (b) there is sufficient current evidence for either A or B that causal means to A's death will not produce any more suffering than would be produced for A if B were not to intervene; (4) the causal means to the event of
A’s death are chosen by A or B to be as painless as possible, unless either A or B has an overriding reason for a more painful causal means, where the reason for choosing the latter causal means does not conflict with the evidence in 3b; (5) A is a nonfetal organism.” Wreen, in part responding to Beauchamp & Davidson, offered a six-part definition: "Person A committed an act of euthanasia if and only if (1) A killed B or let her die; (2) A intended to kill B; (3) the intention specified in (2) was at least partial cause of the action specified in (1); (4) the causal journey from the intention specified in (2) to the action specified in (1) is more or less in accordance with A’s plan of action; (5) A’s killing of B is a voluntary action; (6) the motive for the action specified in (1), the motive standing behind the intention specified in (2), is the good of the person killed.” Wreen also considered a seventh requirement: "(7) The good specified in (6) is, or at least includes, the avoidance of evil", although as Wreen noted in the paper, he was not convinced that the restriction was required. In discussing his definition, Wreen noted the difficulty of justifying euthanasia when faced with the notion of the subject's "right to life". In response, Wreen argued that euthanasia has to be voluntary, and that "involuntary euthanasia is, as such, a great wrong". Other commentators incorporate consent more directly into their definitions. Euthanasia, also known as assisted suicide, physician-assisted suicide (dying), doctor-assisted dying (suicide), and more loosely termed mercy killing, means to take a deliberate action with the express intention of ending a life to relieve intractable (persistent, unstoppable) suffering. Some interpret euthanasia as the practice of ending a life in a painless manner. Many disagree with this interpretation, because it needs to include a reference to intractable suffering. In the majority of countries euthanasia or assisted suicide is against the law. According to the National Health Service (NHS), UK, it is illegal to help somebody kill themselves, regardless of circumstances. Assisted suicide, or voluntary euthanasia carries a maximum sentence of 14 years in prison in the UK. In the USA the law varies in some states.

2. WESTREN CONCEPTIONS OF EUTHANASIA

Active euthanasia is a much more controversial subject than passive euthanasia. Individuals are torn by religious, moral, ethical and compassionate arguments surrounding the issue. Euthanasia has been a very controversial and emotive topic for a long time. The term assisted suicide has several different interpretations. Perhaps the most widely used and accepted is "the intentional hastening of death by a terminally ill patient with assistance from a doctor, relative, or another person". Some people will insist that something along the lines of "in order relieve intractable (persistent, unstoppable) suffering" needs to be added to the meaning, while others insist that "terminally ill patient" already includes that meaning. The distinction between active and passive euthanasia is crucial in Western Medical Ethics. The idea is that it is permissible, at least in some cases, to withhold treatment to allow a patient to die, but never permissible to take any direct action designed to kill the patient. This doctrine seems to be acceptable to most medical doctors in the West. For example, it is endorsed in a statement by the House of Delegates of the American Medical Association as follows:

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. This value is independent of one’s physical or mental state of health, and is based on the principle that God is the sole creator of life and has sovereign authority over life and death. Both active euthanasia and assisted suicide are illegal under English law.
Depending on the circumstances, euthanasia is regarded as either manslaughter or murder and is punishable by law, with a maximum penalty of up to life imprisonment.

**KINDS OF EUTHANASIA**

There are a number of historical studies about the thorough euthanasia-related policies of professional associations. In their analysis, Brody et al. found it necessary to distinguish such topics as euthanasia, physician-assisted suicide, informed consent and refusal, advance directives, pregnant patients, surrogate decision-making (including neonates), DNR orders, irreversible loss of consciousness, quality of life (as a criterion for limiting end-of-life care), withholding and withdrawing intervention, and futility. Similar distinctions presumably are found outside the U.S., as with the highly contested statements of the British Medical Association.

Euthanasia may be classified according to whether a person gives informed consent into three types: voluntary, non-voluntary and involuntary. There is a debate within the medical and bioethics literature about whether or not the non-voluntary (and by extension, involuntary) killing of patients can be regarded as euthanasia, irrespective of intent or the patient's circumstances. In the definitions offered by Beauchamp & Davidson and, later, by Wreen, consent on the part of the patient was not considered to be one of their criteria, although it may have been required to justify euthanasia. However, others see consent as essential.

**2.1. VOLUNTARY EUTHANASIA**

Euthanasia conducted with the consent of the patient is termed voluntary euthanasia.

**1.1. NON-VOLUNTARY EUTHANASIA**

Euthanasia conducted where the consent of the patient is unavailable is termed non-voluntary euthanasia.

**1.2. IN VOLUNTARY EUTHANASIA**

Euthanasia conducted against the will of the patient is termed involuntary euthanasia.

**1.3. PASSIVW AND ACTIVE EUTHANASIA** Voluntary, non-voluntary and involuntary euthanasia can all be further divided into passive or active variants.

**2. EUTHANASIA AS A FACT**

Historically, the euthanasia debate has tended to focus on a number of key concerns. According to euthanasia opponent Ezekiel Emanuel, proponents of euthanasia have presented four main arguments: a) that people have a right to self-determination, and thus should be allowed to choose their own fate; b) assisting a subject to die might be a better choice than requiring that they continue to suffer; c) the distinction between passive euthanasia, which is often permitted, and active euthanasia, which is not substantive (or that the underlying principle—the doctrine of double effect—is unreasonable or unsound); and d) permitting euthanasia will not necessarily lead to unacceptable consequences. Pro-euthanasia activists often point to countries like the Netherlands and Belgium, and states like Oregon, where euthanasia has been legalized, to argue that it is mostly unproblematic. Similarly, Emanuel argues that there are four major arguments presented by opponents of euthanasia: a) not all deaths are painful; b) alternatives, such as cessation of active treatment, combined with the use of effective pain relief, are available; c) the distinction between active and passive euthanasia is morally significant; and d) legalizing euthanasia will place society
on a slippery slope, which will lead to unacceptable consequences. Elisabeth Kübler-Ross, an eminent Swiss American psychiatrist (a pioneer in near-death studies and the author of the groundbreaking book On Death and Dying (1969), where she first discussed her theory of the five stages of grief), encouraged the hospice care movement, believing that euthanasia prevents people from completing their 'unfinished business'.

It concludes that the secular view is centered mainly on two ideas - autonomy and differences of moral values of the human person and that the parameters of these ideas leads to a wide diversion as to what is morally acceptable.

It finds that the Christian position is also based on these two principles however they are limited by the notion that autonomy is a gift not exercisable at the end of life which is only a matter for the donor God and that each life because it is owned by God is of equal value.

It concludes that after a rapid advance to the acceptance of involuntary medically assisted suicide the legal position has begun to retroced to a more conservative position of a personnel only exercise of autonomy in end of life decisions which is the currant position in Ireland.

3. AN APPLIED SURVEY ON THE SUBJECT

A survey in the United States of more than 10,000 physicians came to the result that approximately 16% of physicians would ever consider halting life-sustaining therapy because the family demands it, even if they believed that it was premature. Approximately 55% would not, and for the remaining 29%, it would depend on circumstances. This study also stated that approximately 46% of physicians agree that physician-assisted suicide should be allowed in some cases; 41% do not, and the remaining 14% think it depends.

An Applied objective of the subject

An intolerance for suicide began to take hold in the second and third centuries and gained increasing momentum under the influence of Christianity. Whereas in the classical period suicide was criticized only if it was irrational or without cause, Christianity saw this act as a direct defiance of or interference with God’s will; thus, suicide resulted in the denial of a Christian burial and tended to bring great shame upon family members. St. Augustine declared that “life and its sufferings are divinely ordained by God and must be borne accordingly.” In the 13th century, the teachings of St. Thomas Aquinas epitomized the intolerance for suicide. According to Aquinas, suicide violated the biblical commandment against killing and was ultimately the most dangerous of sins because it precluded an opportunity for repentance.

The impact of scientific and medical discoveries in recent times has changed the nature of the debate on suicide. The increasing ability of physicians to treat bodily ailments, and to extend life, caused the state to have a more direct interest in questions of life and death in the medical context. Strict adherence to religious principles and teachings was complicated by the advances of science and medicine. Issues such as medically assisted death and cessation of treatment, which characterize much of the contemporary debate, have their roots in this period. By the beginning of the 19th century, the medical profession was engaging in a fair amount of discussion on euthanasia, in which philosophers and theologians joined. Much of the discourse focused on the issue of “quality of life” and on the right to determine when this quality had deteriorated to the point where it was acceptable to cease living.

In North America, the seminal case on the question of quality of life and cessation of treatment was that of Karen Ann Quinlan, a 21-year-old who suffered permanent brain damage, and went into a coma, after an episode involving the consumption of alcohol and drugs. Ms. Quinlan’s parents signed a release form to allow physicians to cease use of a
respirator in the treatment of their daughter. When the hospital refused to follow the directive, her parents asked the courts to reverse the hospital’s decision. In 1976, following a ruling by the New Jersey Supreme Court, the respirator was removed. Ms. Quinlan died in 1985 in a nursing home where she had remained in a coma, fed through tubes, for some 10 years.

In Canada, there have been two high-profile court cases involving women with amyotrophic lateral sclerosis (ALS) seeking the right to physician-assisted suicide. ALS causes progressive muscle paralysis, chronic pain, and eventual death without affecting cognitive functioning. The cases of Sue Rodriguez and, more recently, Gloria Taylor represented key developments in the law in Canada and are discussed in more detail below.

The extent to which medical technology can prolong life, quite independent of considerations about the quality of that life, has become common knowledge for most citizens. This means that many persons give active consideration to the limits they will place on their own medical treatment and that of family members.

The increasing cost of health care is another relevant consideration. Estimates indicating that individuals incur their highest health care costs in the final days of life illustrate the delicate balance between sustaining life and containing health care expenses. This fact, some health policy analysts suggest, will become increasingly apparent as more and more of the population move into the older age groups, in which health care needs and their attendant costs increase.

The legalisation of euthanasia in the US state of Oregon, and in both the Netherlands and Belgium has meant that certain types of medical life-ending behaviors, when certain criteria are met, are no longer a matter for the criminal justice system and regulatory authority is delegated to review bodies their composition and remit differ between the three jurisdictions. The first jurisdiction to legalize life-ending behavior by physicians at a patient’s explicit and considered request was Australia’s Northern Territory, but the experiment proved to be short-lived. The Commonwealth of Australia’s General Assembly swiftly moved to overturn the Northern Territory’s Rights of the Terminally Ill Act, which was in operation for less than a year in the last decade, and currently defunct. Any act of life-ending behavior that falls outside of this falls back into the criminal justice system. High penalties tend to apply to those who abuse or violate the law, such as coercing patients or by falsifying documents whereas murder charges can be brought against physicians or anybody else who do not act within the legal framework.

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