Moral dimensions

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Western medicine is increasingly interested in the problem of euthanasia. There are two main reasons for this. One is related to the fact that modern medicine has prolonged not only our lives but also our period of dying. Modern medicine supports hastening death through withholding life supporting treatment or giving high doses of pain relief to those who are dying. Is this morally different from euthanasia? The second reason is the increased emphasis on respect for the patient's autonomy. Doctors have to abide by all sorts of requests from their patients. It is only natural, therefore, to wonder whether we have good reasons to decline a patient's request for euthanasia.

Public support for a system of euthanasia is high in Western countries. In surveys I conducted, as many as 63% of Norwegians, 79% of Swedes, and 68% of Germans thought that if a patient has an incurable disease and doesn't want to go on living, he or she should be allowed to receive a lethal injection (unpublished data). And yet, most doctors and politicians in most Western countries are strongly opposed to legalised euthanasia. Is there any plausible moral rationale behind their opposition?

Three principles

To consider this question I will examine euthanasia using three basic moral outlooks: deontology, basic moral (negative) rights, and utilitarianism (box). I have used sharply distinguished ideal types of these ideas. Of course, all sorts of compromise positions are possible between them, and also quite different outlooks.

Deontology

If some actions are strictly prohibited, as deontology dictates, it may seem natural to assume that killing must be one of them. However, this view is a bit simplistic. According to most deontological ethicists, and the sanctity of life doctrine in particular, only the killing of innocent humans is strictly prohibited. The doctrine can endorse both the killing of animals for food, say, and capital punishment. However, with respect to innocent human beings, the doctrine is very strict. It applies to all human beings (including fetuses and embryos). It applies to suicide in the same way that it applies to murder.

Deontology prohibits only active killing. It is compatible with this doctrine that we allow people in poor countries to starve to death while we are living comparatively well. Even some kinds of active killing can be morally acceptable (and required) as long as it was not intended. For example, it may be morally permitted to give a patient a painkiller that kills her if the intention is to kill the pain not the patient. The death of the patient is then a foreseen but not desired consequence of the action. Provided there is a reasonable proportionality between the good at which one aims and the bad one foresees, it is morally acceptable to give a lethal dose (assuming there was no other way to keep the patient free of pain). Similarly it is permissible to withhold nourishment from a patient in a persistent vegetative state and allow them to die. What this view prohibits is what most doctors and politicians in most Western countries are in opposition to—a system where, at a patient's request, a doctor actively and intentionally kills the patient.

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But is the theory plausible? It puts the same ban on abortion as on euthanasia. And, as was noted above, it makes no moral distinction between murder and suicide.

Moral rights

The basic moral rights view is that we can do as we see fit with ourselves. Clearly, it would thus be morally illegitimate to forbid patients from killing themselves or to forbid doctors from assisting them. Moreover, it would be morally illegitimate to forbid doctors to actively and intentionally kill their patients at their patients' request. This does not mean that euthanasia should be a positive right. According to the moral rights approach, there are only negative rights. A patient cannot require that his or her doctor performs euthanasia. However, if patient and doctor both agree that this is what should be done, no one should meddle with their voluntary agreement. This would be to violate their right to autonomy.

Thus, if it is plausible, the moral rights approach cannot provide any rationale for those who want to object to legalised euthanasia unless it is made a positive right. In countries where euthanasia is practised, such as the Netherlands and Belgium, euthanasia is merely a possibility not a positive right. So these

Three moral outlooks

Deontology—The view that some kinds of actions are unconditionally prohibited. In the euthanasia debate it often takes the form of the sanctity of life doctrine
Basic (negative) moral rights—Each individual owns, in a moral sense, himself or herself. This means that individuals are free to do as they see fit with themselves. According to this view no positive rights exist. We have an absolute negative right not to be harmed but no positive right to receive help when we are in distress
Utilitarianism—An action is wrong if, and only if, an alternative is available with better consequences. In a hedonistic version of utilitarianism we ought always to act to maximise total wellbeing in the universe.

systems seem to be in agreement with the requirements of the moral rights tradition. But is it morally acceptable?

Utilitarianism

In utilitarianism the aim is to act to provide maximum benefit. In some cases it is reasonable to assume that euthanasia would have been the best option, from the point of view of the patient. But according to utilitarianism, we cannot focus exclusively on the patient. Other people may be affected by the patient's decision to opt for euthanasia and, even if euthanasia would be in the best interest of the patient, it may be wrong because of the bad effect on the patient's relatives. But if the relatives support the patient's decision euthanasia would be recommended by utilitarianism.

Even if utilitarianism requires euthanasia in some cases it doesn't settle the question whether euthanasia should be legalised. If utilitarianism is a proper moral point of departure, we ought to opt for the legal system with the best consequences. And it is conceivable that the best legal system prohibits some morally right actions (and allows some morally wrong actions). We thus need to consider the consequences of legalising euthanasia. I will return briefly to this question below. But we must also ask whether utilitarianism is a reasonable moral theory.

Which moral outlook is correct?

There are competent contemporary advocates of all the three competing views I have presented above. So there is no way in a short article to settle the case. Let me just outline my reasons for preferring, in this context, utilitarianism to deontology and the moral rights view.

Deontology focuses exclusively on the moral agent, whereas the rights view and utilitarianism focus on the patient as well. This counts against deontology, especially in the context of euthanasia. It might be of utmost importance to the doctor to know whether his or her killing of a patient is active or passive, intentional or merely foreseen, but this matters little to the patient. To patients it is more important to know that their death takes place according to their wishes. And in health care it is the patient's perspective that should be most important.

In addition, I believe the rigidity of the deontological view counts against its plausibility. The fact that it condemns in the same strict terms murder, euthanasia, suicide, and abortion, renders it implausible. It is as if it were blind to important moral distinctions.

The moral rights perspective, although better than deontology, is also much too simplistic. But whereas deontology is too restrictive, the rights tradition is too liberal. Once again important moral distinctions are glossed over. According to the rights theory, as soon as the doctor and the patient agree that the doctor should kill the patient, a third party cannot legitimately interfere with their transaction unless they can show that they are harmed by it. And this is the case irrespective of how bad the consequences of their transaction are to a third party. The patient need not even to be ill to have a right to euthanasia. Clearly, the patient's relatives may suffer a lot if the patient receives euthanasia, but they cannot reasonably claim that, in the circumstances, they are actively harmed by this decision. This view of euthanasia is too liberal to suit my moral intuitions.

So we are left with utilitarianism. Utilitarianism is focused on the patient but not only on the patient; it is focused on everyone affected by the decision. This seems to me right. But what are the consequences for legalisation of euthanasia, if we assess the question from a utilitarian point of view?

Summary points

- Many Western doctors and politicians oppose legalised euthanasia despite public support
- The question whether to legalise euthanasia has no easy answer
- Three moral outlooks provide different answers
- Nevertheless, permitting euthanasia in limited circumstances seems the most beneficial approach

Utilitarian defence of euthanasia

Utilitarianism raises the right questions with respect to legalisation of euthanasia. If euthanasia is legalised, will this mean a relief to patients or that we all fear being victimised in the healthcare system? Must we fear that when we become ill and vulnerable healthcare professionals and our relatives will coerce us into accepting an offer we can't refuse in order to save money?

To me it seems that the evidence is overwhelmingly in favour of a system of legalisation of euthanasia. Of course, any system of hastening the death of patients can be misused. This is true of euthanasia no less than of other, now legal, forms of doing so. But this is a reason to scrutinise more thoroughly what is going on in general in the healthcare system not to prohibit one rather special form of hastening death (which is bound to be comparatively rare).

Many patients in Western countries already have their death hastened through aggressive palliative measures or abstention from curative treatment, or both. If there is an interest in saving money by not treating futile cases, this is the area that could be the subject of all sorts of abuse. Furthermore, if euthanasia is legalised, all end of life decisions are likely to be more critically investigated than they are now. We know much about how people die in the Netherlands and comparatively little about how people die in other Western countries. So legalisation of euthanasia will probably work in the direction of more, not less, transparency within palliative medicine.

Another argument against legalising euthanasia is that palliative care will not develop. Euthanasia will be seen not as a complement, but as an alternative, to palliative care. This doesn't seem to be the case in the Netherlands, however, where palliative care has developed rapidly since the introduction of euthanasia. The fact that most patients don't ask for euthanasia should be kept in mind when this matter is discussed.

It has also been said that if palliative care is developed, euthanasia will not be needed. Effective palliative care will keep all patients free of pain so no one will ask for euthanasia. I believe that the claim that pain can always be defeated is false (unless you sedate the patient into oblivion), but this is really not what the discussion is or should be about. Patients may request euthanasia for reasons other than pain. Some patients find that they are finished with their lives and their process of dying. They find it humiliating to have to continue living, experiencing mental and physical decay. If there are such patients, and I believe there are, it is cruel to turn down their request for euthanasia. A system for euthanasia would mean that people could approach the terminal phase of their lives without fear. They would know that, if, when their turn comes, and things turn out to be terrible, they have a way out.

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Dutch experience of monitoring euthanasia

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Physician assisted death is known to occur in several countries,[1–5] and probably takes place in others, albeit with different frequencies. Three places have enacted a notification procedure to safeguard this practice: Oregon in the United States, Belgium, and the Netherlands.[6–8] In the United Kingdom, a law on assisted dying for the terminally ill has been proposed and has stimulated much discussion.[9–11] The Netherlands has had a formal procedure for reviewing cases of euthanasia and physician assisted suicide since 1991. The procedure has been evaluated and revised twice.[12] We examine how well the Dutch system has ensured best practice and reporting of physician assisted suicide. Although the Dutch experience cannot solve the question whether legal regulation of assisted dying is desirable, it gives insight into the possibilities of achieving transparency, public oversight, and legal control.

Review procedure

In the Dutch review procedure, euthanasia is defined as purposely ending the life of someone at his or her explicit request. Physician assisted suicide is defined as the prescription or supply of drugs with the explicit intention to enable the patient to end his or her own life. The review procedure aims to stimulate disclosure of cases and ensure verifiability, and adherence to the requirements for prudent practice.

The first review procedure was introduced in 1991 and was legally enacted in 1994. Doctors were required to report cases to the public prosecutor (through the medical examiner). The public prosecutor carried out an initial review and then referred cases to the Assembly of Prosecutors General and the minister of justice for final review. Euthanasia and physician assisted suicide were punishable, but doctors could expect not to be prosecuted if they met the requirements for prudent practice. This procedure was evaluated in 1996, and a new system introduced in 1998.[6]

Under the revised procedure doctors had to report to one of five regional review committees (through the medical examiner). These committees, consisting of a lawyer, an ethicist, and a physician, reviewed reported cases and advised the Assembly of Prosecutors General. The assembly still made the ultimate decision on whether to prosecute, and euthanasia and physician assisted suicide remained illegal.

In April 2002 a new law on euthanasia was enacted that established a revised review procedure. The review committee still examines all reported cases, but only those that do not meet the requirements for prudent practice are subsequently reviewed by the Assembly of Prosecutors General. The committee can request extra information from the reporting doctor if required. Euthanasia and physician assisted suicide are legal provided that the requirements for prudent practice are met.

The central question for review in all three procedures has been whether the requirements for prudent practice have been met. These have not been altered (box).

Effect on notification

The success of the review procedure depends largely on the extent to which doctors report euthanasia and physician assisted suicide. The figure shows the numbers of reported cases between 1990 and 2004.

Dutch requirements for prudent practice in euthanasia and physician assisted suicide[13 14]

Substantive requirements

- The patient's request must be voluntary and well considered
- The patient's condition must be unbearable and hopeless
- No acceptable alternatives for treatment are available
- The method is medically and technically appropriate

Procedural requirements

- Another doctor is consulted before proceeding
- The case is reported as an unnatural death

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