Euthanasia, the doctor and the patient

Marios Papaloukas, University of Peloponnese
IN THIS ISSUE
A person from the first instant of fertilization
The organ donation debate continues
You may have missed:
The Ethics of Assisted Suicide
A letter from Greece: Euthansia, the doctor and the patient

Dear Sir

Although dying is the only certainty in a mortal’s life and although humans are the only species aware of it, no one however is prepared to accept it and considers death as a remote probability concerning all others except himself. This is especially obvious in our modern western society.

In the old days dying was usually a simple matter. When patients reached the terminal phase of their lives, they were waiting patiently for the last moment either in hospital or at home. Very little was expected to be done by doctors (1).

During the last decades however, progress in medical technology was without precedent. Impressive achievements were put at the disposal of doctors such as heart resuscitation, organ transplantations, chemotherapy, artificial respiration, haemodialysis.

This medical arsenal was of immense help for doctors, who are dedicated to preserve lives and make consequently the largest possible use of all the weapons placed at their disposal in their fight against disease.

The result is an impressive increase in life expectancy but with the negative parameter of the prolongation of the dying process. Fear of legal liability leads doctors towards ‘doing more than felt necessary to be sure that neither patient nor family later claims injury or death resulted from not doing what was necessary’ (1).

Therefore doctors are systematically facing a large number of incurable cases who are proceeding toward death for a long period of time.

Many problems are created thus, not only for patients and their whole family but also for doctors and even for the social security funds. It is estimated that the 20% of the overall health expenses in the European Union is spend for the last hours of dying patients and that the bed of a dying person costs 4 times more than a regular one (2).

Thus endless arguments are set off about cases of terminal illness because where death is the only outcome, it is extremely important how this last period in a man’s life takes place.

At the beginning of the 17th century the philosopher Francis Bacon introduced the word ‘euthanasia’ with its modern meaning in the English language (3).
The word ‘Euthanasia’ derives from a compound Greek word : ‘ΕΥ’ meaning ‘GOOD’ or ‘WELL’ and ‘ΘΑΝΑΤΟΣ’ meaning death and literally means ‘dying well, easily, gloriously’. However, today we use this term when we want to describe the intentional administration of medicines in order to end the patient’s life, when suffering is unbearable (4,5) and there is no hope for recovery.

During antiquity, in many ancient societies a kind of euthanasia was applied as far as old people were concerned - ‘geronticide’. There is such an example of social euthanasia during ancient times in the Greek island of Kea (Cyclades). People over the age of sixty were obliged to drink hemlock, because it was generally believed, that those who could not fully enjoy life it was better for them not to live at all (2).

Euthanasia is characterized as ‘active’ when a doctor’s intervenes in ending a patient’s life and ‘passive’ when there is an intentional omission or interruption of whatever treatment a patient is under. The latter is sometime referred to as ‘letting nature take its course’. It is about whether, and how, the patient should be allowed to die (3, 6). The philosopher James Rachels (7) has argued that in terms of moral aspects ‘active’ euthanasia is not any worse than ‘passive euthanasia’, since the outcome is the same and both acts lead to the patient’s death.

When a patient explicitly requests to put an end to his/her life it is called voluntary euthanasia. Many maintain that voluntary euthanasia is a form of suicide, although there is a certain discrepancy between these two notions: Man comes to suicide when he/she is afraid of living and to euthanasia when he/she is afraid of dying. When there is no personal or proxy invitation to end the patient’s life, then it is called involuntary euthanasia (3, 6). In such cases, the motive remaining always the relief from suffering, the important issue is decision-making: Who has the authority and who has the right to make such a decision?

Few other problems call forth more arguments in contemporary medical practice than this question. Unlike all the above mentioned, which generate many debates and much discord, there is a general unanimity in cases of unbearable suffering (4) which remains the main reason for patients requesting euthanasia. Other additional factors are serious disability, dependence, isolation, depression, despair (4,8,9,10,11).

The use of pain-killers for long periods of time may shorten a patient’s life. However, because the purpose is to alleviate pain and make what life remains bearable, no one claims that pain-killers must not be used. The intention is what counts (4, 12, 13, 14, 15). Living under the burden of oncoming death and continuously suffering is not considered a humane and merciful situation. Yet doctors are morally obliged to try and prolong this kind of life. According to their oath they have no authority on decision-making, but also they have no moral or legal obligation to continue applying treatments that have no benefit whatever on a patient’s health (1).

Another difficulty, which arises when faced with moral issues, arises from the fact that different cultures have different notions of what is a ‘good death’. Religions, customs, secularism, individualism and social circumstances have serious impact on people’s ideas and views, thus leading to even major difficulties in the forming of a uniform decision by doctors or by jurists (16).

Lately the principle of individual autonomy is seriously taken under consideration by many legislations, although the patient’s ‘best interest’ is supposed to remain the main
criterion towards the choice of the proper treatment. Self-determination must be respected as long as it is ‘justified by necessity’ and goes on by reason of the futility of treatment. Further invasion of the patient’s body (6) constitutes unethical and immoral conduct on the doctor’s side.

As long as the physician has informed the patient about all alternatives concerning his/her medical future, the latter has the right to decide if he/she will accept or deny the proposed treatment. The patient’s competence and preference must, however, be unambiguous, not leaving the slightest doubt. Life is a gift. It may be given or denied. It is not for us to settle its length. It is a gift over which we have ‘stewardship but no final control’ (6).

This divine part of the human nature, makes decisions difficult even when the law allows some exceptions, as the withdrawal of nutrition and hydration (17). Nevertheless, death by starvation or thirst is, in fact, the only possible outcome as a result of their withdrawal (18).

According to our opinion withdrawing nutrition and hydration should be considered as the worse hypocritical and cruel method of applying euthanasia to somebody even if he/she is in vegetative state. The body suffers for about a fortnight until death (19).

We are afraid also that there is a misunderstanding as to what is a good death: Is it not when someone dies but without pains, being under good medical care, knowing that everything that could have been done was really done and surrounded by those persons whom he/she most loves (20,21)?

Are we going back in time to those primitive tribes that were leaving old people in the forest until they died from starvation or as prey to wild animals? Who will die, or even worse, turn into executioner.

Can ever a doctor be 100% sure that nothing more can be done in order to save a life? (16,18). How many times have terminal patients unexpectedly recovered and lived a normal life for many more years (18)?

Even patients’ wishes often change with changing circumstances; some people have lived to be thankful that their death wishes were ignored (22).

It is characteristic that doctors in Oregon – where euthanasia is permitted – prescribed 326 prescriptions, to people requested them, for ‘drugs to be used in assisted suicide’ but only 208 of them used the drugs and ended their lives (23).

Medical achievements during the last decades are so impressive that no doctor is excused to consider the possibility of a new scientific discovery as improbable (22, 24). Medical history is full of cures for diseases which have been considered incurable (18).

Euthanasia, with or without a court decision ‘involves some form of active killing’ (6) fact that raises obvious objections to the majority of medical profession as well as to the majority of the society at large.

The ethical duty for the doctor remains to try and save lives in conformity with the Hippocratic Oath. The oath is compatible with Christianity, Islam and Judaism but also in accordance with the more prosaic reason that saving lives is the essence of the medical profession (25).
Legalizing physician assisted suicide would fundamentally alter the ethos of medicine, affect patients’ ability to trust their doctors and to trust medical advice, and undermine the terminal patient’s confidence in the health system as a whole (4, 26).

When such paramount moral issues are at stake we are of the impression that a law allowing the practice of euthanasia would easily lead to generalisations and exaggerations. In our opinion, instead of arguing and try to law-make for various kinds of euthanasia, the best thing we have to do, if we want to be honest, is to abolish the idea of all kinds of euthanasia. We have to organize as best as we can and at any cost – as life is not measured in money – hospice centres for terminally-ill patients. This is because, as the evidence shows, the requests for assisting death are fewer in the very well organized centres (23). Furthermore doctors, must, during their training, learn how to treat terminal patients (27, 28). They must learn not only how to control the gnawing pains and symptoms but also how to back them with expertise from a psychological, social and spiritual point of view (21). They should allow God who offered us all life as a gift, to end it as a second gift. After all we don’t know if death is the end or the beginning!

Faithfully

Christos Papaloucas MD, PhD,
Department of Anatomy Thrace,
University, Greece

Marios Papaloucas LLM, PhD, Attorney at
the Highest Court of Greece

Kyriaki Pisteou-Gompaki

References

3 Koutschelins A.: Basic principles of bioethics, medical deontology and medical responsibility (in Greek).
21 Rousseau PC.: Lessons from Lisa. 2003 : Am J Hospice Palliative Care ; 20, (2) ; 155-156.