Voluntary Euthanasia for the Terminally Ill

Elizabeth Hamilton

Sacred Heart University

December 8th, 2020
Introduction

The process of euthanasia is the ending of a life to provide relief from the existence the person was living in. The word euthanasia is derived from the Greek language meaning “the good death.” It comes in two forms: involuntary and voluntary. The focus of this paper will be from the perspective of terminally ill patients' ability to decide for themselves, thus the voluntary method of euthanasia. Voluntary euthanasia highlights a person’s right to autonomy in that the person who is experiencing the pain of the illness can consciously decide as to when they have ultimately suffered enough. They can define the limit and give themselves relief from the reality they are experiencing (Navernouri, 2011); which leads to the same ultimate outcome of their disease reality; death.

A human comes into the world at birth. It is a natural beginning that progresses to a natural end. Human beings, unlike other animals, have intelligence and insight about their life cycle process. The human experience is an emotional, thought-provoking existence that is dictated by a person’s autonomy: humans have the power of free will and self-governance. There is an ingrained power of choice that each person experiences in life, and it is their undeniable right. However, there are still variables that plague human existence. Random things happen to random people which humans have little control over. These things may impact how one strives to live a healthy quality life. Illness may strike a person, and while medicine has been progressing rapidly, there is still so much unknown about the human body and needed life-saving treatments. Diseases, such as cancers or other genetic mutations, can cause terminal illness. In such cases, a person may experience an immense amount of pain and their body and quality of life deteriorate while their health continues to digress. Today’s medical interventions applied to these particular cases may not be able to solve the condition, but can prolong the person’s life.
Voluntary Euthanasia for the Terminally Ill

beyond the bounds of expectations. Human life has an absolute dignity associated with it. Therefore, it makes sense that medicine aims to preserve that dignity. Yet, as a terminal illness progresses and the body and mechanical parts can persevere function, the person can lose quality of life, and from that, potentially the essence of being human. There is a difference between living life and prolonging it. The human experience is meant to be a meaningful journey, where a person is an active participant. In cases of a terminal illness where a person suffers through an immense amount of pain, the patient should have the option of voluntary euthanasia. Physician-assisted suicide is a biologically ethical way to end a person’s pain and give them autonomous control at the end of their life.

**Assessment of Quality of life**

When a person is terminally ill, they may begin to lose their quality of life as their pain management becomes a burden on their ability to be present in their life. Analgesic drugs, such as opioid-like morphine, are utilized to combat the pain that terminal patients are feeling. They work relatively well in controlling pain, but the side effects cause a loss in the human experience. The side effects include constipation, nausea, sedation, drowsiness, clouded thinking, and slowed breathing (n.d. managing pain medication side effects). While constipation, nausea, and slow breathing may cause physical distress, the other side effects may cause mental melancholy and feelings of inadequacy. A patient who can no longer think clearly, may find that losing their ability to comprehend is demoralizing. Their life may become less about trying to live it and more about the preservation of physiological living (Coyle, 2004). A person who is tired and foggy cannot always express the complexities of their emotions and their state of being as intended by the human experience.
The medications that are helping their bodies physically, may end up harming them emotionally and lessening their presence in the human experience. In 2004, a study was conducted analyzing terminally ill patients and pain management. It showed the worry the patients had for the potential loss of self before starting pain killers. One subject interviewed in the study, named Archie, described his intent for pain management to be mindful of preserving his personality and sense of self as it was not a price he wanted to pay. However, as his illness progressed, so did the dosage of his meds. He came to a point where he lost control as his treatment prioritized management of pain over mental presence, which he described, “a tradeoff of managing the pain and managing the consequences of managing the pain” (Coyle, 2004). Another subject in the interview study, named Connie, suffered from drowsiness and fogginess. Connie described it as, “I don’t know how to handle it, you know on the one hand I have less pain with more medicine, on the other hand, I’m not quite there, and I guess I prefer to be quite there you know because the sleeping is horrible…I mean it’s basically like giving up…” (Coyle, 2004). Connie, like Archie, lost her zest for life. She, like many terminally ill patients, was plagued with drowsiness and loss of a conscious ability to reason. Medications which alter a person’s ability to experience the world, are one of the deducting consequences to a person’s life when suffering from a terminal illness.

Based on a study conducted in 2016, it was determined that patients who participated would rather die than have the quality of life that a terminal illness causes. In the study, 180 subjects were given a survey to complete. Each subject was over the age of 60, with an advanced chronic condition, meaning they had a familiarity with being in the hospital. However, they did not yet face life-sustaining care. Specific circumstances were chosen for the subjects, as they have the probability of experiencing the outcomes associated with terminal illness care.
questionnaire asked whether or not a patient would find a particular treatment, or state of a terminal patient, to be better or equal to/worse than death. Incontinence, breathing tube, feeding tube, and needing care from others all the time were the assessed treatments and conditions. Incontinence was the highest as 68.9% of the subjects said it was worse/equal to death, then breathing tube 67.2%, feeding tube 55.6%, then needing care all the time 53.9% (Rubin, Buehler, Halpern, 2016). The quality of life described by the questionnaire is the reality for many terminal patients. The study supported the loss of quality of life associated with a terminal illness. The condition of incontinence may have been considered to be worse than death, as the subjects may consider a loss of dignity that this condition causes. If a person fears a state where they are no longer capable of being in the state they want to be, it should be their right to able to decide if they want to terminate their existence and end their suffering.

**Ethical Reasoning**

Euthanasia is an ethical way to relieve pain based on the quality of life ethics. Quality of life ethics focuses on the humanness and integrity of a person’s life. As terminal illness may cause a lower caliber of life because it can take away the inherent characteristics of human life that are part of the whole human experience. When life is prolonged, and the person goes through suffering, many times only the biological aspects of the person are considered. In such cases, human dignity faces abuse as a person is forced to live through a potentially dehumanizing process, as they slowly deteriorate in mind and soul. The continuation of the body does not always include the continuation of a person’s ability to enjoy life and live, rather only biologically functioning (Fletcher 1973, pp.1-3). The quality of being human is more important than merely being alive. It is easy for people to understand this concept when the patient is brain
dead, as their personhood is gone while the body remains. When patients request euthanasia, unlike brain-dead patients, they are often before the point of being stripped of their personhood. It would be cruel to force a person to endure their identity fading away. While the brain-dead patient suffered this fate quickly, a terminally ill person goes through it slowly. They ask for euthanasia as a way to preserve their dignity. They want to be able to die as themselves rather than the body of the person they used to be.

Along with quality of life ethics justifying euthanasia, a consequentialist theory further supports the right to die with dignity. Consequentialism focuses on the outcome of an action to decide the merit. When a person asks for voluntary euthanasia, they are in a state of immense pain and beginning a loss of self. They are suffering to a high degree. Voluntary euthanasia can free them from their suffering and give them relief. The consequentialist theory supports the outcome of alleviating the person from pain as it is the highest benefit to the patient. If the person were to continue with prolonging life care, it would only cause them more physical and mental distress. This outcome would not be favored based on this theory, since it does not use an all means necessary approach to create a better-aimed outcome in comparison to the starting point. If a patient wants relief from their pain, consequentialism allows a person to find a means to an end, and in turn, it creates a better end (Fletcher 1973, pp.5).

Voluntary euthanasia is a medically beneficial option to patients that is ethically sound as it can be limited by protocol to keep the process in check. Euthanasia is not something to be taken lightly and should have strict requirements for a patient to be able to utilize this treatment correctly without it being abused. Voluntary euthanasia should have five particular features to assume ethical standards. The patient must have an incurable disease that cannot be reversed. Then, they must be suffering from terrible pain which cannot be adequately controlled by
medication. The patient must have a sound mind and ask for the treatment while knowing and understanding the full information. They must be unable to kill themself. Finally, the person helping them must be doing it with the intent of mercy and compassion. If each of the five features is respected, the treatment can be done ethically, as it is performed for the patient’s benefit. (chmidt, 2002 p.133).

Humans are autonomous beings and have the right to exercise that human trait in regards to their body and life in times of terminal illness. Autonomy is the central idea that a person has authority over their life, to control it and make decisions for themself. Humans often allow emotions to play a role in decision making. This role is important as a person can think deeper on the matter and they consider not only themselves but the people around them. In momentous decision-making moments, a person relies on a council to help them decide, which gives them more information from different perspectives. A doctor is a prime example of a person who is a part of a patient’s council. Ultimately, it is still the patient's right and decision what they end up doing, and it deserves respect by all those around them to follow their wishes. Voluntary euthanasia is ethical on the basis it respects and allows a patient to exercise autonomy. It is empowering for a person to be able to take control of their final moments and give dignity to their existence without allowing deterioration to ruin the human experience in the end.

Case Studies

While an able-bodied healthy human may be able to empathize with a patient, it may be difficult to fully understand the quality of life implications a terminal illness creates. The patient’s reality is the strongest evidence to suggest that a person should be eligible to set their limits and undergo voluntary euthanasia if it is their specific want and need. Each case where
Voluntary euthanasia was utilized proved the necessity for this solution based on that particular person. The following two case studies demonstrate the autonomy and dignity that euthanasia provides.

**Case Study 1.** The patient was a female with advanced metastatic carcinoma of the breast. Her prognosis from multiple doctors was that there was “no further conventional treatment that would alter her prognosis, which was that of death in the near future” (Kissane et al., 1998). Her disease was treated with rounds of chemotherapy and surgery, which was unable to stop the spread. As her cancer progressed, she had swelling in her legs and abdominal pain, which required analgesic medication. The patient lived with her daughter as she deteriorated to a bedridden state, and she felt weak constantly. Despite palliative care for six months, she still could not cope with her condition: “I don't like being like this; I want to die” (Kissane et al., 1998). The patient had a sister who died from breast cancer. She watched her sister become incontinent and suffer the other effects associated with a terminal illness. The patient decided to have voluntary euthanasia done so she would not progress to a state that she deemed as unlivable. Euthanasia protocol was followed, she was assessed by many doctors to confirm her prognosis. Once her physical state was determined as truly terminal, she was assessed by a psychologist. The psychologist deemed she was in a proper state where she was capable of making her own decisions. Thus, she was certified to be fully comprehending her situation and not affected by any psychological illness such as depression. The patient was allowed to change her mind as they waited a week. After, the patient moved from the hospital to a hotel. There she exercised her autonomy and underwent euthanasia surrounded by her family (Kissane et al., 1998).
The patient in the first case study had previous experience with a terminal illness. She watched her sister die and knew she would never want to go through that type of deterioration. The patient had lost her mobility and ability to function without drugs. Her quality of life diminished physically to a point where her existence was unbearable, yet it would only get worse. The patient was allowed to carry out her wishes in a peaceful safe environment. If euthanasia was unavailable to the patient, she would have suffered more than she desired. Each day would be out of her control while she slowly lost herself and consciousness to her condition. The patient wanted to live with her humanity, not as a biological machine held together by medications and extra measures. This would have been worse than death in the patient's opinion. The patient was given information and ultimately the ability to make the decision she felt would cause her the least amount of suffering. While other people may have chosen differently in her situation, it is essential to have voluntary euthanasia available for an ethical passing it can provide a particular individual.

**Cast Study 2.** The patient was male and suffered from advanced metastatic carcinoma of the prostate. He was a vibrant person who had many careers such as a carpenter, a pilot, a minister with a missionary society, and a massage therapist. After a divorce, he became a committed Buddhist and got remarried. When the patient's cancer was discovered, there were attempts to eradicate it with multiple surgeries. He had issues from cancer that caused him to need multiple transurethral resections to manage urinary retention. He declined the use of chemotherapy due to the side effects it would cause and received the hormone therapy cyproterone acetate (CPA) instead. Regardless, his health continued to degrade as his cancer was untreatable. He suffered from anemia, which caused him to feel breathless all the time. The pain and weakness associated with his anemia could only be eased with blood transfusions. His bones
became weak resulting in pathological fractures. At one point, he broke a rib from receiving a hug. The patient’s pain was treated with morphine which caused further uncomfortable side effects such as constipation, intermittent nausea, diarrhea, and he required catheterization. The patient had palliative care, yet he was still suffering tremendously and continually asked his care team to end his suffering. All he had left was his mind, and he did not want to lose it to illness. He had a friend who also died from cancer and became incoherent in the end because he was losing himself: “[my friend would] yell and scream, intolerant as hell; you’d realize it’s a last pathetic attempt at asserting himself” (Kissane et al., 1998). The patient was more afraid of further suffering and deterioration than to die on his terms. After a prognosis check from multiple doctors and a psychologist check on his mental health, he received approval to undergo voluntary euthanasia. The patient underwent euthanasia with the support of his wife. His body was allowed to be cremated per a Buddhist tradition (Kissane et al., 1998).

The patient in case study two had a similar story to that of case study one. The only treatment he wanted was a peaceful death, in order to finally get relief. He had a very spirited life which changed when he was diagnosed with cancer; he could no longer do the activities he wanted. Near the end he was bedridden and to the point that any quick movement could and did break a bone. The patient lost the ability to hug another person in fear he would break from the contact. This caused further emotional repercussions because he could no longer have a physical contact with others. He knew what the final stages of terminal illness looked like and did not want to endure the deterioration of his mind. Each physical and mental challenge he faced caused further suffering and agony. The patient wanted a relief that the medications and treatment therapies he was given could not provide. His death was peaceful, unlike the way he was living up to that point. Then after his death, Buddhist tradition was still able to be upheld, and his body
was cremated. The patient had control from the beginning to the end of the process of euthanasia. No able-bodied person was able to force him to carry on through the struggle he no longer wanted. Due to the given choices, he was able to die with dignity on his terms.

**Counter Arguments**

The largest counter-arguments for euthanasia are the religious opposition and the slippery slope ideology. Many religions, such as Judaism, Christianity, and Islam share the idea of the sanctity of human life. Since God has blessed a person with the ability to live, it should not be abused or diminished in any way. Based on the sanctity of human life, some religions would rather a terminally ill patient suffer due to the belief they will be rewarded for their trials that they faced on earth in heaven. Then they also ask patients to pray for comfort, for a cure, or for salvation in natural death. While prayer may be helpful for people with strong faith, there is not enough data to prove that it gives a patient relief of their suffering.

As an example, it has been around 150 years since the apparition of the Virgin Mary in the Grotto at Lourdes, France. Christians believe this place to be capable of miraculous events. Every year 200 million pilgrims visit the site, and from this twelve million, are people with terminal diseases in the hope of a miracle cure from God. The site has 65 associated miracles, since the appearance of the biblical Mother Mary in 1858 through 2011. These supposed miracles are more likely medical rarities due to reason rather than the will of a God (Nayernouri, 2011). Religion is a way for comfort but should not be the sole determining factor in the fate of a terminal patient, especially since not everyone shares the same religious beliefs. An unreligious human should not be denied the desired treatment of relief because others do not believe it is
right. This concept defies the idea of autonomy or self-governance. A person should have control over their body and what they define as morally right for themself.

The other counter-argument is the concept of the slippery slope. A slippery slope is when a set precedent, for progressive ideas, can be abused to unimaginable extents. People are worried that if voluntary euthanasia became more accessible, people would use it more willingly (Cherny, 1996). Instead of just voluntary euthanasia of a clear-minded person, it would extend to other disorders and conditions that have treatment. People understandably do not want others to lose the will to live just because there is an option they can take. Another factor with the slippery slope argument is that in allowing voluntary euthanasia to be utilized, it could make involuntary euthanasia acceptable as well. However, the two different forms of euthanasia have large differentiating factors. Voluntary stems from the patient’s choice and involuntary euthanasia does not. The ideas have different routes to get to the same outcome, and that difference is the defining factor. This differs in the ethics of the two types of euthanasia and disallows the ideas to be associated together. Thus, the slope that the counter-arguments are worried about is not as slippery as they seem (Daskal, 2018).

While the slippery slope causes a real fear associated with euthanasia, it can be controlled by having restrictions and protocols. Euthanasia is an intimidating process that should only be used by patients who can make an informed decision and who determine that there is no other viable option for their relief. Voluntary euthanasia should be an option for certain terminal patients who could benefit from the relief of what they determine is inhumane suffering from their illness and the state of their quality of life. As with other medical treatment options, voluntary euthanasia should be limited to a set of established guidelines for which a patient must qualify to utilize.
Physician’s Duty

A physician's duty is to lay out all the medical options for a patient regardless of their opinion and allow the patient to exercise their right of choice. In cases of voluntary euthanasia, not all doctors support the usage of euthanasia. Most people go to medical school with the intent to cure but have a hard time realizing that death is not a failure in practice for some patients. One of the most famous advocates for legalizing the option of voluntary euthanasia was a doctor named Jack Kevorkian or nicknamed “Doctor Death.” He brought conversation about voluntary euthanasia to the American people. He trusted the ethical reasoning behind voluntary euthanasia and famously said, “my aim in helping the patient was not to cause death. [I aimed] to end suffering. It’s got to be decriminalized.” (Jack Kevorkian, 2007). Kevorkian saw the importance of people having the option and ability to exercise their autonomy regarding their health and life. He fought for his patients and his moral beliefs.

All physicians have the duty to help a patient seek voluntary euthanasia treatment, as Jack Kevorkian did. The Hippocratic Oath is one of the oldest in history that medical physicians take when they graduate medical school. It outlines the principles that doctors abide by and the manner that they are to practice. The Hippocratic Oath read at most graduations these days is the modern one, by Louis Lasagna in 1964. This Oath, confirms a doctors mission to help the patient without causing harm through overtreatment: it states, “I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism” (Lasagna, 1964). Doctors cannot force a patient into treatment, including life-prolonging treatment. They work for the benefit of the sick and utilize only the measures
required. In terms of terminal illness, doctors should not force their patients to prolong their life. They must support the patient and not overstep their bounds.

In addition to not over-treating, the modern Hippocratic Oath puts voluntary euthanasia within a physician’s scope of practice, it states, “If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God” (Lasagna, 1964). A doctor has the ability to perform voluntary euthanasia, but they are not a god. They do not decide who lives and who dies. They act as an assistant in the dying process. A doctor fulfills a request rather than being the determining power. Then, finally, the Oath calls for doctors to ask for help if they cannot perform the patient’s wishes; the Oath states, “I will not be ashamed to say 'I know not,' nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery” (Lasagna, 1964). If a doctor feels unable to perform the request of the patient, it is their job to help their patient find someone who can. A doctor has to be a network of information and resources for their patient and must not be afraid when they are unsure. The profession of a physician is thought to be about prolonging life, but it is also about helping a patient find a suitable way to exist. If this is impossible due to a person’s suffering from a terminal illness, there is a duty to find a suitable source of comfort, even if it may be death.

Conclusion

Voluntary euthanasia is a controversial topic in today’s medical world. The sides are divided in ideology as both parties have different ideas as to what it means to have a humane death. Religious beliefs have driven opposition to voluntary euthanasia throughout history. In this more progressive day and age, both medicine and philosophy have arguments to support this
Voluntary Euthanasia for the Terminally Ill

approach. A human has a right to their existence. They can live the human experience to its fullest ability and the essence of their humanity. Unlike other species, humans have the power of free will and autonomy. A human can decide their fate and set their limits. Their autonomy includes setting a limit on their own suffering and the quality of life they are willing to handle. Many people are uncomfortable seeing others in pain but are willing to hold a person in a state of suffering if it means they are prolonging that person’s life. A patient’s personal perspective should be taken into account in these instances. No one wants to live in a state of unimaginable pain and deterioration. Thus, there is the essentialness of having voluntary euthanasia accessible.

Death is inevitable, and giving a person a choice to take that control, to relinquish their pain is the medically and ethically just thing to do. People already plan for death in advanced directives. These are legal documents, which should also include wishes for voluntary euthanasia under particular circumstances. This would allow a person to plan their death in the manner they want. A person would have an autonomous end rather than an unwanted existence as a biological creature deprived of the human experience.
Bibliography


