Euthanasia: Pros And Cons

This essay will identify and discuss the key pros and cons that have been raised over time in the ongoing debate surrounding the legislation of euthanasia and physician-assisted suicide in the United Kingdom. Euthanasia and physician-assisted suicide have become subject to an intense controversial debate over the last few decades in relation to the moral, ethical and legal status (Patterson, 2008). In addition, this complex debate extends to medical, socio-cultural and religious issues (Harris, Richard, and Khanna, 2006).

The word ‘euthanasia’ is derived from ancient Greek language and means ‘gentle death’ or ‘good death’ and the term is still used in modern Greek (Theofanidis and Mecek, 2016).

It is imperative that a clear differentiation is established between the types of euthanasia and physician-assisted suicide. In terms of euthanasia there are three types: voluntary active euthanasia, involuntary active euthanasia, and non-voluntary active euthanasia (Diaconescu, 2012). Within a healthcare environment the term voluntary active euthanasia can be described as the patient’s voluntary and competent request to the physician to intentionally cause death by the administration of a lethal injection (McCormack, Clifford, and Conroy, 2011). The term physician-assisted suicide describes the scenario where a physician knowingly provides drugs to the patient for self-administration to end their own life (Ricou and Wainwright, 2019).

In contrast to active euthanasia, there is passive euthanasia which is the withdrawing or withholding life-prolonging treatment and ‘do not resuscitate’ (DNR) orders (Theofanidis and Mecek, 2016). These end of life covert forms are routinely carried out in clinical settings where a patient can request not to have their life prolonged by medical intervention. This is a commonly accepted practice in the UK.

Switzerland was the first country in the world to decriminalise physician-assisted suicide in 1942, referring to it as ‘Dignity in Dying.’

As of today, there are only five countries in the world that have decriminalised both euthanasia and physician-assisted suicide. The Netherlands was the first country to legalise the ‘Termination of Life on Request and Assisted Suicide’ act in 2001. Belgium shortly followed with ‘The Belgian Euthanasia Act of 2002,’ and it is the most liberal country whereby the euthanasia law has now been extended to children (Ricou and Wainwright, 2019). The third of the Benelux country was Luxembourg with its 2008 act ‘Right to Die with Dignity.’ In 2015, Colombia passed into law its act ‘The Right to Die with Dignity’ and Canada legalised both euthanasia and physician-assisted suicide with its ‘Medical Assistance in Dying’ law.

In the United States of America there are nine states that have legalised physician-assisted suicide: Washington, Vermont, Oregon, New Jersey, Maine, Hawaii, District of Columbia, Colorado, and California. The state of Montana also has physician assisted suicide; however, this is mandated by court ruling (Danyliv and O’Neil, 2015).

The legislative criteria for euthanasia and physician-assisted suicide differ between countries, with some countries extending their criteria over time (Sear and Fraser, 2017). The United

Kingdom attempted to follow its neighboring European countries by presenting ‘The Patient (Assisted Dying) Bill of 2003’ followed by an amended version ‘the Assisted Dying for the Terminally Ill Bill of 2004’ (Harris, Richard and Khanna, 2006). Lord Joffe who was an untiring advocate for physician-assisted suicide in the United Kingdom presented both versions of these bills to the House of Lords which generated controversy but ultimately the bills were strongly opposed (Tallis and Saunders, 2004). Lord Joffe continued his ongoing battle to decriminalise physician-assisted suicide on four attempts, with each attempt blocked by parliament.

At the heart of the argument in favour of assisted dying is the principle of respecting patients’ autonomy. Smith (2000) claimed that death has been medicalised and sanitised so that it is alien to most people’s daily lives, in contrast to the ancient Greeks’ view, as expressed by Epicurus (341–270 BC) that we should not fear death and accept it as natural. Albert Einstein expressed it thus: “I want to go when I want. It is tasteless to prolong life artificially. I have done my share; it is time to go. I will do it elegantly.” (Goodreads, 2020). This argument was echoed throughout the pioneering work of Lord Joffe and the bills he put forward to the UK Parliament to be enacted. The ethical principle of the patient having complete autonomy in the decision-making process of their end of life care is paramount (Harris, Richard and Khanna, 2006).

Going beyond the argument of patient autonomy, Tallis and Saunders (2004) argue that withholding the option of assisted dying to patients who are suffering is a gross violation of the notion of medical practice rooted in respecting a patient’s wishes. That is, that it is the physician’s role to do what is best for the patient, and that sometimes means assisting them to die. Those that are in support of assisted dying have argued that terminally ill patients who are suffering from untreatable symptoms and unbearable pain should have the option of requesting euthanasia or physician-assisted dying (Tallis and Saunders, 2004). In addition, patients often find themselves as a burden and suffer a loss of dignity. Therefore, the ethical principle beneficence should be fulfilled so that terminally ill patients who are of sound mind should be able to choose a place and time to die humanely (Frost, Sinha and Gilbert, 2014). Furthermore, physicians who are considering patients’ obligations to relieve their pain, suffering and irreversible diseases could think about euthanasia or physician-assisted suicide if legalised, and it would be considered as doing good by their patient (Ricou and Wainwright, 2018). Medical treatment should not always be about extending life.

The key arguments that are against euthanasia and assisted suicide are: improvements of palliative care, doctors code of ethics, protecting the vulnerable and religion.