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Analysis of Contemporary Issues Related to Euthanasia

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Abstract
This argument will demonstrate that the dispute over end of life choice is primarily driven by those who priorities quality of life considerations versus that of others who maintain that the risk of falling prey to slippery slope abuses is too great. Although it is argued here that non-voluntary euthanasia and involuntary euthanasia are risk laden and presumptuous practices, it is reasonable to suggest that the right to escape a demoralizing and futile terminal existence via active voluntary euthanasia ultimately honors' the right principle of life as patient initiated choice and dignity are mutually reinforcing ideals. Right to die advocates have also been criticized for portraying euthanasia in an unduly idealistic light as any process of dissolution purportedly entails some measure of indignity. While the exclusion of futile or burdensome extraordinary medical measures is motivated by quality of life considerations, calls for an AVE option in the face of intolerable terminal pain and suffering are clearly an extension of this same principle. The Oxford Textbook of Palliative Medicine's admission that "certain types of pain are invariably difficult to manage and a small percentage may be intractable to all treatment" has, however, been tempered by palliative care practitioner Professor Peter Ravenscroft who insists that the level of distress can generally be brought to a point that the patient "can live with".

Keywords: Terminal Pain, Voluntary Euthanasia, Palliative Medicine's, Autonomous Demise

Introduction
This discussion will demonstrate that the dispute over end of life choice is primarily driven by those who priorities quality of life considerations versus that of others who maintain that the risk of falling prey to slippery slope abuses is too great. Although it will be argued here that AVE is a necessary last resort option in cases of intolerable terminal suffering, the tendency of reform advocates to downplay slippery slope concerns will, nevertheless, be challenged on grounds that State sanctioned euthanasia could have potentially significant welfare ramifications for all vulnerable patients. In addition to the claim that a slippery slope risk assessment is an indispensable policy consideration, this discussion will also explore the dying experience and pain management dilemmas in the knowledge that these issues will have a bearing on subsequent chapters' political theory appraisal of the euthanasia reform debate.

The Sanctity of Life and Quality of Life Debate
Despite the fact that the Human Rights Declaration, the European Convention, and the International Covenant on Civil and Political Rights enshrine the notion that life is a value upon which all other ends (including individual rights) are reliant, contentions have arisen over claims that life is uniquely valuable irrespective of any external standard or condition. Although this intrinsic good (sanctity of life) ideal is central to the West's moral (Judeo-Christian) tradition, right to die advocates maintain that the value of life is not a given capacity for a "rational, purposeful" existence with "hopes, ambitions, preferences…purposes" and "ideals" are, according to Helga Kuhse, integral factors in ensuring that life is "a means to a further end". This quality of life argument has failed to convince more conservative Insist elements who that the sanctity of (innocent) life is an indispensable component of the good society. Others, such as Peter Singer, have alleged that

this assertion is based upon "fictions" and ethically unsustainable "outmoded views". In fact, James Rachels maintains that the traditional sanctity of life principle is "contrary to reason" because it "places too much value on human life" In the interests of minimizing needless suffering, it has been suggested by Singer that the traditional sanctity of life ethos must be relinquished in favour of a "more compassionate" and "responsive" end of life code. At the heart of this recommendation is a desire to temper rather than eliminate respect for life by accommodating indispensable quality of life considerations. While it has been argued that it is possible to determine if the quality of a patient's existence is negligible or non-existent, it is clearly preferable for competent patients to draw their own conclusions as third party quality of life assessments may misinterpret an individual's actual level of contentment.

The Dignity Argument

Although it is argued here that non-voluntary euthanasia and involuntary euthanasia are risk laden and presumptuous practices, it is reasonable to suggest that the right to escape a demoralizing and futile terminal existence via active voluntary euthanasia ultimately honors' the right principle of life as patient initiated choice and dignity are mutually reinforcing ideals. Critics have counter-argued, however, that an honorable death need not necessitate an autonomous demise as even the most traumatic dying process provides an opportunity for expressions of courage and resolve. Right to die advocates have also been criticized for portraying euthanasia in an unduly idealistic light as any process of dissolution purportedly entails some measure of indignity.

The Extraordinary Measures Issue

John Keown maintains that AVE reform opponents are not without discretion as they generally accept that life is not the "highest good" upon which "all…other basic goods must be sacrificed in order to ensure its preservation". The Catholic Church's Declaration on Euthanasia is an exemplary case in point, as it acknowledges that any medical undertaking which promises only to "secure a precarious and burdensome prolongation of life" is to be avoided. The likelihood of a practitioner bringing to bear extraordinary lifesaving resources is further exacerbated amongst those who tend to view their patients as a medical challenge rather than as persons. Timothy E. Quill claims that Western medical training has inadvertently promoted this rationale, alleging that "the prolongation of life is given a much higher value than the lessening of human suffering", and that, "even in the care of the dying".

Pain Management Dilemmas

While the exclusion of futile or burdensome extraordinary medical measures is motivated by quality of life considerations, calls for an AVE option in the face of intolerable terminal pain and suffering are clearly an extension of this same principle. The Oxford Textbook of Palliative Medicine's admission that "certain types of pain are invariably difficult to manage and a small percentage may be intractable to all treatment" has, however, been tempered by palliative care practitioner Professor Peter Ravenscroft who insists that the level of distress can generally be brought to a point that the patient "can live with". In pursuit of that end, practitioners have long relied upon the potent pain killing properties of morphine. Whilst this potentially addictive analgesic may cause vomiting, constipation, and induce a stupor like state, its most important property is that recipients do not develop a resistance to its ameliorating impact upon severe pain. In cases where patients suffer a particularly adverse reaction to morphine, symptoms can often be alleviated with other medications or else an alternate pain-killer may be adopted. These contingency options should not, however, divert attention from the fact that around 5 per cent of terminal patients still experience unresolved pain despite targeted medical intervention. As a practicing physician, Charles McKhann has confirmed that some patients "suffer severely at the end of life" while fellow practitioner Timothy E. Quill agrees that patients can still experience "anguishing deaths" in spite of the "heroic efforts" of "skilled physicians, nurses, and family members".

US medical authorities have conceded that this is an ongoing problem, as only a minority of physicians practice 'state of the art' pain management techniques. The President of the Australian Association of Hospice and Palliative Care, Dr. Michael Smith, has similarly observed that "the level of knowledge and experience required to effectively manage the symptoms of people in such dire circumstances that Concerns about addiction and/or legal liability have undoubtedly contributed to a culture where some physicians are reluctant to provide adequate pain relief. Indeed, Timothy E. Quill maintains that physicians are "repeatedly warned" in medical school about "the dangers of over-sedation and addiction that can accompany the use of narcotic pain relievers".

The Doctrine of Double Effect

In some instances, medical practitioners respond to the most severe forms of (end of life) distress by placing patients in an unconscious (morphine induced) state. While it is conceded that terminal sedation does not eliminate a patient's pain it is deemed as a preferable approach to active euthanasia by Margaret Somerville because it avoids the allegedly "harmful impact of euthanasia on societal values and symbols". It would defy credibility however to assume that members of the public are unaware that this favoured terminal sedation process can degenerate into a farce, as sufficiently large dosages of morphine may induce a premature death via respiratory suppression. In order to minimise accusations of intentional 'double effect' demise, practitioners are traditionally advised to provide the lowest medication dosage required to ensure adequate pain relief, with higher dosages to be prescribed only if symptom relief is not achieved. As an added safeguard, it is recommended that any decision on medication should appear 'reasonable' to fellow practitioners and nursing staff. This interpretation remains difficult to defend, however, given that beneficence implies a commitment to act in the best interests of the patient who's incurable and intolerable terminal pain could be resolved by acceding to a last resort AVE request. While it is conceded that a patient's suffering can also be alleviated by a double effect remedy, Peter Singer has posed the obvious question "why any dying patient would prefer to be unconscious for a few days, and then die, rather than die straight away.

The Issue of Depression

The President of the Australian and New Zealand Society for Palliative Medicine, Professor Peter Ravenscroft, has attempted to discredit calls for an AVE alternative, having asserted that "existential problems" including a "loss of self-worth", feelings of "fear, guilt, anger, resentment and anxiety" This is, indeed, a significant factor in end of life care as the American Journal of Psychiatry has confirmed that the overwhelming majority of patients who seek a euthanasia termination are "suffering from a treatable mental illness" and "most commonly a depressive condition" Apart from this latter disorder's more obvious manifestations of gloominess and melancholy, depression can leave sufferers with an inability to find pleasure in relationships, a loss of appetite, fatigue, sleep disturbances, agitation, and recurring thoughts of death. The depressive state may also lower a patient's threshold to physical pain, making the challenge of palliation all the more difficult. While the provision of targeted treatment and a supportive social network has been credited with reversing as many as 85 per cent of euthanasia requests, one could argue that the remainder are either incapable of rational thought and in need of ongoing paternal oversight or alternatively, are justified in their appeal for last resort AVE. Questions have, nevertheless, been raised as to whether fallible practitioners can ever be sure that a dying patient who requests a termination is not suffering from a perception distorting depressive condition.

The Doctor–Patient Relationship

Despite arguments in support of strictly regulated AVE, the Hippocratic Oath's sanction against the killing of patients and the contemporary Declaration of Geneva's call for physicians to exhibit "the utmost respect for human life" has prompted counter-claims that the legalization of euthanasia would have a profoundly detrimental impact upon the doctor–patient relationship. In fact, the American Medical Association has declared that active euthanasia is "fundamentally incompatible with the physician's role as a healer", while the Australian Medical Association insists that "doctors should not be involved in interventions that have as their primary goal the ending of a person's life".

Conclusion

Whilst these statements are partly motivated by a desire to ensure that patient trust is preserved, it could be argued that the legalisation of strictly regulated voluntary euthanasia need not undermine the vast majority of patients' relationship with their physician. Although one recent (US) study indicated that 20 per cent of respondents felt that their level of trust in their physician would decline in a post-legalised AVE climate, this potentially misplaced loss of confidence is conceivably less significant than the threat of unresolved intolerable terminal pain Anti-AVE lobbyists have, nevertheless, persisted with claims that State sanctioned euthanasia could ultimately desensitize practitioners to the point where they behave in a callous or unethical fashion. It has been suggested that this problem is likely to be further exacerbated under circumstances where a physician is tempted to relieve themselves and/or others of a particularly difficult patient.

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