

A RESPONSE TO EUTHANASIA INITIATIVES

Physician-assisted suicide—a physician providing the means for a patient to use in the act of self-killing—and euthanasia—the direct killing of a patient by a physician at the patient's request—have recently become subjects of intense debate in the popular media, the political arena, and medical ethics. The controversy arises from the sharp challenge to the long-standing prohibition in medical ethics against physicians intentionally terminating their patients' lives. The outcome of this debate will profoundly influence physicians' role in society, the kind of society we become, and the physician-patient relationship.

Although euthanasia has been promoted and even covertly practiced in the past, it has not been legalized by any Western nation nor has it been given approbation by either the public or the medical profession. Now, however, there are physicians who believe that, under certain circumstances, helping patients die by providing means for self-killing or directly killing patients is ethically admissible. Groups in some states, such as Washington and California, have attempted to legalize these practices, and in the Netherlands euthanasia is already socially acceptable, if not fully legal. It is not unreasonable, given current

The Debate's Outcome Will Affect Physicians' Role, Society, and Physician- Patient Relationships

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trends, to expect that active euthanasia and physician-assisted suicide will be legal in one or more states before the next century.

FORCES SUPPORTING EUTHANASIA

What forces account for the move to rescind one of medicine's oldest prohibitions? We suggest three: an abuse of scientific advancement, a new political philosophy, and the erosion of religious consensus.

Scientific Advancement The unprecedented expan-

Summary The outcome of the physician-assisted suicide and euthanasia debate will profoundly influence physicians' role in society, the kind of society we become, and the way physicians and patients relate to one another.

Three forces account for the move to physician-assisted suicide and euthanasia: an abuse of scientific advancement, a new political philosophy, and the erosion of religious consensus.

The relationship between patients and physicians has often been understood as a covenant with rights on patients' part and duties on physicians' part. Physicians' duties in this covenantal relationship are to act for patients' good (a positive duty) and to do no harm (a negative duty).

Euthanasia and assisted suicide are morally wrong because, as the Judeo-Christian ethic teaches, human beings are creatures of God and have only stewardship, not dominion, over life. But in our pluralistic society, which seems to lack consensus on religion, on communal responsibility, and on common values, one cannot argue against mercy killing and assisted suicide on theological grounds. Our society generally agrees, however, that a discussion of values may take place in the language of moral philosophy, a language that expresses right reason.



sion of medicine's scientific prowess in the past several decades allows physicians today to keep any patient alive for a virtually indefinite period. Unfortunately, physicians have inappropriately used this power too often, mistakenly interpreting the Hippocratic oath as a call to stave off death even when medical treatment is totally ineffective and only prolongs dying.

As more people experience this misuse of medical power, they have come to fear the pointless prolongation of terminal illness, suffering, and death. To gain some measure of "control," some persons have written advance directives to act as a guide when they are unable to express their desires. Others judge these directives to be insufficient. For them, absolute control over their own lives is the only way to prevent unnecessary treatment and suffering. Such persons favor ending their lives themselves, with physicians' assistance or by their own hands—at any time, under any conditions.

Political Philosophy Those in favor of euthanasia and physician-assisted suicide are encouraged by the emerging change in medical ethics. Individualism and commitment to negative rights have long characterized American political philosophy. Increasingly, the political right of noninterference is being translated into a moral right to make one's own moral decisions, irrespective of what others may think. This impetus to moral privatism found its clearest expression several decades ago in the assertion of the legal and moral right to autonomy (i.e., to participation and self-determination in medical decisions). Patient autonomy has become the prime principle of medical ethics to such an extent that it is almost absolutized.

Erosion of Religious Consensus The third force impelling Americans to consider legitimizing physician-assisted suicide and active euthanasia is the loss of consensus on the fundamental value of human life. This stems from two causes:

- The loss of religious consensus on the moral inviolability and meaning of human life
- The increasing skepticism about moral absolutes of any kind, with its inevitable end product—ethical relativism

Interrelated Forces These closely related forces are at work in the whole of Western society. They are most openly expressed in the public support for euthanasia in the Netherlands by religious, as well as nonreligious, people. The polls in our own country indicate that similar forces are at work here. In time American public opinion may match that of the Dutch, with similar results in public policy. This is a particularly ominous prospect at a time when we are considering a change in health policy, which is largely driven by economic and fiscal considerations. What ethical

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considerations there may be are certain to be secular and not Judeo-Christian in their roots.

IMPORT OF PATIENT KILLING

Committed Jews and Christians of all denominations must become aware of the full import of a legitimization of the various forms of patient killing. We take as given the fact that for believing Jews and Christians, human life is a gift from God, that in consequence we are not its absolute masters, but its stewards. We think this is so fundamental that we will not repeat its foundations in Scripture, Church teaching, or tradition.

To understand the internal morality of medicine, one must understand certain concepts and their historical development. "Euthanasia"—the Greek term for "good death"—has taken on the meaning of "mercy killing." In *Dorland's Illustrated Medical Dictionary*, "euthanasia" is defined as "mercy death; the putting to death of a person suffering from an incurable disease."¹ Euthanasia is now further specified as "active" or "passive." "Active euthanasia" refers to the administration of some agent with the intent to bring about death (e.g., a massive dose of morphine to suppress respiration). "Passive euthanasia" (a poor term in our opinion) refers to the withholding or withdrawal, at a patient's or surrogate's request, of some medical treatment, such as cardiac resuscitation, artificially administered nutrition and hydration, mechanical ventilation, or dialysis. The intention here is not directly death, but relief from the burdens of treatment, which for a patient outweigh the effectiveness and benefits. Such withdrawal will eventually result in a patient's death, but the death is caused by the disease process from which the patient suffers, not directly by an act of the physician.

In the Pythagorean corpus of Greek philosophical writing is an oath attributed to Hippocrates, the mythical father of medicine.² This oath was taken by students following the Hippocratic methodology in their profession of medicine. New physicians swore by Apollo, the Greek god of medicine, and humanity to do all they could for patients, never to do wrong to patients, nor to give a deadly poison even if asked, nor to procure an abortion, nor to perform a procedure for which they were not trained. New physicians also promised never to take advantage of patients' vulnerability by sexual or other assault, and always to keep confidences.

In time the Judeo-Christian ethic, spreading from Palestine into the Mediterranean world, superimposed itself on this Greek philosophical tradition. The "One God" displaced Apollo. In the Hebrew wisdom literature the beautiful poem of the physician reveals that the warrant to heal came



from God, the creator and provider of all (see also Eccl 38). The origin of this warrant was emphatically affirmed in the Synoptic Gospels of the Christian Scripture (Mt 10:1; Mk 3:15; Lk 9:1).

In the Koine Greek of the time, healing was expressed in the word "exousia," a word carrying the meaning of a God-given warrant. This word was translated into Latin as "auctoritas," a narrower, more legalistic authority, less related to the divine.³ In later Western philosophical and theological thought, the notion of healing came to incorporate the concept of beneficence. Beneficence was the first ethical principle of the Hippocratic oath, as was its corollary, nonmaleficence. This beneficence was grounded in physicians' expert knowledge and their control of patients' treatment. This concept of beneficence guided medical practice throughout the ages, into our time. In this view, physicians do the best for patients at all times insofar as they can determine what is best.

PHYSICIAN-PATIENT RELATIONSHIP

The patient-physician relationship has often been understood as a covenant with rights on patients' part and duties on physicians' part. The common law recognizes such an understanding in fact. Medical ethics is based on this understanding.⁴

Physicians' first two duties in such a covenantal relationship are:

- To act for patients' good (a positive duty)
- To do no harm (a negative duty)

It follows that physicians have at a minimum the duty to do medical good as they see it (i.e., relieve suffering, cure or contain disease, care for patients when cure is not possible, keep confidences)—when in physicians' judgment doing these things would be for patients' good. If, in physicians' judgment, these are not for the patients' good, there would be no obligation to do them.

Implied in this covenantal relationship is physicians' obligation not to harm patients and always to treat them humanely, as persons and not things. If cure is possible, patients have the moral right to expect treatment to bring about cure, and if cure is not possible, the right to relief from pain and suffering insofar as that is possible. The right to be treated humanely (as a person and not as a thing) presupposes physicians' respect for patient autonomy. Included in this concept of patient autonomy is their right to refuse treatment and to participate in medical decisions.

In our postmodern age, however, autonomy has superseded beneficence,⁵ becoming the prime ethical principle for medical ethics today. Yet patient autonomy is always limited. It may never be absolutized, just as physician beneficence is

limited and can never be absolutized. For example, a patient's desires may possibly harm third parties. They may conflict with a physician's own moral beliefs. They may even violate the internal morality of medicine. A patient's request for euthanasia (or "mercy killing") or for a physician's assistance in suicide is an instance where autonomy may be limited and not absolute.

Traditional Judeo-Christian ethics and contemporary secular humanist ethics are sometimes in opposition on these issues. Many contemporary ethicists believe all persons have a right to totally control all aspects of their own lives, including the right to terminate their own lives.⁶ Traditional Judeo-Christian ethics, on the other hand, maintains that life is a gift from God and that control over life is limited.

STEWARDS OF LIFE

Euthanasia and assisted suicide are morally wrong because, as the Judeo-Christian ethic teaches, human beings are creatures of God and have only stewardship, not dominion, over life. But in our pluralistic society, which seems to lack consensus on religion, on communal responsibility, and on common values, one cannot argue against mercy killing and assisted suicide on theological grounds. Even some Christians and Jews in our society do not share the same faith understandings regarding dominion and stewardship. Believing Catholics do profess that God has dominion over life and humans only have stewardship, as expressed in the statement on euthanasia by the Congregation for the Doctrine of the Faith.⁷

Our society generally agrees, however, that a discussion of values may take place in the language of moral philosophy, a language that expresses right reason. To persuade others, then, we must make our arguments against euthanasia and assisted suicide not on theological grounds (however valid they may be) but primarily on philosophical grounds. We can thus engage citizens who do not share our faith commitment. Certainly excellent arguments can be made on philosophical grounds alone that doctors should not kill patients or assist them in committing suicide.⁸

ARGUMENTS AGAINST EUTHANASIA

Autonomy In considering the euthanasia and physician-assisted suicide argument from the perspective of autonomy, we must remember that autonomy is not absolute and has limitations. Among those limitations are the exclusion of any perceived rights not in the best interest of a person as a self with personal goals and values. It is not in the best interest of any human being to give up his or her autonomy completely and irrevocably.

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Physicians clearly fear litigation if they oppose patients' wishes. However, a patient's autonomy is limited, even when it overrides a physician's ethical values, just as a physician's beneficence is limited by a patient's ethical values. Society also has a stake in this limitation. According to society's mores, freedom is inalienable; one cannot sell oneself into slavery. When patients opt for euthanasia, they use their very freedom to eradicate what they need to be autonomous—life and consciousness. In addition, admitting euthanasia as a choice may actually compromise autonomy. Vulnerable patients can be unduly influenced by physicians' recommendation of death.

Contrary to Tradition Assisted suicide and mercy killing are clearly contrary to medical tradition. The Hippocratic oath forbids them. The codes of ethics of the American Medical Association,⁹ the American College of Physicians, and the World Health Organization forbid them.

Active euthanasia can diminish patients' trust in the healthcare professions. The physician-patient relationship ultimately must be based on trust. The relationship between patient and physician would be greatly compromised if physicians become instruments of death instead of instruments of cure or care.

Killing Versus Letting Die Some euthanasia advocates argue that killing and letting die by withholding or withdrawing treatment are the same. This argument ignores the fact that in euthanasia physicians directly and intentionally cause death. When treatment is withheld or withdrawn, patients die from disease or other natural causes. Treatment may be omitted or withdrawn when it will not be, or has proven not to have been, effective or beneficial and its burdens are disproportionate to its effectiveness and benefit. This principle, based on human reason, is well explicated in the Vatican's document on euthanasia.¹⁰

Palliative Care Euthanasia advocates also justify their position on the basis of beneficence, mercy, love, and compassion. The duty of beneficence indeed obliges physicians to work for a good and gentle death. When disease overwhelms patients, however, beneficence does not require killing, but optimal palliative care—comprehensive physical, emotional, and community support. The fear of intolerable pain and suffering and the fear of becoming a victim of overzealous physicians and dehumanizing medical technologies are both within the power of medicine to remedy. The fear of becoming a grave burden to family or friends is within the power of society to remedy. Unfortunately, effective palliation such as hospice care is not universally appreciated, provided by society, nor practiced by physicians. Proper provision and use of palliation treatment would make

mercy killing and assisted suicide unnecessary, R. J. Nulter argues.¹¹

Immoral Laws Proponents also argue that euthanasia is justifiable because it is approved by a majority of people, as determined by various samplings of public opinion. This argument, that majority opinions can establish what is morally right and good, is seriously flawed. Immoral laws have been passed throughout history. In the United States alone, slavery, segregation, and suppression of women's rights are but a few examples of practices that were legal but certainly never moral. The universality or legality of an act cannot be admitted as the basis or proof of its morality.

Euthanasia is morally dubious in the light of the "internal morality" of medicine. It violates the oath of Hippocrates and the principles that oath upholds. The nature and purpose of medicine are ineradicably grounded in trust. Physicians faithful to this trust must heal, not remove the obligation for healing by killing the patient.

Abandoning Interest in Human Life When a society sanctions killing an innocent person, it abandons a long-standing tradition of its interest in human life (i.e., its role as *parens patriae*). Sanctioning killing devalues all life, but especially the lives of certain vulnerable citizens—the chronically ill, aged, physically disabled, learning disabled, infants, or unborn. To sanction their killing suggests their lives are of low quality and that they are expendable, socially useless, and a burden on society. Eighteenth-century German physician and humanist Christopher Hufeland warned: "If the physician presumes to take into consideration in his work whether life has value or not, the consequences are boundless, and the physician becomes the most dangerous man in the state."¹²

Social sanction of euthanasia presumes a responsibility to monitor the killing process to keep it within agreed-on restraints. Killing, then, becomes bureaucratized and standardized. Laws or regulations will not prevent abuses, as the Dutch experience has shown. Because euthanasia converges with current trends toward containing the cost of care and rationing resources, it is not too great a leap from the need to contain costs to covertly or openly planning euthanasia for those members of society whose care imposes economic burdens. Let us not forget that the Holocaust had its roots in the eugenics movement in German medicine of the 1920s, as seen in German psychiatrist A. Hoch and colleague R. Binding's book *A Life Not Worth Living*.¹³

NOT MORALLY DEFENSIBLE

Active euthanasia and assisted suicide are morally inadmissible. The philosophical arguments sup-

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CONSCIENTIOUS OBJECTIONS TO REFORM

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LIMITS ON BENEFITS

The second, related question is, What limits on benefits are being proposed? Most often this query arises when the media are covering some extraordinarily expensive, high-risk procedure such as a multiple organ transplant. Two related points usually surface.

People reject the notion that a person is entitled to be kept alive at any cost. They are not talking about futile care, but very high-cost-low-benefit life supports. People want to know what is being proposed to establish morally acceptable limits on keeping patients alive at exorbitant expense. With reform rhetoric claiming that most Americans will have more medical coverage, it sounds to many like the medical model of rescue from death is not really being reformed but merely expanded by primary, preventive, and long-term care. In fact, proposed benefit packages are not including many limitations on life-prolonging technology. Is this reform or refinancing?

As a result, people also worry aloud that cost control will fail without limits on benefits. The politically savvy are keenly aware that the American appetite for a wide range of high-quality healthcare services might eat up projected savings and preclude the ability to allocate adequate resources to meet basic needs for housing, crime prevention, legal representation, and job retraining. Consequently, cost-containment efforts could backfire and damage the common good.

REFLECTIONS

The recent emphasis on universal access to comprehensive healthcare services does seem to have moved beyond the prophetic social justice critique in the U.S. bishops' 1981 pastoral, *Health and Health Care*. In 1985 the U.S. Catholic Conference recalled the crucial assertion of the pastoral:

Every person has a basic right to adequate health care which flows from the sanctity of life and the dignity of human persons. The bishops called on the federal

government to be the guarantor of a basic level of health services for all, with special attention to the health needs of the poor, whose interests are usually most threatened.¹

In 1993 the bishops proposed linking the healthcare of the poor to the healthcare of those with greater resources as probably the best assurance of comprehensive benefits and high-quality care.² This clearly calls for more than a guarantee of access to basic services. The Catholic Health Association's reform proposal states that the best strategy to protect the poor is to tie their fate to that of the average American. This strategy arises from the conclusion that the interests of the poor cannot be protected in programs that are viewed as part of the welfare system.³

It is my perception that Catholic retailers, grocers, teachers, and contractors genuinely disagree with this strategy. They also sense that Catholic ethical teaching on the right to adequate care does not require support for universal access to comprehensive services.

As debates over healthcare reform heat up, Catholic leaders might improve their positions by addressing concerns about the apparently privileged status of healthcare services among other human goods. They might strengthen support within their own ranks by clarifying the connections between the right to basic care and advocacy for comprehensive services. These important issues merit serious response. □

NOTES

1. U.S. Catholic Conference, "The Right to Health Care," *Origins*, September 5, 1985, p. 187.
2. Catholic Bishops of the United States, "A Framework for Comprehensive Healthcare Reform," *Health Progress*, September 1993, p. 22.
3. *Setting Relationships Right: A Proposal for Systemic Healthcare Reform*, Catholic Health Association, St. Louis, 1993, pp. 5, 6.

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porting these actions are insufficient and specious. These actions violate the spirit and purpose of medical activity, and their social consequences could be disastrous. Besides, for dying patients, proper pain control and properly employed measures for mouth and skin hygiene, appropriate psychological and spiritual support, and the use of hospice services in facilities or the home all make palliative care effective. Institution of correct palliative care is obligatory for physicians who care for dying patients. Killing is not.

We should not make the concept of death in the twenty-first century "prescribed death." Simply put, physicians cannot kill or assist patients in committing suicide and claim a morally defensible position. □

NOTES

1. *Dorland's Illustrated Medical Dictionary*, ed. 24, W. B. Saunders, Philadelphia, 1965, p. 520.
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8. Edmund D. Pellegrino, "Doctors Must Not Kill," *Journal of Clinical Ethics*, vol. 3, 1992, pp. 95-102.
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10. Congregation for the Doctrine of Faith.
11. R. J. Nuller, "Hospice Care as an Alternative to Euthanasia," *Law, Medicine, and Health Care*, vol. 20, 1992, pp. 127-132.
12. N. Hentoff, "Putting Price Tags on Lives in Oregon," *Washington Post*, August 18, 1992, p. A13.
13. R. Binding and A. Hoch, *Die Freigabe der Vernichtung Lebensunwerten Lebens*, F. Meiner, Leipzig, Germany, 1920.