Does Voluntary Euthanasia Fulfill or Contradict a Physicians' Oath to "Do No Harm"

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Introduction

As the old cliché goes, of all things in this life, only two are guaranteed: death and taxes. The knowledge and inevitability that our life is finite shapes every aspect of how we live out our days and plan for the end. With this in mind, I now ask you to consider what you envision your last moments of life to look like. For most, they picture being surrounded by family and loved ones, holding their hands as they take their last breath. While this is the reality for some, many others – particularly those with terminal illnesses – are not as fortunate. A terminal diagnosis is given to a patient based on two criteria: 1, their condition cannot be cured and 2, it is likely to lead to their death within a defined time frame (What…, 2019). Once terminally diagnosed, all that can be offered to a patient is palliative or hospice care, which focuses on managing one's symptoms and controlling their pain. This period between a terminal diagnosis and death becomes an excruciating game of waiting for both the patients and their families as all options have been exhausted, and nothing more can be done to prevent the inevitable. But what if there were another option? If given the news of a terminal diagnosis, would you want the choice to decide when your final day would be? Would you choose to die with dignity, and take your last breath on your terms?

Voluntary euthanasia, or VE, is a medical procedure in which a physician, with the explicit, informed consent of the patient, "administers a lethal agent for the purpose of relieving their intolerable and incurable suffering" (Euthanasia, 2022). VE provides those with terminal diagnoses an alternative option to living out their final weeks or months in intense and chronic pain, but at what ethical cost? All healthcare personnel are ethically sworn to do no harm unto one's patient, but is the prolonging of someone's life when they have a terminal diagnosis doing more harm than good? All people are deserving of a dignified death, and for those with terminal illnesses, VE provides them the opportunity to die peacefully and on their terms. The procedure of voluntary euthanasia done in the proper manner – at request of the patient and for palliative reasons – is an ethical practice of modern medicine.

Concepts: Practices and Principles Defining Terms

When debating the ethicality of voluntary euthanasia, a foundation of working knowledge must first be established, beginning with distinguishing the differences between passive and active euthanasia. Active euthanasia occurs when a medical professional preforms an action which directly causes the death of another individual, such as administering a lethal dose of an injection with "the intent to end their suffering" (Vaughn, 2012, p. 595). In contrast, bioethicists separate this active form of euthanasia from a "passive" form in which a physician allows someone to die (rather than actively killing them) by *not* providing something which would prolong their life (Vaughn, 2012, p. 595). Examples of passive euthanasia include the decision to stop a patient's ventilator or remove a feeding tube, while being fully aware that the removal of said device will directly cause a cessation of functions necessary for life (Vaughn, 2012, p. 595). While ethicists create this distinction for theoretical debate, the term "passive euthanasia" is not used colloquially in the medical field. Passive euthanasia occurs frequently in modern medical practice, when, at the discretion of the physician, family, or patient, it is decided to halt or remove a life-sustaining treatment. By definition, this is passive euthanasia of a patient, but is it not colloquially referred to as such in modern practice.

Beyond this, active euthanasia (AE) and passive euthanasia (PE) have been further delineated into voluntary and involuntary to further distinguish scenarios in which euthanasia may occur. Voluntary euthanasia refers to scenarios in which a competent patient “voluntarily requests or agrees to euthanasia, communicating their wishes while competent or through instructions to be followed if they become incompetent” (Vaughn, 2012, p. 596). Voluntary euthanasia may still occur through both active and passive means, such as a lethal injection or removal of a ventilator, depending on the scenario. Voluntary euthanasia requires the expressive, competent, and willing consent of the patient and is what will be focused on in this ethical debate. Lastly, nonvoluntary euthanasia is said to be performed on patients “who are not competent to choose death for themselves and have not previously disclosed their preferences” (Vaughn, 2012, p. 596). This type of euthanasia is often used in ethical debates when considering patients who may be incapacitated, as well as infants and small children who cannot communicate their personal wishes. When this scenario arises, it is often the patient’s family, with professional medical guidance, who makes the final decision on behalf of the patient.

Nonvoluntary euthanasia is often used as a point of debate when discussing the “slippery slope” theory and the unethicality of euthanasia. This theory will be addressed and discussed in depth due to its prevalence as an argument for the unethicality of this practice. Within the context of my argument, I will discuss and argue for the ethicality of voluntary euthanasia, which I will refer to as VE.

An additional and important distinction to understand for this context of this paper is the differentiation between Euthanasia and Physician-Assisted Suicide. The word euthanasia is generally understood to be the direct or indirect (aka active or passive) bringing about of death to another person for palliative reasons (Vaughn, 2012, p. 595). As explained in the distinction of active and passive euthanasia, there is direct and physical involvement of a physician or health care professional when someone is euthanized. A doctor uses their own hands to deliver a lethal injection or remove a ventilator, meaning that their explicit actions have directly caused the death of the patient. This is where the root of the distinction between euthanasia and Physician Assisted Suicide (PAS) lies. Physician Assisted Suicide is a scenario in which a patient takes his or her own life, with the aid, but not direct or physical action, of a physician (Vaughn, 2012, p. 596). Scenarios in which PAS occurs is when a patient asks a physician to help them commit suicide by prescribing a lethal dose of a medication, or has the physician describe a means by which to successfully commit medication-induced suicide. In the end it is "the patient – not the physician – [who] performs the final act that causes death" (Vaughn, 2012, p. 597). Many bioethicists argue that PAS is more ethical than euthanasia because it is the patient's own explicit actions which causes their death, not the physician's. This differentiation of ethicality is based on the notion that the actions of one person, resulting in the death of another, is unethical, with no consideration to the specific circumstances in which VE would occur. While the ethical differences between PAS and VE are subject to debate, this paper will focus solely on VE. After all, if the ethicality of VE can be established, such an argument would more than vindicate the practice of PAS.

In the professional medical field, there are moral and ethical principles which are globally agreed upon, and it is expected that all licensed health professionals adhere to and operate under these guidelines. The four main principles which shape healthcare today are beneficence, non-maleficence, respect for autonomy, and justice (Gillon, 2014, p. 111). Beneficence is the duty of a healthcare provider to do good for their patient, and to always intervene in ways which will best benefit their health and wellbeing (Ignatavicius et al., 2021, p. 12). The next principal, non-maleficence focuses on the importance of "preventing harm and ensuring the patient's well-being", no matter the circumstances (Ignatavicius et al., 2021, p. 12). Respect for a patient's autonomy means that the provider must honor any decisions a patient makes and acknowledge the patient's independence and right to self-determination and self-management (Ignatavicius et al., 2021, p. 12). This principle is particularly important when a patient decides to have or refuse a treatment or procedure, even if it against the recommendation of the health care team. Whether or not the physician would agree with their decision, their choice must be honored and respected. Lastly, justice in health care means that all patient's should be given the same level of care and treated equally and fairly regardless of any factors such as age, race, gender, or religious and sexual orientation (Ignatavicius et al., 2021, p. 12). For the purposes of this paper, I will discuss physicians and health care personnel with the assumption that they adhere to, and operate under, these ethical principles which are the current standards of care in modern medicine.

The final, and possibly most essential concept to understand for the purposes of this paper is that of a dignified death. Dignified death, as understood in a medical context, can be defined as death "accompanied by respectful and skillful caregiving" as well as "a death which is largely free from psychological affronts that are not usually perceived as dignified" (International Association, 2021). The concept of dying with dignity is grounded solidly in the ethical principles of beneficence and autonomy, with the understanding that every person has the right to make independent decisions regarding their health until the time of their death. The right to a dignified death is one of the major supporting arguments for an increased availability and legality of VE as it allows the individual to make an informed decision about how they wish to die instead of waiting for their body to give out. Voluntary Euthanasia, for those who fulfill the necessary criteria, facilitates medical autonomy by supporting their ability to have a dignified death and providing an alternative option to traditional hospice care for someone with a terminal diagnosis.

Addressing Common Misconceptions and Arguments Against VE

The use of voluntary euthanasia in mainstream medical practice has been long debated for its ethicality. While some claim that both active and passive euthanasia are immoral, as well as PAS, others draw this line of ethicality at different parameters. Of all the arguments against the use of euthanasia, three justifications which are most often used are that 1) it goes against the medical morals of a physician, 2) the “slippery slope” conundrum, and 3) that there is a distinct, and major, ethical difference between active euthanasia, deemed killing, and passive euthanasia, defined as “letting die”.

The first major argument used in the ethicality debate of euthanasia is that by allowing physicians to preform acts of euthanasia, it would “ethically incompatible with their fundamental moral and professional commitment as healers to care for patients and to protect life” (Vaughn, 2012, p. 619). While this is a valid concern to raise, it can be easily countered when we refer back to the moral pillars of modern medicine which were previously discussed. Euthanasia is shown to be therapeutic when the medical ethical principles of respect for patient autonomy and beneficence are applied. If all physicians adhere to the foundational ethics of standard care, then we know their primary focus in caring for a patient is to do what is best for them and respect their wishes. The argument that VE is incompatible with their moral and professional commitments is invalid, so long as VE is done in the patient’s best interest, and with their informed consent. The idea that we should “do no harm” unto a patient requires us to consider on a case-by-case basis what is harmful versus therapeutic. For someone with a terminal disease who is in excruciating chronic pain, it can and should be considered if it is *more* harmful to prolong their life than give them the choice to voluntarily end it. If we are to do no harm unto our patient, but delaying their inevitable death is causing said harm, then a discussion should be had between the patient and healthcare team about the available options going forwards, including VE. There is nothing moral in delaying the inevitable death of a patient as it puts them, as well as their loved ones, through more pain and suffering psychosocially and physically. For these reasons, if the patient were to decide they wished to be euthanized instead of suffering until their date of natural death, the physician would *not* be violating their ethical oath, rather fulfilling it, by providing that palliative procedure. Furthermore, by providing the service of euthanasia, a physician is supporting the patient's medical autonomy and right to make decisions about their treatments. For these reasons, voluntary euthanasia would not be in moral violation of a physician's morals.

A second popular argument used against the legalization of euthanasia is the application of the "slippery slope" theory. This thought experiment is a utilitarian approach to the euthanasia debate and argues that a "general policy of authorized killing will, step by step, take society down a path to awful consequences" (Vaughn, 2012, p. 604). Those who believe in slippery slope theory hypothesize that if euthanasia were to become widely practiced and legalized, there would be little to stop "active euthanasia being performed in many other cases in which it would be morally wrong" (Vaughn, 2012, p. 622). Supporters of the slippery slope theorem raise concern for patients who may be unable to express their desires and medical wishes being euthanized without voluntary, informed consent, thus leading to an abuse of power by the physician.

While this scenario of a patient who cannot express their medical wishes is not unreasonable, one must ask, can the same not be said for life-saving interventions for those in similar conditions? Patients who are deemed incompetent or unable to understand and make decisions for themselves will have a legally appointed caregiver who has the medical power of attorney over them. This legal guardian or caregiver can be a family member, or a court-appointed individual. This caregiver provides consent for procedures and treatments and is ultimately responsible for acting in what they believe to be the patient's best interest. In this instance, say a patient has an appointed medical caregiver and their condition begins to deteriorate. The advice of the medical team is to intubate them and place them on a ventilator, to which the caregiver agrees. In this scenario, the caregiver would believe that they are acting in the best interests of the patient but could in fact be going against their wishes if they had been in a state which allowed them to express their desires.

The wishes of a patient should never be assumed as everyone has their own beliefs and attitudes towards things like medical resuscitation, and may even chose to be a DNR, or a "do not resuscitate" patient past a certain age or diagnosis. The dilemma of not knowing a patient's medical preferences arises whenever a third-party consents to and makes medical decisions on behalf of a person who has been deemed unable to do so.

This dilemma occurs in the same capacity and has the same implications for both lifesaving and life ending measures. To combat this impasse, and to dispel worries of a "slippery slope" with regard euthanasia, advanced directives and other legal documentation can be implemented. An advanced care directive is a "clear statement that sets out the patient's directions including their wishes and values that need to be considered before medical treatment decisions are made on their behalf" (International Association, 2021). In the Netherlands, where VE is legalized, the laws go a step further and a person can put in explicit legal documentation that "I want to be euthanized when I reach X, Y, Z moment" (Gross & Engelhart, 2021). In the instance of someone who is diagnosed with dementia, they are even able specify that once they hit a certain threshold of the disease progression that they wish to be euthanized instead of allowing their state to deteriorate further. This point of degeneration could be once they are unable to recognize their loved ones or when they lose the ability to speak and control their bodily functions (Gross & Engelhart, 2021). By implementing specific legal parameters such as these, it prevents the possibility of a slippery slope because, while in a competent, sound of mind state, they explicitly laid out their wishes and desires for all stages of their care. This legal documentation would additionally help to support patient autonomy and respect as they are given full control of their future medical care before they have ever entered a state of disease or illness. Through proper planning with advanced directives and laws such as those seen in the Netherlands, the risk of a slippery slope with euthanasia is significantly reduced.

A third argument against the use of active voluntary euthanasia is that many define it to be “killing someone”, versus Passive Euthanasia where the physician is instead “letting them die”. Active euthanasia involves the explicit and direct action of a physician which results in the patient’s death and is branded by many as immoral. In contrast, passive euthanasia is the withholding of something which is necessary for that patient to live, but is seen by some as moral when contrasted with active euthanasia. The fundamental flaw of this argument and justification against active euthanasia is that the line between active and passive euthanasia is *very* thin. If the immorality of active vs passive euthanasia stems from the intent and knowledge of what will happen after the intervention is preformed, then active and passive euthanasia share the same moral ground and therefore are no different. What many fail to consider is that with passive euthanasia, the physician knows full well that the individual is dependent for life on the equipment which is about to be removed. The common example used for passive euthanasia is the removal of a ventilator or feeding tube from someone, and then allowing them to die “naturally”, now in the absence of that life-sustaining equipment (Vaughn, 2012, p. 595). In the event of a passive or active euthanasia, the physician is fully informed and aware of the consequences when that action is taken. If it is known that in removing a ventilator, the patient will die, then I see logically no moral difference between this and the administration of a lethal injection. In both scenarios, the doctor uses his or her own two hands to perform an intervention which will without a doubt result in the death of their patient. This distinction between and acceptability of active vs passive euthanasia, on the grounds that one is killing, and the other is letting die, is fundamentally flawed because of the awareness of the physician of what will occur once that action is taken. For this reason, no moral distinction should be made between the two forms of euthanasia and used to argue against the use of legalized, voluntary, active euthanasia.

Additional Justification for the Ethicality of Voluntary Euthanasia

Today in the United States, voluntary euthanasia – through any means – is illegal in all 50 states. However, in recent years the states of California, Colorado, Hawaii, Maine, Montana, New Jersey, New Mexico, Vermont, Washington, and the statehood of DC have passed legislation in support of PAS, in a limited capacity (ProCon, 2022). In all these states, excluding Montana, the patient must be at least 18 years of age, and have 6 or fewer months until they are expected to die due to the progression of their disease or condition (ProCon, 2022). The successful implementation of legal parameters to obtain PAS in these states has demonstrated the capability of governments to safely provide a means by which terminal patients can die with dignity. While the limited legalization of PAS is a step in the right direction for supporters of these practices, voluntary euthanasia is far from being legalized. Because it is considered so ethically controversial, governments are slow to legalize practices of VE, despite the palliative benefits it would provide for those who qualify. It is my personal belief that VE, when preformed with the fully informed and competent consent of the patient, fulfills a physician's oath to do no harm.

Contrary to the belief of some, if VE were to be legalized on a large scale, it would only be available to those who fulfill very specific criteria. Five conditions which have been proposed by advocates of VE to qualify an individual for the option of a medical euthanasia are as follows:

A) is suffering from a mental illness

B) is unlikely to benefit from the discovery of a cure for that illness during what remains of her life expectancy

C) is, as a direct result of the illness, either suffering intolerable pain, or only has available a life that is unacceptably burdensome

D) has an enduring, voluntary and competent wish to die (or has, prior to losing the competence to do so, expressed a wish to be assisted to die in the event that conditions (a)-(c) are satisfied); and

E) is unable without assistance to end her life (Young, 2021).

These five proposed criteria for eligibility of euthanasia reserve the procedure for those who are in immense suffering physically, emotionally, and psychosocially. If a patient were to fulfill criteria C and D alone, they are objectively in a state of immense pain, burden, and vocally express their desires to end their life, so why now allow them to do so? If patient autonomy and respect for their medical decision is one of the fundamental pillars of modern medical practice, then why should a patients wish to be euthanized *not* be respected under these parameters?

For an individual with a terminal illness who meets all of the above criteria, giving them the option of euthanasia would be not only palliative, but ultimately a relief to both the patient themselves and their families. The aging process is wholly inevitable and is often "accompanied by loss and limitations, and the challenge of having to adapt to new circumstances again and again" (National Library… 2020). Many older adults struggle to cope with the changes associated with aging, and when this natural process is complicated by disease, these problems compound. Accompanied by disease and disability, aging impairs one's normal functions and often leads to a loss of mobility, independence, and a lower quality of life. With this loss of independence and mobility comes an increased sense of burdensomeness for the patient, which in turn decreases their quality of life further. Caring for a chronically and terminally ill family member puts a massive strain on their caretakers and facilitates feelings of guilt in the patient. The option of voluntary euthanasia for those who meet the above criteria would, in a sense, be a therapeutic and palliative option for the patient, as well as their caregivers.

In addition to providing a relief of burden for the patient and their family, it allows those in fragile and terminal medical states, who would otherwise not have a dignified death, the opportunity to do so. Generally speaking, "many are concerned about what the last phase of their lives will be like not merely because of fears … but also because of the desire to retain their dignity, and as much control over their lives as possible, during this phase (Young, 2021). Dying peacefully, and with dignity, is a major concern for those who are terminally ill as their disease will continue to progress and they will experience gradual losses of function and deterioration as their body breaks down. There is no dignity for an individual in slowly losing control of their physical and mental function as they approach their time of death. For terminal patients, all independence and control will slowly be lost as their condition progresses. If provided the palliative option of VE, a sense of control is retuned because at this point, the only thing they *could* control is when and how they die. The provision of VE as an option allows them the choice to have a dignified and voluntary death opposed to succumbing to the state of their illness naturally as it progresses. Without the option of VE, a terminally ill patient will almost certainly die in a manner which is not dignified, nor on their terms. All persons, no matter their situation, are deserving of a dignified and peaceful death free from fear and suffering.

Thus far, much of my support for the ethicality of voluntary euthanasia has come from proposed scenarios and hypothetical patients. Explaining a real-life problem in this way makes it dangerously easy to forget that this dilemma is far from hypothetical. In March of 1991, a physician by the name of Dr. Timothy Quill submitted an article to the New England Journal of Medicine recounting how he helped a terminal cancer patient under his care commit suicide (Vaughn, 2012, p. 610). In his publication, Dr. Quill reflects on this experience and shares that his patient Diane's decision of refusing treatment and "giving up a 25 percent chance of long-term survival … disturbed me" (Vaughn, 2012, p. 611). Despite his own personal beliefs and medical advice, he "gradually understood the decision … and became convinced that it was the right decision for her" (Vaughn, 2012, p. 612). Dr. Quill's support of Diane's medical autonomy and independence soon was taken a step further, when she explicitly expressed to him that when she felt the time was right, she wished to take her own in the least painful way possible (Vaughn, 2012, p. 612). He explains that he wrote her a prescription for barbiturates and made sure she "knew the amount needed to commit suicide" so that she could do so safely and effectively when that time came (Vaughn, 2012, p. 612). In the end, Diane successfully committed suicide by ingesting a toxic dose of the prescription barbiturates when she reached a point of inconsolable suffering and pain. While Dr. Quill did not take a direct physical action that resulted in her death, he provided her with the knowledge and means to commit suicide, thus making this an instance of PAS.

In my opinion, Dr. Quill's decision to support Diane's end-of life wishes, and providing her the means to do so, was entirely ethical. Dr. Quill states explicitly that "to think that people do not suffer in the process of dying is an illusion. Prolonged dying can occasionally be peaceful, but more often the role of the physician … is limited to lessening but not eliminating severe suffering" (Vaughn, 2012, p. 613). Dr. Quill recognizes that dying is often painful, and for those suffering terminally, the prolongation of this process extends their life, but in what capacity? As far as I am concerned, prolonging a life of suffering which is medically guaranteed to end is not ethical by any means. Although there are clear and distinct differences between PAS and VE, Dr. Quill's experience demonstrates the necessity of, and demand for, therapeutic end-of-life options for terminally ill patients.

A final point of justification for the necessity and ethicality of VE is that it is the most palliative intervention which can preformed for a terminal patient who is deeply suffering. Physicians routinely provide palliative care to patients though pharmacological and non-pharmacological means and are morally obligated to do so. It is ethically indicated to provide as much comfort, safety, peace, and pain management to a patient up until the moment they are declared deceased. If a patient wished to be voluntarily euthanized, it would be the most ultimate form of palliative care that a physician could provide. Voluntary euthanasia eliminates the patient's pain and suffering while providing them a peaceful and dignified death. For these reasons, as well as its support of patient independence and respect for autonomy, voluntary euthanasia is proven to be a procedure which fulfills, rather than contradicts, a physician's oath to do no harm.

Conclusion

Of all things in this life, two are universally experienced by all: death and the human experience. To be human is to innately wish to be dignified, respected, and treated with care from the moment we are born until we take our final breath. All people are deserving of a dignified death and providing voluntary euthanasia as a palliative option for those who meet the parameters allows them the ability to die peacefully with dignity. Physicians of modern medicine practice under foundational moral grounds, and with the duty to do no harm unto their patients. While it’s argued that the practice of voluntary euthanasia violates a physician’s oath as a health care provider, this argument can be dispelled based on the ways in which we define what is harmful, or rather *more* harmful to a terminally ill individual. In the case of those who would qualify to be candidates for VE, their condition has deteriorated to a point at which extending their life will casue greater harm than good.

To conclude, by offering, and preforming VE for a patient, a physician fulfills, rather than contradicts, their medical oath to do no harm because of the parameters in which it is performed.

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