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At Issue: Should Active Euthanasia Be Legalized?

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At Issue:

Should active euthanasia be legalized?

YES

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Americans have a common-law and constitutional right to refuse unwanted medical treatment. This right extends to the removal of life-sustaining equipment, including the administration of artificial nutrition and hydration. This "right-to-die" should extend to aid-in-dying, or active euthanasia, for the terminally ill, at their request.

Patient autonomy weighs heavily in favor of the legalization of voluntary active euthanasia. Respect for a person's autonomy requires that his or her considered value judgment must be taken seriously, even if that judgment is believed to be mistaken. Of course, the person desiring aid-in-dying must be both competent and fully informed. This implies voluntariness and disclosure of the risks, benefits, reasonable alternatives and probable results.

Relief of suffering, always a major goal of medicine, provides the best rationale for legal aid-in-dying for the terminally ill. Some argue that the Hippocratic Oath flatly prohibits physician participation in voluntary active euthanasia. The oath, however, contains an internal inconsistency that may make it impossible to adhere to in cases of intractable pain. The oath requires physicians to relieve pain, as well as giving no deadly medicine. In such cases, both courses — relieving pain and not giving a deadly drug — may not be possible. . . .

Another reason for legalizing active euthanasia relates to regulation of the practice. It is currently occurring outside the law and without any reporting requirements. Few cases are discovered, fewer are prosecuted, and juries are hesitant to convict in those cases that are brought to trial, causing unnecessary expenditures and wasting judicial resources. Legalization, with medical record documentation and reporting requirements, will enable authorities to regulate the practice and guard against abuses, while punishing the real offenders.

Even with legalization, inadequate pain control and depression must be addressed. Some have argued that the physician-patient relationship is based on trust and that trust would be violated if doctors were allowed to participate in voluntary active euthanasia. In fact, the opposite my be true: Patients who are able to discuss sensitive issues such as this are more likely to trust their physicians.

Such open dialogue will enhance detection of treatable depression. . . . A study of euthanasia in the Netherlands shows that two-thirds of patients who asked their physicians for assurance that they would be assisted in dying when at the end stage of their disease did not need the assistance because other suitable alternatives were given.

NO

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FROM *ABA JOURNAL*, APRIL 1993

The distinction between letting people die and killing them by lethal injection is now an integral part of the medico-legal landscape. This is the compromise we have arrived at in the struggle to take a humane approach toward seriously ill patients while still preserving as many traditional restraints against killing as we possibly can. This may be neither the logician's or the philosopher's way, but it may nevertheless be a defensible pragmatic way to do so.

As eminent bioethicist Thomas Beauchamp of Georgetown University has written, rules against killing "are not isolated moral principles," but "pieces of a web of rules" that forms a moral code. "The more threads one removes," warned Beauchamp, "the weaker the fabric becomes."

For that reason, I think that the legalization of active euthanasia will have much greater impact than is generally realized on our society and on the dynamics of the sick room. Criminal penalties create unconscious as well as conscious inhibitions against committing certain acts.

But if active euthanasia were legal, these acts would not only be thinkable, but speakable — an acceptable alternative to treatment that could and would be discussed in polite conversation.

The first person to broach the subject might be the physician or a relative or close friend. Or the gravely ill person might ask advice of those close to her. What should relatives and friends tell her? How would a patient react to the suggestion that she end her life? How many patients would opt for euthanasia because they feel obliged or pressured to do so — to relieve their relatives of financial pressures or emotional strain? And how many severely ill patients will feel that to reject euthanasia, once it is a viable alternative and others are "doing it," would be selfish or cowardly? . . .

We may be fairly sure of one thing. If we legalize active euthanasia for only the "terminally ill," it will not remain limited for very long. At first, living-will statutes provided that the directive only became operative when its maker became "terminally ill." But in response to strong criticism that such a restriction unduly limited the impact of such legislation, a growing number of states have removed the limitation either by statutory amendment or case law.

We may be fairly sure of another thing. If active euthanasia is legalized, it will not be confined to competent patients. As active euthanasia grows in acceptance, there will be a strong impetus to extend the same "benefit" to the incompetent patient who has a life-threatening illness but has never expressed any desire for euthanasia.