Euthanasia and Allowing to Die

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In our modern world human life has been depreciated. Life now is "cheap." A "cult of death" is far spreading throughout. We now fight against life at all its stages: even before it begins, by contraception and sterilization; in its earliest days, by abortion and infanticide; when it is mature, by suicide and murder; and finally when it is nearing its end, by euthanasia —always with the hope of creating a better world through an "easy death"!

Like abortion, euthanasia is also creeping into our modern culture. Many people nowadays do not believe in life as such —much less in the sanctity of life. Their only concern is "the quality of life" in the abstract, and their own standard of living in practice. And so, we can suppress new life, have fewer children (or none at all). We can also get rid of the ill and unproductive members of society, young and old, just because they are considered an unbearable economic burden for the rest of us.

Thus, in modern secularistic society, killing is acceptable, utilized as the final solution to human problems. Human life in itself no longer has sanctity and dignity, as John Paul II tells us in his encyclical *Veritatis Splendor* (Ch.III). What is now important is the quality of life, the extent to which an individual's life contributes instrumentally to the attainment and enjoyment of purely human and personal values. Whenever some human individual's life is not of sufficient quality - whether measured from the individual's own perspective or from the perspective of society, or both -that life becomes a disvalue. Such a life is unwanted because it is useless; it is evil because it is unwanted; it must be destroyed because it is evil.

To those of us who believe in the sanctity and dignity of human life, this secularistic conception of life is unreal and almost incredible. It is

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hard to believe that a society that has so heavily committed itself to social welfare —and health care— could turn around and systematically seek to limit and reduce the burden of welfare by killing people. But the legalization of abortion is a fact in many parts of the world. And many unwanted babies are destroyed with impunity by their own mothers. Euthanasia is also widely used, not only with severely suffering patients, but also with people declared "unwanted" simply because they are senile, insane, or defective.

This is the problem we are confronted with in this essay.

In the presence of different value systems competing for the solution to this and similar problems at the end of life, the options available to us are limited and the decisions difficult.

I shall try to come out with a reasoned analysis of the problem of *Euthanasia* and "Allowing to die in peace" (*Orthothanasia),* from the perspective of the patient's moral obligation to respect and maintain life and health, rather than from the health care professional's point of view. I shall view this problem from within a Catholic moral-theological framework.

From this perspective, the principles of *Human Dignity*, *Double Effect*, and *Ordinary-Extraordinary Means*, are certainly central for moral decision making, especially with respect to the use of artificial life support measures.

First of all, I shall define and identify some terms, which are significant in order to understand the problem. Afterwards, I will present briefly the content and meaning of the three "aspects" of the problem, namely, *Euthanasia*, *Dysthanasia* and *Orthothanasia*. And finally, I shall conclude with a concise moral evaluation.

Definition of Terms

There are many euphemisms, slogans and value-laden words frequently used with reference to euthanasia issues. The uncertainty and ambiguity of many commonly used terms has created confusion in many peoples' minds, including health care practitioners and bioethicians..., who until now remain puzzled not only by the number of terms used to describe the medical status of the unconscious patient, but also by the divergent meanings of death and dying, and the different limits of refusing treatment.

Indeed, terms mean different things to different people. To avoid, then, seeing ourselves "talking to ourselves" rather than to "each other", it will certainly be convenient to clarify some of the most relevant and commonly used phrases to avoid misunderstanding and confusion. Examples:

Death

Death has always been a "fact of life." Dying is a process, but death is an event. It is of utmost importance to have a clear idea of what constitutes death so that we do not treat the dead as though they were alive, nor the living as though they were dead. The living may still require life-sustaining treatment. But when a person has died, all treatment and care should cease.

The relevant moral question centers on whether "neocortical" or "brain death" is more consistent with an adequate understanding of human life, and with human death also.

In the past people simply died and...were buried. Now, death does not come alone and perhaps that is why "the dead" now are not buried sometimes; now death is "adjectivised." Thus we have "Brain death," "Clinical death," "Biological death," "Natural death," "Spiritual death," and "Total death," and so on and so forth.

When is a person really dead?, we may ask. Answer: When the "adjective" is "killed". Then the person is dead. So it was before, is now, and will always be!!!

For all practical purposes, then, a person may be declared *really* dead when he reaches an irreversible cessation of total brain functions, according to the usual and customary —or reasonable— standards of medical practice,(AMA). Or, as the Vatican Pontifical Academy of Science, in 1985 said, "A person is dead when he has irreversibly lost all capacity to integrate and coordinate the physical and mental functions of the body."

Death with Dignity

"Death with Dignity" is dying in a way which is not unduly burdened by the prolong use of life-sustaining technology in an alienating and depersonalizing environment, —as that of an Intensive Care Unit— the ICU.

It is not "death or dying with dignity," but the dignity of the dying person that must determine what measures are to be taken to sustain his life, perhaps even beyong the natural limits.

The incorrect use, however, of the term "death with dignity" has become something of a movement, and a slogan to romanticize death, and to promote the so-called "right to die."

Right to Die

"Right to die" is a curious way to refer to a natural inevitability. The "right" at stake here is not to die, but to make the request for euthanasia or "assisted suicide." So, another faddish slogan.

Catholic morality, however, limits the right to reduce treatment based on a moral order, which requires human beings to act as stewards of their lives and health, and not as absolute arbiters of their ultimate destiny.

Mercy Killing and *Compassionate Murder*

"Mercy killing" and "Compassionate Murder" are two terms for euthanasia. They are used to suggest that persons who commit euthanasia do so out of mercy and compassion for the victim, and to end the victim's pain and suffering. The infliction of death, however, may be inspired by infinitely more complex and mixed motives besides compassion, pity and mercy.

According to the Vatican Declaration on Euthanasia, "mercy killing is killing for the purpose of putting an end to extreme suffering, or for saving abnormal babies, the mentally ill or the incurably sick, from the prolongation, perhaps for many years, of a miserable life, which could impose too heavy a burden on their families, or on society." (A. Flannery, O.P., *op.cit.*, p.512).

Assisted Suicide, Aid-in-Dying, and *Helping One to Die*

These three expressions are similar and have the same common objective of helping someone to commit suicide. The three terms, however, conceal more than they reveal. All sorts of "aid" can be given to the dying, such as appropriate pain control, companionship, love, care, etc.; but these terms are not used to indicate those types of aid. Usually they refer to health-care practitioners, who, in one way or

another, help terminally ill patients commit suicide by providing the means and/or the knowledge to take one's own life.

Helping one to die is, of the three, the most neutral syncnym of euthanasia, and the one that euthanasia's advocates prefer. The difference between "aiding suicide," "helping one to die," or "assisted suicide" and "direct participation in homicide" is sometimes difficult to determine. Aiding or counseling a person to commit suicide, and homicide itself, are sometimes extremely closely related.

Is there any difference, for example, between a person who, at the dying man's request, prepares a poison and leaves it on the bedside table for him to take; and a person who helps the patient to drink it, or who administers it directly, at the request of the dying person who is unable to take it himself?

There is reason to fear, therefore, that homicide of the terminally ill for ignoble motives may readily be disguised as "aiding suicide" or "assisted suicide."

Again, the Vatican Declaration on Euthanasia is very clear in its moral evaluation of "assisted suicide" and "aiding-in-dying": "No one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly. Nor can any authority legitimately recommend or permit such an action. For it is a question of the violation of the divine law, an offence against the dignity of the human person, a crime against life, and an attack on humanity." (*Ibid.* p.512).

Other Acceptable Terms

Closely connected with the concept of euthanasia, and thus often associated with it, in different degrees, though generally acceptable, are the following commonly used phrases: "Allowing to Die," "Letting die," "Do not Resuscitate" or "D.N.R." and the best received, "Palliative care" or the "Hospice approach."

With hopelessly ill patients in a dying situation, as implied by these terms, when the burdens far outweigh the benefits of a proposed treatment, the health care practitioner concentrates on suppressing pain, avoiding extraordinary, burdensome therapeutic techniques, and generally seeks to ease the dying patient towards a peaceful and natural death.

Indeed, as the Vatican Declaration on Euthanasia affirms, "This in our day is very important, especially at the moment of death, to safeguard the dignity of the human person and the Christian meaning of life, in the face of a technological approach to death that can easily be abused." (*Ibid.*, p.514).

Euthanasia, Dysthanasia, Orthothanasia

To help put some light, and logic, into this terminological labyrinth, I now propose to streamline and group together this complex spectrum of death, dying, and refusing treatment situations into only three single, and mutually exclusive, categories, namely, *Euthanasia*, *Dysthanasia* and *Orthothanasia*.

By choosing these three Greek-rooted terms, I hope to minimize, if not totally avoid, the still prevalent medical and ethical confusion brought about by the constant misuse of so many equivocal and euphemistic expressions, which the proponents of euthanasia have popularized with their continuous campaigns for legalization of euthanasia.

Euthanasia

"Euthanasia" etymologically is derived from two Greek words (*Eu* and *Thanatos*) which mean "easy death" or "happy death." For centuries the term has been used in reference to actions by which a person is 'put to death' painlessly, usually to avoid further suffering from an incurable disease, or 'to end' an irreversible comatose condition. In this sense it is often called "Mercy killing," "Compassionate murder," or even "Death with dignity."

Euthanasia, then, is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used." (Vatican Declaration on Euthanasia, in A. Flannery, *op.cit.*, p.512).

Taking a human life by omission is, in moral perspective, the same as taking it by commission. Thus no distinction is made between, for example, intentionally starving a person by withholding nutrition and hydration, and stabbing him to death. Even if this is done with a good intention, e.g., out of mercy, pity or compassion, it is morally wrong. So,

what is called euthanasia —in all its forms— has always been condemned by Catholic morality, and this is true of voluntary as well as involuntary euthanasia. The only difference between the two is that voluntary euthanasia would constitute suicide as well as homicide.

Although it is true that an omission can be just as effective as a positive act in bringing on death or shortening life, it remains true also that an act of omission from which death results is not in itself immoral. The decisive factor is the intention. It is when this is done to end or shorten the life of the patient that it becomes immoral. Since this is what happens when some means to preserve life are deliberately not provided because of the quality of life of the patient, then that inaction constitutes intentional euthanasia by omission. Then one is not merely letting the patient die, but actually killing him.

Euthanasia's functional characteristics are: (a) confronts life; (b) advances death, helps to die, favors death; (c) shortens or reduces life; (d) kills.

Dysthanasia

"Dysthanasia" also derives from the Greek *Dys* and *Thanatos* meaning "Bad [Difficult, Ugly] Death." Thus, etymologically is the opposite of euthanasia. And consists in trying to prevent or *stop* death in any possible manner, or *at all costs* through the use of extraordinary, disproportionate, burdensome means, which in reality only prolong the dying process or terminally comatose life, by interrupting the biological process of death, perhaps for a few hours, days or weeks, and often without any real therapeutic proportionate benefit to the patient.

The moralists in general have little problem approving withholding and/or withdrawing such "burdensome" means. Many physicians and nurses, however, are not so ready to remove life-supporting measures and allow a patient to die. Indeed, health care professionals and moralists approach the dying patient with different emphases and attitudes. The moralist is more concerned with how the person dies, while the physician in particular is more concerned with how to prolong life.

The moral issue in death and dying situations, however, is not whether patients can be kept alive, but whether there is obligation on their part to do so (cf. Declaration on Euthanasia: A. Flanery, *op. cit.* p.514).

Dysthanasia is a modern problem, directly opposed to the right of the patient to refuse 'extraordinary' —and so 'optional'— medical treatment, resulting mainly from the abuse of biomedical technology, by which the patient is made to die an *ugly* death, isolated and "abandoned" in the cold environment of the Intensive Care Unit!

The solution to this difficult problem is not easy to find, as there is no absolutely clear answer as to when death occurs, but there are fairly good guidelines as to when it is no longer necessary to make heroic attempts to sustain biological life. Extraordinary means, which are used very frequently in dying situations, are rarely used because of any obligation of the patient or his family. Some physicians honestly believe they must exert every last effort to prolong life. Their views must be respected, but certainly they should also be open to dialogue. We all need considerable reeducation on the whole subject of death and dying. Few people are able to view it in a truly Christian perspective.

Dysthanasia's functional characteristics: (a) confronts death; (b) delays death, makes dying difficult; (c) prolongs, extends, lengthens life; (d) does not allow to die, it stops death.

Orthothanasia or *Allowing to Die in Peace*

Etymologically, "Orthothanasia" comes from the Greek *orthos* (right or good), and *Thanatos* (death). Thus, meaning "rightful dying" or "good death."

With this term, of recent coinage, and not yet enjoying popular acceptance, I refer to the kind of right attitude towards death that should be developed by everybody concerned with the care of terminal, incurable, comatose or persistently unconscious dying patients.

Orthothanasia means "right" or just "good death", i.e.,.death at one's own appointed time and designated "hour." (*Eccl.* 3,18). Orthothanasia stands between the two extremes of Euthanasia and Dysthanasia. Orthothanasia simply means "caring for the dying" or the medical practice that "allows the patient to die in peace."

Orthothanasia is, therefore, the ethico-moral ideal, both doctrinally and in practice, being the following its functional characteristics: (a) neither advances nor delays death, it helps in or while dying; (b) neither shortens nor lengthens life; (c) neither favors death, nor makes it difficult; (d) neither confronts (opposes) life nor fights for it; (e) it does not kill, it simply permits, allows to die.

Concluding Moral Evaluation

The word Euthanasia is often used with different meanings and acts in mind. Positive, direct or active euthanasia is usually contrasted with negative, indirect or passive euthanasia. The difference between the two concepts is one of action as opposed to omission or inaction.

Voluntary euthanasia —or *assisted suicide*— is also contrasted with *involuntary* euthanasia —or *mercy killing*—, using as the criterion for the distinction the fact that the "victim" did or did not consent to his death, whether caused by some positive act or by an omission.

In moral perspective, the distinction between omission and commission is practically irrelevant, as inaction is held tantamount to action, for example, when there is duty to act, and failure to do so would constitute negligence. Thus, no moral distinction is made between intentionally starving a person and shooting him to death. Both interventions are euthanasia. And even if that is done for a good purpose, like mercy or compassion, it is always wrong and unjustified, and therefore immoral as contrary to natural and positive law.

Health care professionals' primary duty is to fight for life and against death ("Do good and avoid evil"). But they should also realize that at some given time or stage during the patient's dying process, the optimal treatment for him may no longer be struggle to maintain a purely vegetative or clinical life through the use of *extraordinary* means, but rather to allow death to occur, while continue providing the individual with all the *ordinary*, palliative care required to relieve his pain.

The patient, as master of his own life, within certain limits and conditions of course, should also be master of his death. He should be able to exercise a constant choice over the way in which he intends to live his final moments. Heroic, ineffective, or burdensome measures, when not requested or accepted by the patient, violate his rights, by imposing upon him a constrain which in fact fails to take into consideration his wishes and his right to refuse —personally or through proxy— such extraordinary-optional means. That would be *dysthanasia*.

The decision to allow oneself or another to die in such circumstances *is not equivalent to suicide* nor euthanasia. On the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense

on the family or the community. (Vatican Declaration: A. Flanery, *op. cit.*, p. 514).

Moral theology clearly differentiates between intentionally causing death by positive or negative deliberate acts, from withholding or withdrawing the use of extraordinary means with the patient's consent thus "allowing the patient to die." The former is euthanasia, and is morally unacceptable, and so should be legally sanctioned; while the latter is *Orthothanasia*, and can be perfectly justified in the name of personal autonomy or right to self-determination, and the principles of Stewardship and Double Effect.

One is, therefore, guilty of euthanasia if his intention is to bring on or procure death, or even if he simply omits something necessary to preserve life. If his intention, however, is to spare the patient a burdensome treatment, or one that is useless to preserve life, and allows himself to die by letting death occur or letting nature take its course, then the omission can be justified. The intention is the decisive factor. When the action is performed *to end* the life of the patient, that makes it immoral. We may not kill, but we may allow to die.

As Pope John Paul II says:

> "The physician is not the lord of life, but neither is he the conqueror of death. Death is an inevitable fact of human life, and the use of means for avoiding it must take into account the human condition.
>
> When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted." (*The Mystery of Life and Death*, October 21, 1985).

And St Paul, in the Epistle to the Romans, says: "If we live, we live to the Lord, and if we die, we die to the Lord. So then, whether we live or whether we die, we are the Lord's. For to this end Christ died and lived again, that He might be Lord both of the dead and of the living." (*Rom.* 14,8-9)

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