EUTHANASIA AS AN ETHICAL CONTROVERSY IN THE CONTEMPORARY WORLD

Polycarp Ugwu, PhD
and
Okewu Michael Peter
Claretian University of Nigeria
Phone num: 08038947424; Email: okewupeter@yahoo.com

Abstract

Euthanasia, the intentional ending of a person's life to relieve suffering, continues to be a subject of intense debate in contemporary society. This paper examines the ethical considerations surrounding euthanasia, exploring arguments for and against its legalization. Drawing on philosophical, legal, and medical perspectives, the study delves into the complexities of autonomy, beneficence, non-maleficence, and justice in the context of end-of-life decisions. Additionally, it discusses the role of cultural, religious, and societal factors in shaping attitudes towards euthanasia. Through a comprehensive analysis and from utilitarian perspective, euthanasia may be considered morally permissible if it maximizes overall well-being by relieving suffering. Thispaper aims to contribute to the ongoing discourse on euthanasia and gives insights into its ethical implications in modern society.

Keywords: Euthanasia, Ethics, Autonomy, Beneficence, Justice, Utilitarianism

Introduction

Euthanasia has been a hotly debated social question for many years. For many reasons people ask for assistance to end their lives. However, for a human being death is as certain as life, though most of the time there is an existential anxiety accompanying it. The spontaneous psychological fear of death is aggravated by the present state of practice and discussion on euthanasia, as the possibility of directly and indirectly killing people has come out in the open, even in certain countries with legal approval.The controversy on legalization of euthanasia widened to include lawyers, scientists including the general public. This implies that there have been many schools of thoughts formed in the past for and against euthanasia. For instance, in 1935 the first group that was for the legalization of euthanasia was formed by a group of doctors in London and was called the voluntary Euthanasia society. Another society was established in 1938 in the United States and was named the Hemlock society, with a purpose to support individuals' decision to die and to provide help when they were ready to die (Chackalackal, 2000).

In addition to the above concerning euthanasia,religious groups were as firm as ever. More especially in the wake of death with dignity campaigns, the congregation for the Doctrine of the faith issued a declaration on euthanasia which stated thatno one can in any way permit the killing of an innocent being, whether a foetus or embryo, an infant or an

adult, or an old person. Later on, John Paul II issued a philosophically consistent and broad-based defense of human life in his encyclical *Evangelium Vitae* in 1995 and asserted that the expression mercy killing is a misnomer and that in truth it is only mercy perverted (Paul II, 1995). The controversy about euthanasia centers on the moral permissibility of ending the life of a terminally ill- patient. Those who opt for euthanasia based their argument often on freedom and those who are against it base their argument on the value of life.

Euthanasia: Its Meaning and Etymology

The etymology of euthanasia helps to reveal the meaning of the term. Like most upstanding and respectable philosophical terms, euthanasia has its roots in Ancient Greek language; it is based on a combination of the terms *eu* meaning well and *thanatos* meaning death, referring to the deliberate ending of a person's life to alleviate suffering (Richards, 2009). While some view euthanasia as a compassionate response to terminal illness and unbearable pain, others argue that it raises profound ethical questions about the value of human life, the role of healthcare professionals, and the sanctity of life. In contemporary society, euthanasia remains a highly contentious issue, with divergent perspectives influencing legal, medical, and moral frameworks. Euthanasia is thus the act of seeking to provide a good death for a person who otherwise might be faced with a much more unpleasant death — hence the term mercy killing (Daniel, 2018).

Ethical Perspectives on Euthanasia

Ethical debates surrounding euthanasia often revolve around fundamental principles such as autonomy, beneficence, non-maleficence, and justice. Proponents of euthanasia argue that individuals have the right to make autonomous decisions about their own lives, including the option to end suffering through euthanasia. From a utilitarian perspective, euthanasia may be considered morally permissible if it maximizes overall well-being by relieving suffering. Moreover, proponents emphasize the importance of respecting patients' wishes and providing them with dignity and compassion in their final moments.

On the other hand, opponents of euthanasia raise concerns about the potential for abuse, coercion, and the devaluation of human life. They argue that legalizing euthanasia could undermine the sanctity of life and erode trust in the medical profession. From a deontological standpoint, euthanasia may be seen as a violation of the principle of non-maleficence, which prohibits harm to others, including the intentional ending of life. Additionally, opponents question the reliability of informed consent in end-of-life decisions, particularly in cases of vulnerable populations such as the elderly or disabled.

Legal and Medical Perspectives

The legal status of euthanasia varies across countries and jurisdictions, reflecting diverse cultural, religious, and ethical beliefs. Some countries, such as the Netherlands, Belgium, and Canada, have legalized euthanasia under strict regulatory frameworks, allowing patients to request assistance in dying under specific circumstances. In contrast, many

other countries maintain prohibitions on euthanasia, viewing it as incompatible with the principles of medical ethics and societal values.From a medical standpoint, healthcare professionals grapple with ethical dilemmas when faced with requests for euthanasia. While the primary goal of medicine is to alleviate suffering and promote well-being, the role of physicians in facilitating death remains ethically fraught. Medical associations and regulatory bodies provide guidance on end-of-life care, emphasizing the importance of palliative care, symptom management, and open communication with patients and their families (Gordon, 2005). However, navigating the intersection of medical ethics, patient autonomy, and legal obligations can be challenging for healthcare providers.

Cultural and Societal Influences

Cultural and societal attitudes towards euthanasia are shaped by myriads of factors, including religious beliefs, historical experiences, and public discourse. In some cultures, euthanasia may be viewed as a compassionate act of mercy, while in others; it may be condemned as morally reprehensible. Religious traditions often play a significant role in shaping perspectives on the notions of death and dying, with interpretations of sacred texts informing ethical stances on euthanasia.Moreover, societal debates and media representations contribute to the polarization of opinions on euthanasia, with emotive narratives highlighting individual cases and ethical dilemmas. Public opinion polls consistently show varying levels of support for euthanasia, reflecting the complexity of attitudes towards end-of-life decision-making.

Types of Euthanasia

There are different ways to categorize the various types of euthanasia and it is critical to be confident and familiar with these categorizations.

Voluntary Euthanasia

Voluntary euthanasia occurs when a person makes his own choice to have his life terminated in order to avoid future suffering. Active voluntary Euthanasia is a deliberate intervention, by someone whose life is at stake, solely intended to his own life. (Chackalackal, 2000).

Non-Voluntary Euthanasia

Non-voluntary euthanasia occurs when a decision regarding premature and merciful death is made by another person, because the individual to be euthanized is unable to make a decision for himself. This form of euthanasia is most commonly associated with young infants or patients in a coma, who cannot, due to the nature of their age or condition, make any decision for themselves (Gordon, 2005).The above offers a differentiation of types of euthanasia in terms of the person making the decision. In addition, we can differentiate between types of euthanasia based on the *method* involved in ending a life.

Active Euthanasia

If a person is actively euthanized it means that his/her death was caused by external intervention rather than natural causes, most likely through a lethal injection or the voluntary swallowing of a deadly cocktail of drugs.

Passive Euthanasia

Passive euthanasia occurs when a person is allowed to die due to the deliberate withdrawal of treatment that might keep him alive. Thus, a person who is passively euthanized is allowed to die via natural causes even though methods to keep them alive might be available. A person who has a life-support machine switched off, for example, dies via natural causes but only as a result of a decision to allow natural causes to take effect (Varga, 1984). Although euthanasia that is both voluntary and passive is not particularly common, euthanasia could come in any combination of methods and decision makers as laid out.

Arguments in favour of Euthanasia

It can be argued that voluntary active euthanasia is ethically justifiable. If a patient is competent, autonomy dictates that he should have the right to choose when and how he will die. In addition, the principle of justice asserts that it is unjust to deny anypatient the opportunity to end his or her pain.

1) The argument of poor quality of life. Those who advocate euthanasia and physician-assisted suicide argue that in some circumstances living is worse than dying, that the pain and suffering caused by a terminal disease may make life so agonizing and unbearable that death may seem "an act of humanity" and physician-assisted suicide a way to die with dignity (Richards, 2009). The physician will act under the principle of beneficence to relieve the pain and suffering of terminally ill patients. For the dying patient, suffering may go far beyond pain. This includes: progressive loss of activity, mobility and freedom, increasing helplessness and dependence on others, physical discomforts such as nausea, inability to swallow or talk, fear of dying, incontinence, weakness, loss of dignity, and dementia. Life loses all quality and meaning to the point that death is preferable.

2) Respect for autonomous persons demands recognition of their right to decide how they will live their lives. This includes the dying process, the ability to choose one's own destiny. We have the right to avoid intolerable suffering and exert control over the way we die. Some authors believe there is a right to commit suicide and, therefore, to be free of unreasonable restrictions on the means by which one can exercise this right. Battin has argued that there is an unequally distributed, but fundamental, right to suicide which we have because it can be constitutive of human dignity, at least in a negative sense, when life becomes unbearable (Sharon, 1990). The patient's right to self-determination has been a most central argument in favour of physician-assisted suicide. Often it is assumed, without argument, that this implies a patient's right to request another agent to intervene so as to bring about his or her death. Even with adequate palliative care there are cases in which it is not possible to avoid the suffering (Michael, 1990).

3) The principle of beneficence, compassion with the suffering. This has been used as an argument in favour of euthanasia. In this way, · euthanasia is considered a virtuous act. The non-abandonment of the patient has been part of the traditional care provided by physicians. Physician assisted suicide must be judged in light of this ethical principle of non abandonment (Michael, 1990)
4. The distinction between passive and active euthanasia has been criticized for dependence on problematic conceptions of causation and on the belief that the sheer difference between killing and letting die is morally relevant. From the patient's point of view, discontinuing life support measures and active voluntary euthanasia are similar in that the fundamental desire is for an earlier and more comfortable death. The intention is morally irrelevant in the evaluation of the morality of the action. They are also similar morally in that both are done with the intent of ending life (Daniel, 2018).
In the case in which discontinuing supportive measures and allowing the patient to die produces days or weeks of extreme discomfort, active euthanasia seems to be morally preferable. For some, discontinuing a ventilator cannot be considered a refusal of treatment, but a request to be killed. For Patrick Hopkins there is no metaphysical, essential, and intrinsic moral difference between machines and natural bodily organs, so that omitting treatment is a form of killing since we deprive the person of an organ that can only function with the aid of a machine or medical technology and that we need to set aside our prejudices against the artificial, and extend the option of good killing (active euthanasia) to those trapped by nature. If our society recognizes that life can be sufficiently burdensome on life-sustaining treatments, such as a respirator or dialysis machine, and that this medical intervention can be withdrawn or withheld (what some call passive euthanasia), then it can be sufficiently burdensome to justify active euthanasia (Michael, 1990).
5) The principle of double effect is a form of active euthanasia. Physicians are allowed to give increasing doses of narcotics when there is a severe pain or, it is presumed, with the knowledge that these drugs depress respiration and could hasten death.
6. John Hardwig has argued that when modern medicine allows us to survive far longer than we can take care of ourselves, there is a duty or responsibility to die in consideration of our loved ones, so as not to impose crushing burdens on them. In a time when total medical funding is restricted and being continually reduced, it may not be ethical to engage in extremely expensive treatment of terminally ill people (Chackalackal, 2000, 32).

Responses to the Arguments

1) Quality of life issues are confused with the value that the quality of life has. Quality of life issues have a strong subjective component. Very easily the health care professional will substitute his/her quality of life standard for that of the patient. Human life has an intrinsic value. Good health cannot give dignity to human life because health does not

possess life in itself, rather it participates in life. The dignity of the person cannot be erased by illness. Rather, loss of dignity is imputed to the patient by reactions of caregivers and family to the patient's plight or appearance (BMJ, 2005).

2) The terminally ill patient is in an extremely vulnerable position, so that his/her autonomy is diminished, suffering from depression, anxiety, fear, dejection, rejection, and/or guilt. Under these conditions, it is very difficult to have a clear conscience and some will almost blindly follow the suggestions of a physician. To bring about death by euthanasia is not within the competence of the medical profession. Physician-assisted suicide is not consistent with the doctor's pledge to heal and treat. Physician-assisted suicide is against the traditional ethical codes (Hippocratic, World Health Association).

It will lead to distrust in physicians. Furthermore, we do not have a right to commit suicide, for the simple reason that life does not belong completely to us. No one can say that he/she has given life to himself/herself. Recently in two unanimous decisions, the Supreme Court of the United States declined to constitutionalize the right to death with dignity. In these, the plaintiffs contended that the statutes violated their patients' Fourteenth Amendment "liberty interest," so that there is a constitutionally recognized right to die that outweighs the state's interest in preventing suicide by "terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians." Not all intimate choices about one's life qualify as protected rights (Hippocratic, World Health Association).

3) The compassion that is talked about by the proponents of euthanasia reflects a distorted view. True compassion does not eliminate the sufferer, but seeks to relieve the cause of the suffering. Otherwise, the life of the patient is devalued. Besides, compassion is a spiritual quality, which means "suffering with," to be presented to the sufferer. It is not a principle or a self-justifying reason (BMJ, 2005).

4. There is a special relationship between the doctor and patient. An omission of an act, if it brings about harm, may bring legal liability. If a competent patient refuses consent to treatment or continued treatment, the legal effect is that the physician is absolved from his or her duty by the patient. The physician terminates the treatment, but the subsequent death is caused by the underlying disease which the physician no longer has authority to treat. The physician is not killing the patient but letting him die. Ordinarily no one is under a duty to help a neighbour, such omissions to act bring no liability.

We cannot forbid the voluntary acceptance of a death which medical intervention can only postpone. What is forbidden is unlawful killing. Often in the dialogue there is confusion between passive euthanasia and euthanasia by omission. The latter brings legal liability but the former does not since natural deaths are not killing and thus are neither illegal nor immoral and do not confer responsibility. In this sense, it will be helpful if the term passive euthanasia is avoided while we retain the qualification of euthanasia by

omission, which implies a negligent act. An example that intention has its place in moral life is that when the person does not die after removal of the treatment, the person is left alive. This is not satisfied by assisted suicide. It is one thing to desire death and bring this about actively, and another to desire death and allow it to occur. It is one thing to respect the will of the patient to reject treatment and another to take his life. It is not merely a psychological difference, but also a moral one. To allow someone to die of a disease for which we are not responsible and cannot cure is to allow the disease to be the cause of death. The intention of allowing one to die is compassion and not death, while the intention of active euthanasia is death as a means for compassion.

5. Optimal palliative care could provide adequate pain relief for most terminally ill patients. Inpatient hospice units provide an example of supportive measures at the end of life with comfort care rendering superfluous any consideration of physician-assisted suicide. To legalize physician-assisted suicide would divert attention away from pain relief and palliative care. The easy road for the health care professional is to be free from frustration, hostility and anguish that come from hopeless cases. The issue of hastening death with palliative care interventions for terminally ill patients is accepted as ethical and legal, provided the intention of the physician is to relieve pain and other symptoms and not to hasten death. A disproportionate sedation can cause interruption of feeding and hydration of the patient, who will die of hunger or thirst in a state of unconsciousness, or will die of overdose. In this case, euthanasia can be hidden and is affected by an omission that leads to the patient's death by hunger. Ethically, the physician must look for pain relief that will carry less risk and still free the patient from unnecessary suffering.

6) To allow physician-assisted suicide would leave an impact on other sufferers who are ill, aged, or weak. This would devalue their lives and they may undergo assisted suicide under pressure. Further pressure is exercised if there are economical constraints. This undermines the call to generosity to those who surround the patient, who must free the patient from extra pressures.

Ethical Theory in Relation to Euthanasia: Utilitarian Approach
Utilitarianism a version of consequentialism defines morality in term of maximization of happiness of the greatest number of people. In other words, it is an ethical theory based on the principle of utility, the principle of the greatest good or the principle of the greatest happiness (Omoregbe, 1993).

According to utilitarianism, utility is the moral standard; it is the criterion or yard stick with which good actions are distinguished from bad actions. By utility, the utilitarian means pleasure or happiness. For them by implication there is nothing that is in itself right or wrong. Thus, killing or dying is wrong only when it leads to bad consequence, and it can be good if it leads to good consequences. So, saving a life can only be good if it leads to good consequence.
According to F.M Kamn, it is permissible to treat someone in his best interest though we

foresee that this treatment will rapidly cause death, it is permissible to kill or assist in killing someone intending his/ her death when this is in his/her best interest (Chackalackal 2000). So, for the utilitarian death or killing per se has moral worth if and only if it leads to better consequences for the greatest number.

James Rachels, a prominent Utilitarian posited thus if we have decided that euthanasia, even passive euthanasia is desirable in a given case, then we have decided that in this instance death is no greater an evil than the patient's continued existence. There is nothing wrong with being the cause of someone's death if his death is all things considered a good thing. And if his death is not a good thing, then no form of euthanasia, active or passive is justified (Rachals, 1986).

In conclusion, Utilitarian analysis places at the forefront the question whether the particular person will be better off alive or dead and whether others will be better off with him alive or dead. From this standpoint, Peter Saunders analyses the worth of human life thus, man is nothing but the product of matter, chance and time in a godless universe, nothing but a highly specialized animal. The value of an individual human being is determined by his level of rationality, self consciousness, physical attributes or capacity for relationship. Human life that has less of these qualities is of less value and can be disposed of (Sander, 2024).

Conclusion

As already pointed out earlier, it is very doubtful whether there can ever be common ground between the proponents and opponents of such a controversial moral issue as euthanasia. The utilitarian argues for the maximum good of the majority, but the question can be raised how do we calculate the greatest good for the greatest number of people? Ethical egoism, another school of thought values a group as the same as individuals. By implication there is nothing like majority here. In addition, accepting the position of the utilitarian then we can infer that not only euthanasia is permitted, but also it would thereby licence all sort of killing in so far as will benefit the majority.

The contemporary situation attests to the fact that there are many moral theories that may conflict with one another. As earlier emphasized, those who argue for euthanasia generally lay emphasis on the question of humanness. And this humanitarian appeal is often conjoined with an appeal to the primacy of individual freedom. Thus, they stand by those two following arguments: Firstly, it is cruel and inhuman to refuse the plea of a terminally ill person that his or her life be mercifully ended in order to avoid future suffering and indignity (T.A Mappes & J.S Zembaty, 1981).

Secondly individual should be free to do as they choose as long as their actions do not result in harm to others. That is since no one is harmed by terminally ill patients undergoing euthanasia; their freedom to have their lives ended in this fashion should not be infringed. While for Kant one cannot kill in the name of freedom because it is freedom

that makes one responsible. For Kant killing is against the universal principle of humanity. This implies that man who is rational and moral should follow the dictates of good actions as stipulated by moral law. It will be something irrational for men to start killing each other in any form. Euthanasia continues to provoke intense ethical controversies in contemporary society, touching upon fundamental questions about autonomy, beneficence, non-maleficence, and justice. As medical technology advances and populations age, the discourse on euthanasia is likely to evolve, with shifting legal and ethical landscapes. It is essential for policymakers, healthcare professionals, and the public to engage in nuanced discussions that respect diverse perspectives and uphold the principles of compassion, dignity, and respect for human life.

References

Beauchamp, T. L., & Childress, J. F. (2019),*Principles of biomedical Ethics (8th ed.).*Oxford: Oxford University Press.

Chackalack al, S. (2000),Euthanasia*: An appraisal of the controversy over Death,* Bangalore: Dharmaran publication.

Daniels, R. B. R. M(2018), Euthanasia *and Assisted Suicide: Lessons from Belgium*, Cambridge: Cambridge University Press.
Gordon M.R (2005) *Euthanasia: A Reference Handbook*, Santa Barbara: ABC-CLIO

Keown, J. (2002), Euthanasia*, Ethics, and Public Policy: An argument against Legalization.*Cambridge: Cambridge University Press.

Mappes T.A. & J.S Zembaty, (1981), *Bioethics*, New York: Mc Graw Hill Company.

Michael, M. (1990) *Euthanasia and Physician Assisted Suicide*, New York: Paulist press.

Omoregbe, J.(1993), *Ethics: A Systematic and Historical Study*, Lagos: Joja Educational Research and Publishers Ltd.

Paul J. II, (1995), *Evangelium Vitae*, Rome: City publication.

Rachels, J. (1986), *The End of Life: Euthanasia and Morality*, Oxford: Oxford university press.

Richard H. K., (2009), *The Right to Die: Understanding Euthanasia*, Westport: Greenwood Publishing Group