

INVITED COMMENTARY

EUTHANASIA : AN UNRESOLVED CONFLICT BETWEEN SUSTAINING AND DISCONTINUING LIFE

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Gazi Medical Journal 8 : 153-157, 1997

"Death is not a problem of life that's lived through, nor is amenable to treatment but the process of dying is very much a part of the person's life.This is the period of the human dilemma of the living-dying process"

E. Mansell Pattison

Euthanasia is simply defined as a pattern of practice that acts specifically with the goal to end life (1). The only aim of this procedure is to terminate the life of a patient for a quick and painless death. By this definition, the act is not considered euthanasia if the aim is not to end life.

Euthanasia is classified as passive or active, depending on the initiative of the physician. Recently, there is a tendency to define euthanasia as voluntary, involuntary, and nonvoluntary active euthanasia in terms of the physician's intent. The relevant ethical and legal issues necessitate a clear grasp of the different terms to be discussed.

1. Definitions

a. Voluntary Active Euthanasia: Upon patient's request a full informed consent is obtained and the physician intentionally administers medications or uses other interventions to bring about the patient's death. The patient should be informed about the possible outcomes of the disease process clearly and he should be competent

to understand the implications of his decision. Because of the ethical and emotional issues involved, there is a consensus in Western countries to refer to voluntary active euthanasia when the term euthanasia is used.

b. Involuntary Active Euthanasia: The physician intentionally administers medications or uses other interventions to induce death in the absence of any request from the patient and/or a full informed consent. Although the patient is competent to give informed consent, he either denied or is not asked to do so. Ethics of this procedure is controversial.

c. Nonvoluntary Active Euthanasia: The physician intentionally administers medications or uses other interventions to cause the patient's death, although the patient is incompetent and mentally incapable of requesting it, as in case of comatose patients or children.

d. Physician-Assisted Suicide: The physician provides medications or other interventions to a patient with the understanding that the patient intends to use them to commit suicide. It mainly differs from the voluntary active euthanasia by the performer of the act. There are different opinions about this type of euthanasia. Some commentators support permitting physician-assisted suicide but oppose the voluntary active euthanasia, by

proposing that the former will prevent abuse. On the other hand, many opponents of this belief claim that this act is morally and ethically similar to the active euthanasia, since in both situations the intent is the same (2). They maintain that suicide is not a criminal offense, while assisting or counseling a person to commit suicide is. Proponents of this idea accept the assistance of suicide in some cases but the assistant should be someone different from the physician (3).

e. Passive Euthanasia: Life-sustaining elements are withheld from the treatment of the patient. Withholding this treatment from a patient who already is known to be dying does not necessarily terminate the life immediately, but lets the disease process run in its natural course.

f. Indirect Euthanasia: The physician intends to relieve pain with narcotics or other medications which incidentally may cause death. Since the intention is not to cause death, by definition it is not widely accepted as euthanasia. The use of medications to relieve pain even if it shortens the life, as in case of passive euthanasia is considered to be ethical by both physicians and non-physicians in some situations. The opponents of this idea point out that there is no difference between killing someone and letting one to die.

2. Historical Antecedents:

Debate on the ethics of euthanasia and physician-assisted suicide date from ancient Greece and Rome, where many physicians gave their patients the poison for which they were asked (4, 5). The opposition to euthanasia was a minority view and one of the main points that distinguished the traditional Greek physicians from that of the Hippocratic tradition. In his famous Oath, Hippocrates defines the traditional role of the physicians by stating that:

"I will neither give a deadly drug to anybody that asked for it nor will I make a suggestion to this effect-in pureness and holiness I will guard life and my art" (1).

Between 1870 and 1936 heated debates took place in the United States and Britain and by 1880s euthanasia had become a major topic of medical meetings and editorials, while in 1890s lawyers, forensic and social scientists joined the debate. Later on, debates moved from these areas into the politics. In their book named "The Permission to

Destroy Life Unworthy of Life", a professor of psychiatry and a lawyer proposed that the individuals with incurable diseases, the mentally ill and deformed children possessed "unworthy lives". The writers proposed these individuals to be a financial burden to the society and polluted the genetic pool with defective genes. Therefore, the society should "protect" itself from these "unworthy lives". This minority view, became the integral part of the nazi propaganda later on. 1930s saw an upsurge of debates about euthanasia in medicine in the United States and Britain, which flowed to the public. "Voluntary Euthanasia Legislation Society" was founded by British physicians. The outbreak of World War II, the discovery of Nazi concentration camps and the genocide carried out by the German physicians muted the euthanasia, but not completely eliminated it. In the late 1950s, the controversies of ethics of euthanasia were reviewed in the legal literature, which prompted research in this taboo area. Additionally, a number of factors converged to challenge the previous cultural denial of death. Medical advances prolonged life so that a major segment of aged reminded the society of the end of life. New medical techniques of organ transplantation, dialysis, and radical medical and surgical therapies confronted medicine and the culture with hard decisions about life and death. Thus, people started having a greater degree of autonomy regarding when they die, although this brought no additional capacity to influence the inevitability of death. In 1970s and 1980s legal cases brought euthanasia into the public forum in the Netherlands. Euthanasia is permitted while it still remains illegal in this country. Currently, these debates gain prominence in many countries.

3. The Arguments for and Against Euthanasia

The ethical arguments about euthanasia have not yet yielded conclusive results. While they discuss mainly the same issues, both the proponents and the opponents reach separate conclusions.

a. Autonomy: The proponents claim that the people have their own goals and values for their lives. In addition to their education, marriage, and career choices, they also should have the autonomy to decide the time and manner of their death. Others oppose this idea since the request for euthanasia is a cry for validation of life and life's purposes rather

than a real will to be killed (2). Moreover, autonomy does not justify euthanasia, on the contrary death irreversibly alienates autonomy.

b. Well-being of Individuals: Clinically it appears that, the dying patient copes with the stress of dying in the same way he had previously coped with life stresses. Thus, a dying patient, except for the physical pain and defects, may have an unbearable anxiety or psychic pain depending on the emotional coping styles that assume primacy over intellectual coping styles (6). In case living is more painful than death, euthanasia is a "psychological insurance" to relieve the anxiety of individuals who worry about having uncontrolled pain and suffering before death. On the other hand, the people against euthanasia define this aim as a superficial and simplistic response to the problem of suffering. It is not a solution for the patients who experience intractable pain or suffering early in the course of the disease (2), because many patients with irresistible pain may be treated to some extent and it is unwise to change this policy for hard cases.

c. Ethical Dilemma: The proponents of euthanasia claim that there is no ethical difference between active and passive euthanasia, between the act and the omission, between killing and letting die. If withholding medical treatments is acceptable, than active euthanasia should also be acceptable. People against active euthanasia deny this statement. They point out that both the intent and the act of the physician in passive and active euthanasia are different, and withholding medical treatments does not necessitate immediate death.

d. Unwanted Consequences: These arguments also involve the negative consequences of euthanasia. The opponents hold that, any case of abuse will bruise the trust in physician-patient relationship. Moreover, legalization of euthanasia will oblige the patients who feel guilty of being a burden on their families to choose euthanasia to spare them of the discomfort they will face attending a chronic bedridden patient. On the other hand the proponents of this view maintain that, these assumptions are too speculative and inconsistent with the experience in Netherlands. The patient will eventually trust the doctor more, when he knows that he will aid him to die when necessary.

4 The Rationale for Arguments on Euthanasia in Turkey

In Turkey, euthanasia attracts increased attention from the medical circles. Recently, some cases received publicity in the media appealing for euthanasia. Although their demands possibly consist of appropriate treatments of their diseases rather than getting help in the dying process, they still create enough controversy to stimulate discussion.

Ongoing laws of the Turkish Republic, Turkish Civil Law (TCL) and Turkish Criminal Law (TCRL), as well as the international legislature state that "the right to live" is one of the basic human rights that is inborn, and can not be quitted or transferred (7,8). According to the Medical Deontological Rules (MDR), the physicians assume the responsibility of taking care of human life, health, honor and assist the patients to achieve their optimum function and well-being (9). Although physicians are free to choose among therapies in the best interest of the patient, they must have an intention to heal even if the patient's demands are to the contrary, because harmful activities on the part of the physician are not immune to the TCL and TRCL (7,8). Moreover, not even a terminally ill patient has the freedom of choice between life and death (8).

The laws of the Turkish Republic consider all patterns of practice that acts specifically with the goal to end someone's life as an intention to murder, and the physicians involved in this act can be prosecuted for homicide. Article 448 of Turkish Penal Code (TPC) states that anyone killing someone intentionally is subject to punishment of 24-30 years in prison, while giving no specifications about a patient's desire to obtain assistance to die from a physician (9). As in the case of active euthanasia, under the article 454 of TCRL, which states that assisting or counseling a person to commit suicide is a criminal offense and can be punished by 3 to 10 years in prison, physician-assisted suicide is forbidden in our laws (7).

While the regulations in Turkey are against active euthanasia and physician-assisted suicide, there are less strict rules against passive and indirect euthanasia. The use of pain medications, even if it shortens the life of the patient, can be accepted to be within the context of intention to heal (9), since the aim is not to end life but to relieve the pain. In

conclusion, indirect euthanasia can be legally acceptable in some situations in Turkey.

Similarly, the regulations concerning organ transplantation(10) license the withdrawal of life sustaining elements from a patient, whose family rejects to give permission for organ transplantation even after the confirmation of brain death. Moreover, within the daily medical practice, partly because of economic difficulties or limited sources of our health system, the terminally ill patients are sometimes discharged from hospitals with the seemingly humanistic intent of providing the patient a comfortable death. In some cases these patients do not have an access to medical care. Furthermore, it is possible to encounter some physicians advising the family to take the patient home, claiming that there is nothing left to do for the patient anymore. Being not unique to our country, this practice is also encountered elsewhere. Whether these practices can be interpreted as passive euthanasia and regulations on inpatient treatment can legalize passive euthanasia deserve a formal discussion by authorities, addressing hard decisions about life and death, while confronting these medical and cultural issues. Otherwise these practices will go on without a serious consideration is given on the concept, the contents and the limitations of euthanasia.

5. Proposal

Opponents, as well as the proponents of euthanasia, advance their own notion over the same foundation, namely "the human rights". Thus, same principles may be the corner-stones of two opposite extremes on the subject of euthanasia. Although possessing apparently objective criteria, "the human rights" harbor flexibility and subjectivity when it comes down to life and death situations.

Although increased attention is being given to the evaluation of the attitudes of the physicians towards euthanasia in Turkey, official view regarding euthanasia is far from clear. It needs to be discussed whether it is ethical to set up the legal and cultural background that will provide people freedom to decide for their own life in certain circumstances or to guard the rights of others without giving consideration to their emotional needs under the protective shelter of human rights. Only after the completion of this debate final conclusions can be drawn about the practicability

of the act of euthanasia.

Once a decision is reached, other problems need to be faced. If euthanasia is not accepted by the community, the medical professionals should be extremely sensitive about the so called "letting die" process. The health policy should be so arranged that the terminally ill patients will have the opportunity to be treated in well-organized medical centers.

If authorized, baseline criteria should be discussed. Advocates of euthanasia propose some safeguards in order to protect the patient and the physician. Initially, the request for euthanasia should be made by a competent patient in writing. Second, the patient should possess full mental capacity and ability to understand and judge his situation and the implications of his choice. As a third criteria, depression and other type of psychiatric disturbances should be treated. Lastly, the decision for euthanasia must be given by certified physicians who can not be charged for the procedure, and all cases of euthanasia should be reported to an official body which evaluates the incidents for potential abuse. On the other hand, the available data in the Netherlands which is a prototype of the industrialized country that permits euthanasia show that a significant number of euthanasia cases do not adhere to the agreed upon conditions for permitting euthanasia. Moreover until 1993, physicians were reluctant to report these cases. These findings show that clearly defined criteria for selection of euthanasia cases and strict sanctions in case of abuse are mandatory.

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