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Examining the Ethical Dimensions of Euthanasia: A Comprehensive Analysis

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Abstract: ***The Greek terms eu and thanatos, which indicate good death or a gentle and easy dying, are the roots of the English word "euthanasia." But if euthanasia is defined in this way, cases that are not actually euthanasia can be classified as such because a murderer can likewise kill anyone for no reason at all in order to further his own goals. Therefore, it may be claimed that euthanasia can be used for people who have a terminal illness that cannot be treated, whose suffering is hidden from his loved ones and makes it difficult for him to survive. It is beneficial for someone who constantly believes that dying would be preferable to experiencing such awful suffering. In this case, euthanasia is used, in which the patient's life is ended with the assistance of a doctor and with the patient's and his family's consent. Is euthanasia actually acceptable at this point? No, instead, someone could abuse it to further his or her own selfish ends by exploiting the chance for human relief. That is to say, one can misuse euthanasia or use it to his or her own delight with the aid of the law. This essay aims to demonstrate if euthanasia is truly a question of relief or murder covered up as relief. Additionally, someone might believe that we do not have the authority to take a life that we are unable to save.***

Key words: Medical Ethics, Euthanasia, Active Euthanasia, Passive Euthanasia, Morality

Modern medicine has made significant progress in life preservation and extension. However, modern developments have made it more difficult to treat those whose lives have been considered to be worthless due to a lack of hope for improvement. Euthanasia is a choice for certain people who have incurable conditions or unbearable pain. It is seen as a means of ending unavoidable misery or taking back control of one's death from technology that extends life. Euthanasia, according to the Medical Dictionary for Lawyers, is the "act or practice...of putting persons to death painlessly who are suffering from incurable or malignant diseases, as an act of mercy"[1]. Euthanasia comes in four flavours: involuntary, passive, consenting, and active. Active euthanasia includes the administration of a fatal medication. One characteristic of passive euthanasia is the denial of life-sustaining treatment or sustenance. Voluntary euthanasia is the practise of a patient choosing to discontinue receiving care or end his or her life. Among them is reasonable suicide. It characterises the decision to commit suicide made by a mentally competent individual who has reasoned out their options and whose peer group is aware of their intentions. Involuntary euthanasia is the term for the compassionate killing of someone without their permission.

In the Greek language, euthanasia was originally called "good dying" (eu thanatos). Around 400 BC, Greek and Roman philosophers and historians first used the phrase to refer to a sudden death that is free from excruciating pain. The act of hastening a patient's death or alleviating their pain using medical or non-medical means was not known as "euthanasia." However, such a course of action cannot have been unusual in antiquity given that the so-called Hippocratic oath clearly barred helping in a patient's suicide. Everyone who took this pledge vowed not to prescribe any lethal medication or offer any lethal advice. The concept's importance in modern culture has changed substantially. Even while the phrase's original meaning of "good dying" has been preserved, it now refers to someone else supporting the dying person throughout their final days rather than the effectiveness of the dying process itself. Francis Bacon was the first to draw a distinction between two categories of assistance that, in his view, a dying patient is entitled to: external euthanasia, "whereby the dying may pass more easily and quietly out of life," and euthanasia interior, the "spiritual preparation of the soul" for death[2]. According to Bacon, the priest's preparation that was entirely spiritual was insufficient.

Decisions about euthanasia are particularly difficult in the realm of bioethics because they require addressing a painful fact that everyone must eventually face, frequently unwillingly: death. However, I will concentrate on examples where patients are terminally ill because these situations plainly include individuals who have given their consent to end their lives. The fundamental argument against a patient's desire to end their life is that, on general, people detest dying. Things become considerably more difficult when a hospital is involved because one of its many goals is to actually stop people from dying. This is another argument

[1] McCrary, S. and J. Botkin. (1960). Medical Dictionary for Lawyers (3rd ed.), p.287.
[2] Bacon, Francis. (1961). The Works of Francis Bacon, Vol.9, Fromman Publishers.

against euthanasia, both active and passive. While analysing a specific bioethical situation, it is crucial to recognise the four core bioethical principles of autonomy, beneficence, non-maleficence, and justice. Although some of these four principles are more crucial than others depending on the circumstance, they are all necessary for understanding an issue and developing a solution. Although changeable, the principles provide a general structure. Autonomy and beneficence are the bioethical principles that are most relevant in the biomedical discussion of euthanasia for terminally ill, voluntary patients. The distinction between active and passive euthanasia actually reduces the patient's autonomy because it labels the agent as external rather than the patient acting as the agent. I make two claims: (1) Both active and passive euthanasia are morally acceptable because patients can exercise their autonomy by having this choice.

The richness of literature that explores the many elements of euthanasia has been written by many authors, including academics, laypeople, medical professionals, and legal experts. supporters of euthanasia Supporters of active voluntary euthanasia argue that it is morally necessary to respect a patient's choice to end their life in the event of a terminal illness, excruciating pain, or irreparable suffering. "Heroic" or unusual medical techniques that prolong life and intensify misery are associated with being dehumanising and indecent, neglecting human suffering, "quality of life," which is regarded as a legitimate consideration in making decisions and shouldn't be sacrificed in favour of the quantitative preservation of life as an absolute value[3]. Since passive euthanasia still necessitates some level of activity, many proponents of euthanasia claim that the distinction between the two is misleading. In particular, an act of omission and an act of commission are comparable since they share the same aim and result. Nevertheless, according to Rachels, the distinction is crucial to medical ethics. Withholding treatment and allowing a patient to die may be appropriate in some situations, but actually killing a patient is never acceptable. The problem is that "allowing to die" can be a drawn-out and uncomfortable process. The removal of a breathing tube, in Rachels' opinion, will cause suffocation, a horrific situation that is less forgiving than an instantaneous, painless lethal injection[4]. According to Dutch physician Peter Admiraal, "the only thing passive about passive euthanasia, is the physician' - there is no ethical difference between not initiating life support and a lethal injection"[5].

Some opponents of euthanasia support killing in other situations. The death sentence, self-defense, and compassion killing are three instances where murder may be justified, according to the British Medical Association (BMA). The BMA does not consider mercy killing to be part of end-of-life care. Instead, mercy killing is employed during warfare, such as when a soldier is killed to prevent being kidnapped and exposed to horrifying enemy torture[6]. According to some, doctors should make a distinction between stopping a patient's therapy and actively taking their life because doing otherwise would violate the moral rule that "doctors must not kill." It is widely believed that if doctors were seen as both "healers" and "killers" in the doctor-patient interaction, which inherently entails an imbalance of power, patients' trust in them would be severely weakened. Additional arguments against voluntary euthanasia focus on the results of its legalisation. The "slippery slope" theory contends that the legalisation of active involuntary euthanasia will unavoidably follow the legalisation of voluntary euthanasia. Those who employ the "slippery slope" defence typically bring up the Nazi euthanasia project.

Any ethical justification for favouring or opposing euthanasia is complicated by the fact that death is generally seen as "bad" in society. While considering euthanasia as a way to end a life, it's important to hold back any associated feelings, even though they might make the situation more complicated. As a result, I've decided to use a deontological framework to argue for its moral acceptability. As Vaughn put it, "Deontological theories say that the rightness of actions is determined not solely by their consequences but partly or entirely by their intrinsic nature"[7]. According to deontology, fulfilling one's moral obligations is necessary for moral behaviour. I'll employ a patient-centered deontological ethical framework in this case because the nature of these euthanasia cases depends on the patient's agreement. The patient-center deontology theory is rights-based rather than duty-based, but it is deontological in the sense that one must look at the act itself, not its repercussions, to determine whether it is morally correct. The autonomy principle of Immanuel Kant can be used to argue that a person should never be treated as merely a tool for another person's ends. It is against human nature for someone to use another person for their own gain. Kant's concept of autonomy can help and be used to handle any bioethical difficulties, especially euthanasia. According to Vaughn, Kant's principle of respect for persons comprises the following: never treating a person as a mere means; admitting that people have intrinsic value as opposed to value that is conferred upon them; and the intrinsic value of humans, "derives from their nature as free, rational beings capable of directing their own lives, determining their own ends, and decreeing their own rules by which to live"[8]. Even though Kant would

[3] Law Reform Commission of Canada (1982) Euthanasia, Aiding Suicide and Cessation of Treatment, working paper 28 (Ottawa: Ministry of Supply and Services.
[4] Rachels, J. (1975) 'Active and Passive Euthanasia,' New England Journal of Medicine, 292:2:78-80.
[5] Douglas, T. (1990, April 21) 'Euthanasia is a Rubik's Cube,' The Vancouver Sun, p.C11
[6] British Columbia Royal Commission on Health Care and Costs (1991) Closer To Home (Victoria: Crown Publications)
[7] Vaughn, Lewis. Bioethics: Principles, Issues, and Cases. 2nd ed. New York: Oxford University Press, 2013. 35.
[8] Vaughn, Lewis. Bioethics: Principles, Issues, and Cases. 2nd ed. New York: Oxford University Press, 2013. 38. Print.

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contend that euthanasia is morally wrong, when the patient has given consent, it is ethically acceptable. This is as a result of his autonomy principle. Thus, distinguishing between passive and aggressive euthanasia lessens patient autonomy.

I am not passing moral judgement on whether death is a noun or an adjective since I do not believe that euthanasia's moral acceptability depends on that distinction. The morality of the euthanasia acts I am investigating originates from the individual performing the action. According to James Rachels, there is no visible difference between active and passive euthanasia, hence making the distinction between their moral acceptability is pointless. As a result, in accordance with the conventional viewpoint, decisions regarding life and death are made on an individual basis "irrelevant grounds"[9]. He asserted that murdering is not always worse than letting someone go in cases where euthanasia—either active or passive—is preferred. Because they think that killing is wrong, many people think there is a moral difference between these two types of euthanasia. He gave the example of two men, one of whom drowns a child while the other two watch the child drown and die. According to Rachels, there is no difference between acting and not acting because a dead child will still be the result. He also said that active euthanasia would be preferable in circumstances where the decision has been taken to stop protracted suffering since it averts the severe and agonising anguish that would follow letting someone go.

Even while this has nothing to do with my contention that autonomy is a legitimate justification for euthanasia, it's crucial to emphasise that passive euthanasia can sometimes be more painful than aggressive euthanasia. The belief that passive euthanasia is morally preferable to active euthanasia is also supported by the legal system. In order to show that the distinction between active and passive euthanasia is unpersuasive, I will make use of Rachels' defence. Both active and passive euthanasia include an action when a patient deontological ethical framework is being used, according to Rachel, hence the agent is what should be investigated to determine whether euthanasia is morally acceptable. A doctor may choose to halt all further treatment or provide a pharmaceutical cocktail as a method of death as the necessary step for euthanasia. One could claim that the physician who carries out one of these procedures does so on behalf of euthanasia. The patient's choice to choose euthanasia is respected, but it loses some of its power when the doctor is revealed as the agent. The patient's decision to end their life serves as the agent because euthanasia would not be possible without it. As a result, even if the doctor administering the medication may be the actual agent and face bodily responsibility, the patient and their decision over how to pass away are the true agents. The key factors for moral acceptability are the decision itself and the person who makes it, not the physical momentum of carrying out the deed.

According to the autonomy principle, euthanasia is morally acceptable. However, I also believe that the distinction made by bioethical societies is incorrect for the same reason. The autonomy of the patient is diminished when someone asserts that there is a difference between active and passive euthanasia since this distinction implies that euthanasia is brought on by an outside force while, in reality, the patient is choosing to employ euthanasia on their own. By limiting a patient's autonomy, we diminish their value as a person, prohibit them from acting as an end in themselves, and prevent them from acting as a free and reasonable human being. Additionally, "active" and "passive" convey distinct expectations for the act itself as a method of death: "active" denotes action, while "passive" denotes inaction. This is incorrect, according to Rachels. Even if both types are acts in and of themselves, there is an issue with these particular terminology because inherent values are associated with them. It is analogous to saying that one may create death by acting or not acting, which could result in the doctor having the power of a deity regulating death. In light of this contradiction, euthanasia is stigmatised as immoral. The comparison also implies that, despite the fact that situations are frequently complex, people frequently view euthanasia as either violent or peaceful.

Despite the fact that there are many broad objections to my thesis that are founded on theological or teleological grounds, in my opinion, the most important portion of my article would be to address the issue of striking a balance between the autonomy of the patient and the beneficence of the doctor. The issue is how to reconcile the fact that patient autonomy takes precedence over the doctor's judgement in euthanasia situations if the doctor does not want to be the one to give the patient permission to employ euthanasia. Is it morally right to give a doctor a specified task to complete only because the patient's autonomy is valued? The best way to tackle this issue, in my opinion, is to start by asserting that a doctor should never be required by law to advocate euthanasia in a hospital. If a doctor vehemently objects to it, I don't believe they should be forced to give their patients the choice of active or passive euthanasia. Instead, the emphasis of my argument is that, if a patient elects to commit suicide through this approach, the doctor ought to be present to support rather than block the process out of personal motives.

Therefore, the doctor can continue to uphold the ideal of beneficence in their profession regardless of how they define beneficence. If they respect patient liberty and provide euthanasia as a viable alternative, they are upholding the beneficent principle by really meeting the needs of their patient. If a patient has received all available information, as is the doctor's duty, and the

[9] James Rachels "Active and Passive Euthanasia" in Vaughn, Lewis Bioethics: Principles, Issues, and Cases, 2nd Edition. New York: Oxford University Press, 2010. 649-652. Print

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potential outcomes of the medical plan have been explained, it is not the doctor's job to prescribe a course of action for them. Kant thought it was paternalistic for a doctor to dictate what they thought was best for the patient. While the doctor's freedom is unaffected because it is debatably his obligation to defend patient autonomy, this disrespects the patient and restricts their freedom. The doctor should ultimately uphold the patient's autonomy despite making a proposal. Because doctors lack the tools to measure suffering and the justifications for evaluating a patient's motivations for using euthanasia, they can never truly know what is best for the patient when they are consenting adults; it is therefore extremely unreasonable to justify imposing their judgements on the patient.

Euthanasia is a very divisive and difficult issue to resolve when a multitude of factors are at play in each particular circumstance. Euthanasia, on the other hand, seems to be the most sane option for a patient who has decided to end their lives since it actually allows them the chance to act in the way they believe is most logical. In cases where a patient is terminally ill and wanting to be put to death, the autonomy principle is the most important one. This is because the nature of these circumstances makes it difficult for anyone outside of the patient's family to know what is best for them, and as a result, they have no right to impose their views on a patient. Instead, these circumstances merely highlight internal, autonomous motivations for doing what is best for oneself and exercising one's independence. Deontology, and particularly patient-centered deontology, is the best ethical framework for evaluating the moral acceptability of euthanasia because it relies on patient autonomy and bases choices on the act and agent themselves rather than the consequences. I used James Rachels' position that there is no distinction between active and passive euthanasia because they both entail an action to argue that the agent of the action is what should be investigated to assist assess the moral acceptability of euthanasia. I claimed that by treating the agent as external rather than the patient acting as the agent, the distinction between active and passive euthanasia actually reduces the autonomy of the patient. I got to the conclusion that autonomy is the real agent, and that is what convinces us that both are morally acceptable.

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