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BIOETHICS DISCUSSION GROUP

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EUTHANASIA

1. What is euthanasia?
Euthanasia is defined as any behaviour that is aimed at causing the death of a person where the motive is to bring an end to current or predictable suffering, either at the request of the person or in the absence of such a request.

2. It is legitimate to distinguish between active and passive euthanasia, depending on whether the objective (causing death) is achieved by an act of commission or an act of omission.

The term passive euthanasia is often incorrectly used, especially where death follows failure to provide or the discontinuation of treatment, or the use of pain killers. Nowadays doctors have such a range of therapies at their disposal that prudence and respect for the patient require the doctor to ask whether such means are appropriate. In addition, it has become possible to relieve most forms of pain without unduly endangering the life of patients**.**

Failure to provide inappropriate or disproportionate medical treatment should never be referred to as passive euthanasia! By inappropriate medical treatment we mean any means that provides no therapeutic benefit, and by disproportionate we mean that it provides little benefit in relation to the costs or privations that it would impose.

For example, there is no reason to call halting chemotherapy treatment against cancer passive euthanasia where in the judgement of the doctor, the treatment has become largely ineffective and more a source of suffering for the patient. However, it would be quite another thing if halting treatment was used as a means of intentionally causing death, or if pain killers were used to deliberately accelerate death.

3. In almost all European Union countries there are associations calling for the legalisation or other forms of tolerance for euthanasia. They use as arguments the autonomy of the person **(**implying the right to dispose of one's own life) and the desire to control suffering.

These reasons given are subject to reservations: without going into the principle of autonomy in general, it should be stressed that, in these cases, the autonomy referred to involves another person. Indeed, the request for euthanasia is addressed to a third party, in the majority of cases to the medical profession. This involves an illegitimate transfer to doctors of an autonomy that is essentially alien to them. Moreover, such a request fundamentally changes their

mission: they would no longer only have to fight to save life, but also have to cause death. The relationship between the doctor and patient would be profoundly affected.

4. A request for euthanasia is generally made in situations of great distress where the person could be influenced to a varying degree by the attitude of his entourage. The patient sees himself as he is seen by others. A request for death could therefore stem from a conviction that he has become a burden on others; it then becomes a clumsy way of wishing for relief. Such a request then takes on an ambiguous nature that could easily be misunderstood: once relieved of their pain and discomfort and in good care, many people do not repeat their previous request for euthanasia. This seems to indicate that patients no longer wished to live under the earlier conditions, but did not really want to die.

5. It should also be forcefully stressed that this theory of "the right to die with dignity" and legal tolerance of euthanasia confer onto doctors an excessive right. In the final analysis, it would be the medical profession that would decide the fate of who should live and who should die. Even where trust in the responsibility of the medical profession seems to be merited, one should not overlook the fact that abuses remain possible, especially in a situation where therapy becomes increasingly expensive in a context of limits on health expenditure.

6. No human being has the right to judge that the life of another is no longer of value. Any form of tolerance of euthanasia is symbolic in nature: it affirms that the life of a member of our society has lost its value.

The prohibition of homicide occupies an important place in any society. We note that there are currently schools of thought that call for making a few exceptions in apparently well-defined situations, backed by a number of guarantees. However, these guarantees could prove to be rather fragile, and what a given legislator intended to apply to exceptional circumstances might subsequently be easily extended.

Legalisation of death in exceptional cases and any form of social tolerance in this field would indicate that, in the eyes of society, certain lives are no longer worth living. Such legalisation would put unacceptable pressure on vulnerable persons who themselves doubt the sense of life.

Denying the sense of life is to deny the very foundation underpinning the recognition of the dignity of persons, whatever their situation or whatever alterations affect their mental capacity. It is therefore sophism to employ the argument of human dignity to justify such legalisation of death.

It is true to say that certain persons do not accept interventions on their bodies or any alteration in their physical or mental capacity. However, in the view of the Bioethics Discussion Group, the unconditional recognition of the dignity of every person is the very foundation of human rights and a fully humane society.

NB

In this context, useful reference may be made to the following documents:

- the Declaration made in 1980 by the Congregation for the Doctrine of the Faith
- the Encyclical *Evangelium Vitae*, chapter III
- the various Episcopal Declarations of 1975 and 1991