7

Everything Under Control: How and When to Die - A Critical Analysis of the Arguments for Euthanasia

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1. Introduction

The aim of this chapter is to provide an analytical overview of some of the arguments used in current discussions of euthanasia.[1] Before doing this, however, several introductory remarks are necessary. First, the scope of the topic will be defined, as not all discussions which are related to "euthanasia" interpreted in a very broad and unspecified sense will be included. The second remark concerns the semantics to which the term "euthanasia" in this chapter refers. The third remark will deal with the methodology applied in this study.

The debates about both the morality and legality of euthanasia have been a significant phenomenon of the last decades of the twentieth century and one can expect that they will remain a source of powerful controversies well into the twenty first century. Within these debates, euthanasia is often replaced by "(physician-)assisted dying" (Quill & Battin, 2004; Young, 2007), or extended to an "assisted death" (Lewis, 2007; Lewy, 2011), a broad term under which both euthanasia and assisted suicide are subsumed. The general term "assisted death" is not understood as euthanasia in the sense used both by legislation in the countries in which euthanasia has been legalized and by its debaters who use this quite precise notion of euthanasia. Finally the term "assisted death" is not conceived in the sense as the term "euthanasia" as being used in this article. The use of the broad notion of euthanasia leads to the fact that many diverse situations are discussed under the term "euthanasia". So John Keown identifies the problem when he notes that "much of the confusion which besets the contemporary euthanasia debate can be traced to an unfortunate imprecision in definition. Lack of clarity has hitherto helped to ensure that much of the debate has been frustrating and sterile." (Keown, 2002, p. 16). For its similarity with "assisted death", euthanasia is being frequently discussed within similar but distinct contexts such as assisted suicide, medical futility, life sustaining treatment and (other) end-of-life decisions (Bauer-Maglin

[1] The proposed title for this article was originally "Euthanasia *pro et contra*: Analytical synopsis of argumentations for and against euthanasia". Its aim was to provide a synoptic and comparative analysis of both types of arguments used for support or refusal of euthanasia. However it soon became clear that such an approach transcends the format of one book chapter. So instead of a very short analysis of all arguments for and against euthanasia, only five leading arguments *for* euthanasia have been critically scrutinized.

&Perry, 2010; Onwuteaka-Philipsen, 2003; van der Maas, 1991). It is obvious that the decisions in clinical medicine- both in palliative and intensive care- encompass a much broader spectrum than just the issue of euthanasia (Battin et al., 2007; Kinzbrunner & Policzer, 2010; Wanzer & Glenmullen, 2007; Wennberg, 1989). As such, if two people are discussing whether 'euthanasia' should be legalized or criminalized and by the same word they understand two quite different things, their discussion will be fruitless and meaningless; they will be addressing each other without being able to reach any common ground, instead developing two distinct monologues.

Although for euthanasia and assisted suicide the same or similar arguments can be used, for the purpose of this book it is held that euthanasia and assisted suicide are two diverse entities –from both a moral and legal point of view (Watts & Howell, 1992; Beech, 1995). Consequently in discussions on issues raised by those two concepts, two distinct notions should be used. To this effect, the debates on both assisted suicide and physician assisted suicide and the arguments used in this context will be not included in this chapter. The scope is demarked by the topic "euthanasia", although the same or similar arguments are used in assisted suicide debates as well.

Despite the fact that in some current debates taking place under the term "euthanasia", "assisted suicide" is discussed, "euthanasia" in this chapter is semantically understood not as a notion common for both "euthanasia" and "assisted suicide". The term "euthanasia" within this chapter means that one person brings about the death of another person because the first person believes that the life of the second person, who has asked for euthanasia, is so miserable that it would be better for him/her to be dead. More precisely, *A* kills *B* upon the request of *B* for the sake of *B*. The motive of *A,* who commits the act of euthanasia, is to benefit *B*. In contrast, assisted suicide is basically a suicide: *B* kills *B*; *A* is solely providing help, not taking the life of *B*. Albeit the help provided by *A* is an essential element in the death of *B* (*B* probably would be not able to kill him/her self without this help of *A*), *B* still has the possibility and freedom not to complete the act and not to kill him/her self. *B* remains the author and originator of his/her act even though his/her free volition may be diminished.

Thus the term euthanasia is here understood as a deliberate act of termination[2] of the life of *B* by *A* upon an explicit request of *B*. In addition to the benefit of *B*, a set of other criteria must be fulfilled so that one can use the term euthanasia in a precise sense: (a) person *B* must be suffering the terminal stage of an illness or undergoing unbearable suffering (the Rotterdam criterion for euthanasia); (b) person *B*, having an enduring, voluntary and competent wish to die, has expressed repeatedly this wish; (c) the act of euthanasia is performed by a physician. The last condition is naturally not a necessary condition – euthanasia can be conducted by anyone – however the fact that a physician is conducting euthanasia is of relevance as far as the medical profession is involved in the administration of euthanasia. The last condition is not often mentioned in the argumentations *pro et contra.* Since euthanasia in the countries where it has been decriminalized is administered by members of the medical profession, the participation of a physician in euthanasia is a relevant circumstance. The second condition introduced (competence) means that the term euthanasia is understood to refer to so-called "voluntary euthanasia", i.e. a competent person makes a voluntary request (the repetition of this request serves as a guarantee of the

[2] The term "termination of life" (instead of "killing") has been used as a neutral description, which is open to diverse value-laden interpretations, including "taking life", "killing" or "homicide".

consistent and authentic will of the person wishing to die). It would be counterproductive to set a framework for the analysis of arguments of euthanasia if such a term were to include various imprecisely specified forms of assistance in dying. Therefore, for the purpose of this chapter, the term "euthanasia" will refer to "active voluntary euthanasia". So-called "passive euthanasia" will not be included here in the term "euthanasia" even though one can repeatedly find such references in literature – fortunately less and less often. If euthanasia is defined in the above mentioned sense, then there is no point talking about "passive euthanasia". We should not mix "killing" (an active action) with "allowing to die" (the deliberate lack of application of treatment that would only increase suffering and prolong dying, but not involving administration of drugs which causes termination of life).[3] Thus to refer to "killing" (active euthanasia) and "allowing to die" (passive euthanasia) by the same word (euthanasia) is semantic nonsense. Provided the term "euthanasia" is used within the introduced semantic framework, euthanasia can only be active by nature.

The other two types of euthanasia, namely "non-voluntary euthanasia" and "involuntary euthanasia" are not *prima facie* included in the following argument survey; one of the main arguments for euthanasia (autonomy) would not be applicable to both types.[4] Non-voluntary euthanasia, the termination of the life of a non-competent person by someone other than that person or termination of the life of a person who is not able to express his/her will may be supported by a compassion argument, but not in conjunction with the autonomy argument. The question as to whether someone can authorize another person to make the decision about euthanasia on their behalf by making a request to be killed (the third person *C* is requesting euthanasia for person *B* and the physician *A* terminates the life of *B* upon request of *C* who has been authorized by *B*) is quite different from the question mentioned above (*B* requests euthanasia from *A* and *A* conducts euthanasia upon request of *B*). The issue of substituted judgement used in intensive care, where person *C,* as health care proxy, makes a decision for person *B* is quite different from the substituted judgement in the context of euthanasia for many reasons. First the rationale for the substituted judgement is to follow the authentic will of a non-competent person in health care and his/her individual (value-based) preferences regarding a particular treatment in the given clinical conditions as much as possible. Furthermore in intensive care a decision about treatment *has* to be made (one of the therapeutic options has to be decided upon and realized) in difference to non-voluntary euthanasia where there is not an objective necessity to conduct the act of euthanasia; *a fortiori* if the authentic will of the patient is not known. There is no imperative to follow the unknown will of the person in the case of euthanasia. In addition, in many cultural contexts, providing treatment (or either withdrawing or withholding treatment) in a non-competent patient is adopted not upon the request of one single person (health care proxy) but by all persons involved (i.e. relatives and the whole therapeutic team including nurses, psychologists, social workers and other non-medical staff).

So within the following analysis of arguments, the focus is on active voluntary euthanasia. All sub-forms such as euthanasia of minors (e.g. terminal stage of cancer in small

[3] The "passive action" of allowing to die can include not only passivity in the sense of diverse avoiding of treatment (e.g. withholding or withdrawing); it can also include "active actions" such as the psychological or spiritual accompaniment of a dying person or the support by those close to the patient.
[4] "Non-voluntary euthanasia" and "involuntary euthanasia" will be included mainly in the role of counter-argumentation.

children) or euthanasia of (extremely immature) newborn children with abnormalities has naturally to be discussed, however some of the arguments would have a different and modified form, taking into account the particular context (e.g. parents as decision-makers), but maintaining a certain congruence. A distinct argumentative framework would be appropriate for involuntary euthanasia, also for killing a person despite an explicit expression of his/her opposition towards euthanasia. Such a framework is not elaborated in this chapter.

The last introductory remark refers to the methodology of this chapter. During the last few decades several studies that (also) deal with the arguments concerning euthanasia have been published.[5] They provide a valuable source of diverse views on euthanasia. The majority of studies about euthanasia have been written as manifestos which serve to support one side of the controversy. They are often intended as tools to be used by either the opponents or by the proponents of euthanasia, being akin to instruction manuals or catechisms: if you are against/for euthanasia, therein are to be found the arguments you can use in debates to support your position. In difference to many monographs on the ethics of euthanasia, this text strives to provide a critical analysis of the arguments *for* euthanasia only. An analytical and comparative synopsis of both types of arguments remains beyond the scope of this chapter.

Various numbers of arguments for and against euthanasia are listed within current literature. Similarly, different categories of arguments are used in euthanasia debates - for instance arguments based on rights, philosophical arguments (the universality of moral rules vs. tolerable exceptions), practical approaches (regulation of euthanasia by law) or religious belief (only God can give and take life). It is practically impossible to list the arguments for euthanasia as pure arguments *for* euthanasia, while at the same time giving another inventory of arguments *against* euthanasia, as if both lists were mutually exclusive and reciprocally independent. The opposite is true. Many of the *pro* arguments can simultaneously be *contra* arguments and vice versa. So the resultant categorization of arguments derives from the precondition that the individual arguments can be assigned as to their prevalent use as arguments *for* (e.g. autonomy) or as arguments *against* (e.g. slippery slope). It has to be noted that some other arguments are so truly "ambidextrous" i.e. the base of the same argument can be used both for and against euthanasia, that assigning them according one camp is fleeting at best. Some aspects of the arguments can be utilized or even manipulated in different ways or have an inverse complement in the form of counterargument - for example autonomy as one of the primary arguments for euthanasia can be challenged by one of the serious counter-arguments, namely that of competence (to which extent a terminally ill or unbearably suffering person is competent to make an autonomous choice).

The only alternatively appropriate option would be to go through the individual arguments and analyse them without labelling them as predominantly *pro* or *contra* arguments. This approach could be regarded as unbiased (or less biased) but at a cost where the individual arguments would be almost neutralized with regard to their stance on euthanasia, with the outcome and justifying power of the arguments being lessened

[5] Beauchamp, 1996; Behnke & Bok 1975; Bernards, 1989; Biggar, 2004; Brody, 1989; Cohen-Almagor, 2001; Dworkin, 1993; Dworkin et al. 1998; Engdahl, 2007; Gentles, 1995; Grisez & Boyle, 1979; Harris, 2005; Keown, 1995, 2002; Leone, 1999; Medina, 2005; Moreno, 1995; Morgan, 1996; Oosthuizen et al., 1978; Rachels, 1986; Roberts & Gorman, 1996; Snyder 2006; Torr, 2000; Wekesser, 1995; Young, 2007a.

considerably or disappearing altogether in the analytical critique. This would be contrary to real life application of these arguments used in euthanasia debates not as neutral arguments but as either *pro* or *contra* arguments. So the chosen general differentiation of arguments has to be taken rather as an auxiliary framework than as the final definitional scope. The following figure shows a matrix of the arguments,[6] based on the prevalent dichotomy *"pro et contra"*.

PRO	*CONTRA*
Autonomy	Competence
Right to die	Inviolability of human life – a human right
Unbearable suffering	Sanctity of life doctrine
Compassion	Prohibition of killing (Hippocratic tradition)
Human dignity	Risk of abuse
Patient's best interest	Slippery slope
Quality of life	Quality palliative care – as a/the alternative to euthanasia
Health care costs	Patient's good[7] – as an counterargument to the pure economical calculation
Legalization	The compromised role of the physician
Transparency	Vulnerability – social pressure

Fig. 1. Synopsis of arguments for and against euthanasia

Some of the arguments complement each other (e.g. autonomy and competence). Other arguments, located on the same line, illustrate the respective sides of a viewpoint. The added value of such a matrix is the emphasis on complexity. In euthanasia debates, arguments usually have an either/or, either for or against structure. This matrix seeks to "interweave" diverse arguments, putting them into a fabric of dualities. For instance, proponents would argue for the decriminalization of euthanasia in the following way: let us regulate what is being done anyway, regulated euthanasia is better then the grey zone in which it is occurring today. But the legalization of euthanasia would also affect the public role of the physician, who would become both healer and killer in the same person, with the potential to put vulnerable patients under social pressure. And these aspects have to be considered as well.

2. The arguments for euthanasia

According to the methodology described above, some of the main arguments for euthanasia will be analyzed. The remaining *pro* arguments will be scrutinized less intensively. It has to be highlighted that all arguments have their objections and counter-objections; so all of the *pro* arguments can simultaneously be used as *contra* arguments. Therefore, while dealing with the objections to the *pro* arguments, the *contra* argumentation is in fact scrutinized inherently.

[6] For purposes of this study, only the first five leading *for* arguments have been examined.
[7] Misbin, 1992; Sullivan, 2005.

The following structure of analysis of the arguments has been adopted:

1. Introduction
2. Description

The argument will be characterized by its most relevant features, and presented in a simplified version. The aim here is to provide a fair and well-balanced presentation of the argument (including diverse ways in which it is used).

3. Contextualization

The aim is to provide information about the background of the argument, placing it into a broader context, showing from where the argument is derived.

4. Presuppositions

In euthanasia debates, the precondition(s), as departure point(s) for the arguments are rarely stated. The aim is to clarify what the argument presupposes, what its preconditions are or which ethical theory are related to it.[8]

5. Analysis

In connection to the second step, an analytical and comparative explanation of the arguments is provided (how the argument is used in euthanasia debates); a critical analysis of both the argument and its objections is given.

6. Evaluation

The argument is assessed as to its strong and weak points, to its explanatory and justificatory power and coherence. The role and usage of the argument in euthanasia debates is addressed.

7. Conclusion

Within this structure the first five of the arguments listed for euthanasia have been critically analyzed. The analysis of the remaining five arguments have only (for the reason given above) been outlined.

2.1 Autonomy

2.1.1 Introduction

Autonomy is frequently given as one of the main arguments for euthanasia (Achille & Ogloff, 1997; Begley, 1998, 2008; Brock, 1992; Quill et al., 1997; Smith, 1989; Tulloch, 2008), usually in conjunction with the right to die (Dworkin, 1993; Finkel et al., 1993; Ogden, 1994; Smook & de Vos-Schippers, 1990). As per its proponents' arguments, a ban on euthanasia imposes a considerable restriction on the options of an individual to govern his/her life, denying a competent individual's ability to shape his/her own death. Opponents' arguments are based on different interpretations of autonomy and its role in the life of individuals: self-determination regarding one's own death (euthanasia) would be a false autonomy. Other opponents argue that the positive principle of autonomy (and self-determination) cannot outweigh the prohibitive (and therefore negative) principle of not killing. The essence of the euthanasia controversy is the tension between the values of life and individual liberty.

[8] The vocalization of the presuppositions is of significance for mutual understanding in euthanasia discussions. Otherwise these starting points, often based not only on certain ethical theories but on personal beliefs, or on various dogmas and ideologies which (even as non-identified) play a pivotal role in the debate, if not revealed cannot be addressed, rendering the debate both more difficult and superficial and inconclusive.

2.1.2 Description

Autonomy is certainly one of the essential values of Western societies and is therefore worthy of protection. The autonomy argument states that a person, while asking for euthanasia, expresses his/her personal choice, realizing his/her autonomy. The request for euthanasia is part of the human freedom to terminate one's own life (Dworkin, 1993; Russell, 1975). Thus the euthanasia request of a competent individual is a basic freedom to define the framework and conditions of his/her life, more precisely it is a decision about how that life should be lived and ended. To ask for euthanasia means to end one's own life in a prearranged way, without loosing control over one's own process of dying and death. From this point of view, euthanasia is the execution of control over one's life and death. Therefore euthanasia can and has to be practiced and has to be legalized, because the legalization of euthanasia protects and promotes the autonomy of an individual. Euthanasia not prohibited by law or legislatively decriminalized is an essential element for the execution of autonomy. On the other hand the criminalization of euthanasia results in a restriction of autonomy. The legalization of euthanasia also eliminates unnecessary or inadmissible barriers to the right to die.

The legalization of euthanasia argument has at least two forms, the two prime ones we will call liberal and libertarian respectively.[9] Within the liberal approaches, individuals can express their autonomy by asking for euthanasia. However the physician, also having his or her own autonomy, is not obliged to administer euthanasia since the autonomy of the patient is not paramount to the physician's autonomy. The moderate liberal approach tries to weigh the detrimental side-effects of the legalization of euthanasia vis-à-vis the benefit one can see in promoting autonomy (The Danish Council of Ethics, 2006). Such an approach would assess the importance of legal euthanasia for personal autonomy. All the necessary regulatory tools would have to be applied to avoid the abuse of autonomy by the heteronomy of others (including the abuse of legalized euthanasia in the form of non-voluntary or involuntary euthanasia). Within a liberal framework, euthanasia is tolerated either as a form of individual preference (despite the fact of being a criminal act, euthanasia in practice is not legally prosecuted and such a "grey zone" is in practice tolerated) or as a form of societal free choice (the decriminalization of euthanasia – the model in the Netherlands, Belgium or Luxemburg). (Gomez, 1991; Muller et al., 1994; Thomasma, 1998). Thus the genuine autonomy of the individual requesting euthanasia in a specific clinical situation is crucial.

Within the libertarian approach, decriminalization of euthanasia is an imperative of autonomy; euthanasia has to be legal, individuals have the right to request euthanasia, physicians have the duty to administrate euthanasia and in some radical approaches, individuals have not only the freedom but even a moral duty to request euthanasia in situations where the suffering is unbearable, the quality of life too low and dissatisfying and the dignity of person hurt, when in short to die is better than to live. Thus the demand of liberty would predetermine a call for euthanasia. The initiation of the use of force by one individual against another is contradictory to libertarian understanding. The libertarian approach would postulate the suspension of laws banning euthanasia. This radical (ideological) form of duty to request euthanasia (in certain situations) would be close to

[9] This terminology is not usually used in euthanasia debates and it can rightly be criticized. For the purposes of this study, the terms liberal and libertarian have been used instead of saying 'less liberal' and 'more liberal'.

authoritarian and totalitarian thinking. Ironically, these extreme perspectives on both sides are very close each other.

2.1.3 Contextualization

As a prerequisite to the concept of autonomy one of the central features of liberal political philosophy can be found: a commitment to respect the dignity of persons. This states that it is not sufficient to do good for patients and to forestall their harm. Doing good could endanger their dignity (Childress, 2000). Therefore the primary concern is that the persons are respected in their dignity; dignity is the base for autonomy, or in other words, dignity is expressed in the form of autonomy. From the respect for persons as the first principle, it follows that a person has the right to make his/her own life shorter in order to maintain a certain quality of life (shorter but better), while keeping or protecting dignity. Thus making life shorter is a necessary means of making it better as a whole (Velleman, 1999). James Childress describes this typical feature of Anglo-American thinking in the following way: "Autonomy does not imply that an individual's life plan is his or her own creation and that it excludes interest in others. The first implication focuses on the source, the second on the object of autonomy. Neither implication holds. Autonomy simply means that a person chooses and acts freely and rationally out of her own life plan, however ill-defined. […] Thus, personal autonomy does not imply an asocial or a historical approach to life plans. It only means that whatever the life plan, and whatever its source, an individual takes it as his own". (Childress, 2000, p. 149). With regard to death and dying, personal autonomy in the form of shaping one's own life and imparting sense and meaning to it is even more relevant than in everyday life. "The way people die is of great importance to individuals' overall perception and understanding of their existence." (The Danish Council of Ethics, 2006). We do not have any better alternative to autonomy in Western societies but we have diverse societal and cultural contexts in which autonomy is realized.

2.1.4 Presuppositions

Autonomy is regarded as not only for one of the primary values in Western societies but also for one of their fundamental rights. However the debates on autonomy and euthanasia presuppose that we have some notion (*Vorverständnis*) of what autonomy and self-determination mean. Autonomy is certainly not a univocal concept in philosophy, having two main and significantly diverse expositions in European thinking.[10] The prevalent notion of autonomy in euthanasia debates can be encapsulated as the following: I want to be the author of my life whose decisions have to be dependent on my will, I want to be the subject not an object (Berlin, 1969). One of the most influential concepts of autonomy in bioethics is the one of Principlism: "Personal autonomy is […] self-rule that is free from both controlling

[10] Autonomy in the continental European tradition can be represented by Immanuel Kant (*Grundlegung zur Metaphysik der Sitten*). The notion of autonomy in the Anglo-Saxon tradition is based on authors such as Jeremy Bentham, John Start Mill or Isaiah Berlin. For Kant, autonomy is (a freely accepted) commitment to the universal law given by the maxim of the will (autonomy is expressed by the Categorical Imperative). For Kant, autonomy is the highest (and the only acceptable) principle of morality; any heteronymous morality has to be rejected. In contrast, autonomy is for Mill an individual free choice, free from any social or political control or constraint. Autonomy for Mill coincides with liberty and independence (*On Liberty*). For Mill, autonomy is an issue of (subjective) liberty; for Kant, autonomy is an issue of (objective) reason.

interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice." (Beauchamp & Childress, 2001, p. 58). However beyond the Western hermeneutics of autonomy, different presumptions could be identified in other cultures.

Autonomy follows from liberal theories which put the individual, fundamentally free and rational, into the centre; the individual not state legislation knows better what is good for his/her life. The individual, not state institutions, has to decide in which way to die. The autonomy argument is based on the liberal notion of freedom: as long as one is not causing harm to another he/she can (and has to) exercise his/her freedom. Autonomy in euthanasia debates presupposes the following structure of argument: If an action does not violate the moral rights of another individual and promotes the good of the person concerned, then that action is morally good. Since euthanasia does not violate the moral rights of others and promotes the good of the persons concerned (of everyone involved) euthanasia is morally good. Thus euthanasia is not only an action which could or should be tolerated, it is much more so an action which has to be performed, promoted and protected.

The sense of autonomy comes from the notion of positive freedom. Not only must I not be coerced by someone (negative freedom) but as an individual I want to be my own master: "I wish my life and decisions to depend on myself, not on external forces of whatever kind." (Berlin, 1969, p. 131) Once the right of a person to make his/her life shorter (and better) is recognized, the second presumption consists of being in favour of deferring to an individual's judgement regarding his/her own good. This presumption means that an individual has the right to life and to die in his/her own way, by his/her own convictions about which life is better for him/her. (Velleman, 1999). In contrast "making someone die in a way that others approve, but he believes to be a horrifying contradiction of his life, is a devastating, odious form of tyranny" (Dworkin, 1993, p. 217).

The next condition of autonomy is the freedom to choose between several options for an action. The patient (moral agent) has a preference for performing the elected act (*preference autonomy*). From this point of view euthanasia is a preferred autonomous choice, for instance the patient prefers euthanasia to palliative care and to suffering. The principle of autonomy as a basic faculty of self-determination presupposes that every moral agent is an autonomous agent. This means that not only the patient has his/her autonomy but so does the physician. To be autonomous agents is a precondition for the defence and protection of self-interests. Therewithal the principle of autonomy presupposes more than that an individual is an autonomous agent, but also a rational agent able of decision making and of (moral) action. The autonomy argument assumes that the individual is fully capable of autonomy.

In summary autonomy presupposes capacities such as understanding, reasoning, deliberateness, freedom of choice and self-governance.

2.1.5 Analysis

As has been demonstrated, the core concept of the autonomy argument is based on freedom: one wants to be the author of his/her life, who in turn shapes his/her death and dying, while making an autonomous choice as to how to die (rational self-governance). A request for euthanasia is an expression of the fundamental value to have one's own life and its circumstances under one's own control. The contrary would be a fatalistic belief that delegates the right and duty of control over one's own life and its course to some external power. Some people would argue that to repudiate control over one's own life is

irresponsible, while on the other hand to realize autonomy regarding the final stage of life is regarded as a form of responsibility. A petition for euthanasia would be an act of proper responsibility, being both within the faculty and quality of a person who attempts to influence the design of his/her life by making efforts in accordance with his/her best convictions. In his analysis of the right of self-termination, David Velleman, he himself suffering from cancer, argues that the person living his/her life is therefore the best judge of the value that its continuation would afford him/her — despite the fallibility of his/her judgement. A person's judgement, being usually more reliable than anyone else's, and based on his/her values, tends to be self-fulfilling because it can respond to its own set of values. The justification for deferring to a person's judgment about serving his/her own good goes beyond her reliability as a judge. Respect for a person's autonomy requires that we defer to the well considered judgment about his/her own good even when we have reason to regard that judgment as erroneous. Thus, if an individual is capable of making the autonomous choice of asking for the termination of life which he/she deems to be not worth living, then he/she has the right to be guided by his/her own judgment. (Velleman, 1999). The question of whether the person asked to provide euthanasia has therefore a duty to conduct euthanasia will be discussed later.

Preference autonomy has been introduced as one of the conditions for autonomy. However many authors argue that preference autonomy is a necessary but not sufficient condition for an autonomous action, emphasizing the relevance of preference building. The preference is very much influenced by society, by its dominant morality and by societal expectations, and by the stage of psychological and moral development of the concrete person. So preference autonomy could easily mislead the real and authentic preference of the person asking for euthanasia. Thus for some authors the determining condition for autonomy is *dispositional autonomy*: the autonomous agent is able to reflect on his/her preferences, and be able to change his/her first-order preferences (Holm, 1998). "If disposal autonomy requires preferences that are fully self-chosen and authentic in the way described by Camus, Sartre, and other French existentialists, very few persons would ever be autonomous." (Holm, 1998, p. 270) It can also happen that a person is autonomous in one area, while not being autonomous in another area. The autonomous person who has self-governing capacities sometimes fails to govern him/herself due to temporary constrains caused by illness, depression or other conditions that restrict his/her options (Beauchamp & Childress, 2001). Autonomy can also be understood as an ideal, something very important and worthy to possess that however, not everybody achieves in his/her lifetime. In euthanasia debates the autonomy argument is used as a non-idealist moral requirement, rather one based on real situations. So as the decisive criterion for autonomy the following determiner has been proposed: autonomous is a person who is substantially autonomous; then autonomy is understood as *substantial autonomy* (Beauchamp & Childress, 2001, p. 60). Autonomy in these debates is also a faculty of a mature person who has the basic understanding of the circumstances of his/her life, who chooses and acts intentionally and who, free of constrains, is determining his/her life and death.

With regard to some of the psychological concepts of personal development (J. Piaget, E. Erikson, L. Kohlberg), autonomy is taking various faces and roles during one's life. In relation to developmental psychology, autonomy can also be understood gradualistically: autonomy is something what we progressively acquire, develop and lose. Then the question of to what extent a dying person has real autonomy is reciprocal to the question of to what extent has this person lost his/her autonomy (understood as full autonomy, as dispositional

autonomy or as substantial autonomy). Thus any claim of autonomy (autonomous choice) is valid only if the person concerned (patient) still posses the necessary degree of autonomy. In some clinical situations such as a terminal or pre-terminal stage, there is a high probability that the person does not possess full autonomy; the question which has to be clarified is whether there exists a dispositional or substantial autonomy.

There are at least two main objections to the autonomy argument. The first objection, departing from the fact that not all persons in all situations have full autonomy, concludes that at a normative level with regard to life and death not everyone can be presumed able to make such an autonomous choice (some persons may have the full capacity of autonomy but on the policy level it is not feasible to distinguish full and partial autonomy and to discriminate persons, therefore the more practical conduct is to repudiate the autonomy argument as such). The second objection, departing from the fact that someone who is dying or in the (pre)terminal stage of disease (and life) is not a fully autonomous agent, invalidates the autonomy argument for a dying person.[11]

The counter-objection to the objection which states that true autonomy of a dying person is not possible at all or rarely possible is the following: Even if the choices of many persons asking for euthanasia are psychologically and socially shaped and conditioned, they must be respected as real choices. (Battin, 2003).

The other objection to the autonomy argument states that one cannot impose on another person a duty to do what the other person does not (subjectively) agree with or what is (objectively) morally wrong, even if the choice of the requesting person was made freely and rationally. (Battin, 2003). The counter-objection bases itself on the lack of sufficient proof that euthanasia as such is morally wrong and on the presumption that a well thought out decision done in accordance with the values, preferences and conscience of the person concerned, though being possibly wrong, is the best one can do and therefore it morally obliges the person concerned to act accordingly. Another counter-objection is based on the presumption that no one is obliged to do what the other person requests, especially in cases when there is a conflict in moral assessment regarding the requested action. (Battin, 2003).

The autonomy principle does not insist that a free, well-considered choice of an individual must be respected. The person who is asked to perform euthanasia also has her autonomy which can prohibit or allow the requested act of euthanasia to be performed; in some cases the performer's autonomy, guided by compassion, could even oblige the person to conduct euthanasia (with or without being requested).[12] The next objection to autonomy states "that a decision about one's own death is something fundamentally different from other life decisions and life choices" (The Danish Council of Ethics, 2006). Therefore it cannot be meaningfully said that a person's own death is a subject of a free and autonomous choice.

The next objection is built on the fact that "the concrete circumstances surrounding the choice scenario in the form of the role played by the doctor, society and the next-of-kin mean that the request for euthanasia will have arisen partly or wholly out of a situation in which autonomy cannot be practised, either because the person is not competent or because of direct or indirect pressure from their surroundings."[13] (The Danish Council of Ethics, 2006). So the aforementioned circumstances in such a case, either partially or fully disqualify the autonomy argument and its legitimacy for euthanasia.

[11] The competence of a dying person would be a part of the counter-argument.

[12] The compassion argument is discussed below.

[13] Social pressure as a negative consequence of legal euthanasia is a strong objection to this argument.

Finally there is a fundamental objection to the autonomy argument: Based on the previous analysis of autonomy in the context of an autonomous request for euthanasia and despite the broad consent that autonomy is an essential value to person's life, it is not obvious that legalization of euthanasia would automatically promote the individual's scope for practising autonomy as authentic self-determination. (The Danish Council of Ethics, 2006).
Therefore, critics would re-qualify autonomy as something that not only has to do with self-conception (as architect of one's own life) but also with self-identity, interpersonal recognition and the vulnerability of a dying person.

2.1.6 Evaluation

In euthanasia debates, arguments based on autonomy often erroneously presuppose that we all use one and the same concept of autonomy; autonomy in these debates is predominantly identical with autonomy in the sense of Anglo-Saxon liberal political philosophy. However, there is a significant difference between the meaning (and history) of autonomy in moral philosophy and the appropriation of the term in euthanasia debates (Schneewind, 1998). This difference is frequently overlooked in euthanasia debates.
Furthermore, an autonomy argument based on dignity (or related to dignity) implies a diverse notion of dignity (for example dignity characterized by empirical features as it is the case in philosophical Empiricism or dignity as it is understood in philosophical Personalism). Therefore some autonomy arguments are rather collateral discussions than a *dia*-logical enterprise.
A specific category is built by the arguments based on an ideological concept of autonomy (Ells, 2001). Eventually the relationship between the meaning of autonomy in moral philosophy (ethics) and its usage in euthanasia debates is highly selective and tenuous (Jennings, 2007). The prevalent concept of autonomy used in euthanasia debates is the concept derived from Berlin's negative liberty: negative liberty here being a necessary condition for autonomy, sometime identified with autonomous action. This approach mirrors the liberal individualistic culture of the Anglo-Saxon world, while relating less to other cultural settings and their respective philosophical traditions. Autonomy, a prerequisite for moral standing and basic moral values, has been criticized in particular by many European and other non-Anglo-Saxon authors, by feminists (e.g. Ethics of Care) and Communitarians. These authors criticize the emphasis on autonomy as a product of American society (different from values such as vulnerability or solidarity, as emphasized in the European tradition), the masculine tradition in moral philosophy, which neglects feminine moral experiences (the fact that less women than men ask for euthanasia) and its stress on atomic individualism (Communitarians).
Respect for the autonomy of the individual has always been given as the principal argument for euthanasia, understood as an active medical intervention to intentionally terminate life at the explicit request of the patient in the Dutch debates (Gunning, 1991; ten Have & Welie, 1992, ten Have, 2001). However, there have been a number of cases occurring without the explicit request of the patient (ten Have, 2001), without respect for the autonomy of the individual. So the theoretical autonomy argument is being invalidated by some instances of practice.
Autonomy indisputably should be considered a necessary but not a sufficient condition for a moral life (Callahan, 1984); what is needed as well is a broader perspective that includes interpersonal relations and interdependence (Christman & Anderson, 2009; Gaylin &

Jennings, 2003). These aspects are usually neglected in euthanasia debates that adopt autonomy as its main argument.

2.1.7 Conclusion

Despite the fact that no single concept has been more relevant in contemporary bioethics than the concept of autonomy and that the autonomy argument has played a pivotal role as the principal argument for euthanasia, autonomy can be used in euthanasia arguments in both support for and rejection of euthanasia. In this context the competence of the patient requesting euthanasia must be recognised as one of the main counter-arguments.

2.2 The right to die

2.2.1 Introduction

Beside autonomy the right to die is usually given as the most common argument for euthanasia (Cavan, 2000; Dorman, 2010; Ferguson, 2007; Stefoff, 2009; Sunstein, 1997; Yount, 2009). In recent times, many studies dealing with the right to die have been published and the ethics of the right to die has been reflected upon.[14] In some cases euthanasia even is directly equated with the right to die (Humphry & Wicket, 1986; Jussim, 1993; Wilshaw, 1974; Woodward, 2006). Euthanasia is not only the expression of a fundamental freedom but also a right one has. This right is understood as a moral right which can be claimed as a moral warrant or as a legal right supported by law which can be claimed in the legal sense. The simplified version of the argument states that every person has the right to die (whatever "right" means here). This right includes the power to specify the conditions and circumstances of one's own death and dying so the right to die includes autonomous determination *when* and *how* the person wants to die. Opponents argue that the right to die does not exist and therefore cannot be claimed.

2.2.2 Description

The usual form of this argument is based on the moral fundament of the right to die (Feinberg, 1992). This moral right can be expressed as the right to control one's own body and life and consequently to determine at what time, in what way, and with whose help one will die. The other form of the right to die is the right in a legal sense, a right which either exists (or should exist) as a specific right or can be derived from other rights such as from the right to life.

In the debates about the right to die (euthanasia) one important distinction has to be made, namely between the positive and negative right to die (right to self-determination). "A positive right of self-determination implies that a person can *demand* to have euthanasia carried out, providing the criteria for being able to request euthanasia are otherwise met." (The Danish Council of Ethics, 2006). Thus the positive right of self-determination implies that there is an objective duty to conduct euthanasia if requested; *B* requesting euthanasia imposes an obligation to perform euthanasia on *A*. While a negative right does not imply any *entitlement* to demand to conduct euthanasia. "Legalization here would merely mean that euthanasia is an action that is not illegal. No

[14] Bernards, 1989; Blocher, 1999; Cosic, 2003; Haley, 1999; Moreno, 1995; Ogden, 1994; Rebman, 2002; Russell, 1975; Scherer & Simon, 1999; Tada, 1992; Uhlman, 1998.

one is *obliged* to comply with the request for euthanasia, but it is legal to carry out euthanasia if the individual meets the qualifying criteria for having euthanasia carried out." (The Danish Council of Ethics, 2006). There are diverse practical implications if euthanasia is understood as a positive or negative right.

2.2.3 Contextualization

Historically the right to die has been recognized after World War II in the context of human rights development.[15] Several factors, such as advances in medical science (by technological means, life can be significantly prolonged or continued almost indefinitely), reduced sudden deaths, greater incidence of death from degenerative diseases, greater incidence of becoming elderly, dispersed families (atomic family) and increased institutionalization of the elderly have led to the recognition of the right to refuse (futile) treatment or to discontinue treatment (withdrawing) in medically desperate situations. Since the 1960s, the right to die has been supported by human and civil rights movements that have emphasized the right of self-determination, individual empowerment, bodily integrity and the right to control end-of life decision-making. In the 1970's and 1980's, the right to die was used as an equivalent to voluntary passive euthanasia based on the patients' right to refuse treatment.[16] The right to refuse treatment (and to die) being the precondition for the right to die being understood as an active termination of life (killing)[17] (Matthews, 1987). Some authors associate the right to die with the right to physician assisted suicide but not with euthanasia (Sunstein, 1997).

Two different settings of the right to die can be identified: a moral claim and legal claim. These two settings and two different forms of right are often intermixed in euthanasia debates. Therefore which type of reasoning used should be distinguished in euthanasia debates. There are at least four different types of reasoning based on the right to die: moral reasoning (euthanasia as a moral right), legal reasoning (euthanasia as a legal right), euthanasia as a positive right and euthanasia as a negative right.

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[15] The key declarations for the furthering of human rights development, which have been the background for euthanasia as the right to die, were The UN Declaration of Human Rights (1948), The European Convention of the Protection of Human Rights and Fundamental Freedoms (1950) and The International Covenants on Economic, Social and Cultural Rights and on Civil and Political Rights (1976).

[16] The "Patient's Bill of Rights" (which includes the right to reject medical treatment even if such refusal causes death) was adopted by the American Hospital Association in 1973. The American Society for the Right to Die (the former Euthanasia Society of America) has promoted the legalization of a living will (1974) which includes refusal of treatment (called "passive euthanasia"). The Patient Self-Determination Act (1990) has implemented the right to die (refusal of treatment) by legally requiring all health care institutions to provide patients on admission with information regarding their rights to make decisions about medical treatment (to accept it or to refuse it); this right (to die) has been confirmed by the U.S. Supreme Court (1990) based on constitutional liberty rights.

[17] In this chapter only the right to die in the context of the right to be killed (active voluntary euthanasia) is discussed. The right to die as the right of a competent patient to refuse (futile) medical treatment even if it results in death (letting die) is not covered here as the right to euthanasia. The argumentations about passively hastening death, forgoing life-sustaining treatment as they have been discussed since the Karen Ann *Quinlan* case (1975), as well as the forgoing of artificial nutrition and hydration and legalisation of physician assisted suicide have not been included. The focus is on actively hastening death by (active) euthanasia.

2.2.4 Presuppositions

The right to die presupposes that such a right exists and that this right can be exercised by a competent (autonomous) person who is terminally ill or who is suffering unbearably. The basic presumption is that in order to exercise the right, two conditions have to be met: an external and internal one. The first condition lies in the absence of any external pressure on the person exercising this right. The second condition is defined by the lucidity of the person concerned. This internal condition means that the person (patient) is fully competent with a clear intention regarding euthanasia.

The right to die derives from the idea that humans should be as free as possible and as little suppressed as possible; unnecessary restrains on human rights are in principle bad. In contemporary euthanasia debates this link between right and freedom can be found very often, although not always in an explicit way. So the "right" argument and can be transformed into a "freedom" argument (autonomy) and vice versa. It is important to emphasize that one can acknowledge the right to die without necessarily agreeing to its legal codification.

2.2.5 Analysis

Within this chapter, if the right to die has been defined as the justifiable claim of a competent, terminally ill person to avoid excruciating suffering by embracing a timely and dignified death; then euthanasia is a moral right based on ordered liberty.

There are diverse constructions how to derive the right to die (which does not exist as such in the form of a positive law) from the existing legal provisions. Some argue that the fundamental human right to life equally includes the right to die. So the right to die does not have to be created or acknowledged as a specific right. Insofar as human beings have the right to life, which is more than just a right to exist but also covers a minimum quality of life, then he/she has the right to influence the process of dying which, in difference to death, is part of life (active voluntary euthanasia) (Downing, 1970; Downing & Smoker, 1986; Wilshaw, 1974). Since dying, despite the tabooization of death and dying in our culture, is one of the most significant events in human life, one has the right to make his/her dying as good and meaningful as possible.

Another attempt to deduce the right to die is to derive it from the rights to privacy and freedom of belief. However this deduction, using a specific concept of privacy which also encompasses the right to die as the private issue (under the presupposition that death is inherently a private issue) is more debatable than the deduction of the right to die from the right to life.

Some people deduce the right to die from the worthlessness of life: on the grounds that life is not worth living one has the right to die. Opponents remind that such argument has been used for justification of eugenic euthanasia by the Nazis (*lebensunwertes Leben*). This deduction presupposes that life may be worth living in one case, being worthless in another. This results in the value of life becoming relative, depending on specific situations and changeable factors - as it was in the Nazi period.

From another background comes the utilitarian argument, justifying the abridgement of life (and the dying process as part of life) if the dying process is unpleasant and exceedingly painful. By shortening the dying process then both the unpleasantness and suffering of this process are reduced. In this way the right to shorten one's own life (dying) is established and justified. The utilitarian argument based on a reduction of unhappiness and suffering is

very often used in euthanasia debates – not only to support the right to die (and the right to shorten one's own dying/life) but also in arguments based on compassion and suffering. The utilitarian argument of a reduction of suffering provides the justification for the right to die. So the right to die is not solely the right of an individual to self-determination but also a right which affects the social benefits of all persons involved (relatives, health care personnel); it also reduces their unhappiness and suffering. Despite its social utilitarianism, the right to die does not imply a physician's duty to kill the patient. As an individual right the right to die should be exercised solely by its bearer - that is to say by the person requesting euthanasia only. However the right to die (as an individual right) can be converted into a social right which empowers society to reduce unhappiness and suffering by administrating euthanasia without request.

In difference to suicide where a person is killing him/herself, claiming he/she has the right to do so (and he/she certainly has the right to do so in the sense that he/she is at the same time the bearer of such right and the one who is exercising that right), the person who claims the right to be killed as the bearer of such right is not the person who is realizing this right. From this follows that no physician can be forced to administrate euthanasia on a patient who claims the right to be killed since such a claim does not constitute a duty of the physician to realize this specific right that the patient is claiming. If the patient's right to be killed would be a standard patient's right within the reciprocity of right and duty framework (*A* has a right, *B* has a duty towards *A*), then physicians would have an objective duty to administrate euthanasia in patients who claim this right (or possibly even in patients who do not claim this right but who fulfil the criteria for realization of this right, e.g. intensive suffering, futile clinical prognosis) (Smith, 2006). The only exemption from such an objective duty of the physician would be one of conscientious objection. One should distinguish whether euthanasia as the right to die belongs to the introduced right-duty framework or not. To avoid the right-duty framework some authors suggest distinguishing between rights/liberties and privileges. As such, then the right to die would be a specific form of privilege. A privilege does not imply a duty for anyone else (Williams, 1977).

In some specific areas such as neonatal and child euthanasia, the right to die is especially problematic; as the origin, scope, justification and purpose of parental rights are unclear (Chervenak, 2006; de Vries & Verhagen, 2008; Lindemann, 2008; Moreno Villares, 2005; Schneider, 1988; Verhagen & Sauer, 2005).

2.2.6 Evaluation

The differentiation between euthanasia as a negative and positive right is crucial:

"If arguing for the legalization of euthanasia as a negative right, the practical implementation of euthanasia will depend on there being some people among those able/entitled to carry out killing on request under such a law who are willing to do so. If arguing for the legalization of euthanasia as a positive right, a legitimate request for euthanasia will result in individuals or institutions being obliged to accommodate that request. But the positive right can be graduated in terms of the authorities or persons in whom that obligation is vested. In one radical variant, it is possible to envisage all doctors being obliged to carry out euthanasia. A less restrictive variant might mean that the health services as such were obliged to arrange for euthanasia to be carried out, while leaving the individual doctor free to choose whether he or she wishes to perform euthanasia. […] A positive right of self-determination regarding euthanasia cannot be introduced without simultaneously acknowledging that, in certain cases

provided for in law, society is duty-bound to take the life of a human being. A negative right of self-determination regarding euthanasia, on the other hand, can be introduced on the grounds that euthanasia, under certain circumstances provided for in law, is a matter for the judgement and conscience of the individual. The fundamental difference is that the first form of legalization, more so than the second, turns euthanasia into a communal, general matter, which must be acknowledged by society as a whole as being worthy of aspiring to ethically." (The Danish Council of Ethics, 2006).

Some authors reject the right to die argument on the grounds of benefit and harm (Velleman, 1999). The common religious counter-argument states that the right to decide when and how to die belongs to God. (Gill, 1998; Larson & Amundsen, 1998; Manning, 1998). The common secular counter-argument is doubly based on obligation. First the right to die does not imply a legal obligation of another person to conduct euthanasia. Secondly our rights are limited by our obligations. One may have a right to die however one has also obligations to other people such as our partners, family, friends, healthcare professionals (Finkel et al., 1993). The enactment of the right to die (euthanasia) would affect other people so we must consider the consequences such an exercising of the right to die would have on them (grief, sorrow, guilt, anger). The enactment of the right to die could affect the professional integrity of the physician who would conduct euthanasia. All these consequences have to be measured against our right to die and the individual rights have to be balanced against the good/consequences of the community and society in general. (Sullivan, 2005). Regardless of the fact that these consequences might seem to be practical (the dying process of a person suffering extremely has been made easier), one of the negative consequences is the risk of vulnerable persons' integrity being undermined, whereby the principal argument is switched from one of autonomy and right (voluntary euthanasia) to compassion (possible involuntary euthanasia).

The limitations of the right to die are provided not only by the obligations to society but also by the rights and duties of other persons who are requested to provide euthanasia. There is not an evident moral right to kill a person even upon his/her explicit request. Likewise there is not an objective moral duty to conduct euthanasia upon explicit request. It is obvious that a legal obligation to administrate euthanasia does not exist; the establishment of such a legal obligation would require a substantial transformation of our democratic society, based on fundamental rights and liberties.

2.2.7 Conclusion

The right to die is one of the main arguments for euthanasia. It is closely related to autonomy and to the principle of respect for autonomy. So in some discussions both arguments (right to die and respect for autonomy) are intertwined into the right to autonomy. However, there is no unanimous consent that the right to die exists (that it can be derived from other rights such as from the right to life), and the right to die argument can also be used as an objection to euthanasia, in that this right does not exist. Despite its moral or legal appeal it serves poorly as a medium for debate as common argumentative precepts are difficult to establish.

2.3 Unbearable suffering

2.3.1 Introduction

Unbearable suffering is one of the criteria required by Dutch and Belgian legislation on euthanasia. One would assume that the right to die argument is not a sufficient legal

requirement for the decriminalization of euthanasia since there is no broad consent that such right exists or that it can be derived from other rights in a very convincing way. Similarly the autonomy argument alone is not strong enough an argument to justify legal euthanasia. No doubt every competent person has his/her autonomy, however to justify autonomous choice in the case of euthanasia would require some additional conditions. Otherwise any competent person would be able to request euthanasia - regardless of the circumstances they find themselves in - as a legitimate tool to terminate his/her life. The only validator would be a reference to his/her autonomy. So when legislators were specifying some additional conditions under which the autonomous choice could be decriminalized there was the evocative condition "unbearable suffering", which made sense, as all else being equal, no person in their right mind would prefer to die in a painful way or with immense suffering. So among the circumstances that could lead one to choose death for him/her self and/or for a loved one, unbearable suffering occupies the prime position. The expression "unbearable suffering" clearly states that not every painful process within health care entitles one to ask for euthanasia but only great ongoing pain and suffering which trespass one's faculty to tolerate it can be a legitimate reason to request euthanasia. Proponents of euthanasia defend the decriminalization of killing on request in well defined situations as a kind of last resort and under serious conditions.

It comes as no surprise that both proponents and opponents of euthanasia agree that the prevention and alleviation of people's suffering has been one of the noble goals of medicine from ancient times and that compassion is a valued emotion in general and in health care in particular. However, they heartily disagree about the extent to which the means can be justified by the end (alleviation of pain and suffering). (The Danish Council of Ethics, 2006). While proponents argue that the alleviation of terrible suffering in desperate situations justifies killing a person on her request, opponents do not tolerate alleviation of suffering by removal of its cause (a suffering human being), arguing that pain and suffering have to be controlled medically (pain killers, terminal sedation), but not by killing.

2.3.2 Description

The suffering argument can be briefly described in the following way: Once a person is suffering to an extent which is beyond her will and capacity to tolerate such a degree of pain and suffering, having become "unbearable", than he/she should not have to bear it. Moreover, all medical attempts to relieve this unbearable suffering have been unsuccessful and unsatisfactory to this person. Then the basic rule about impossibilities which do not establish moral commitment would apply: *ad impossibilis nemo tenetur* (no one is obliged to do what is not possible). Thus, as a last option, it is morally right to help this person not to suffer unbearably and on compassionate grounds to terminate her suffering and life.

2.3.3 Contextualization

With regard to suffering, it is a paradox of contemporary medicine that thanks to powerful technological advances the lives of many people have been saved but an additional suffering of many other people is being produced and prolonged. Despite the fundamental physicians' obligation to relieve suffering, little attention is explicitly given to the issue of suffering in medical practice; it is not unusual for suffering to occur not only as an implication of disease but as a result of its treatment. (Cassell, 2004).

Suffering is usually associated with pain. However suffering is not identical to pain. Pain, being caused physically (e.g. by injury or metastatic cancer), can be onerously assessed: one cannot see pain, but feel its manifestation. As clinical findings demonstrate, the amount of pain a person reports is not directly related to the degree of disease. There are important psychological factors which help to explain why people perceive, report and give meaning to pain in different ways. Pain, perceived as hurt, is a highly subjective experience, affected by mood, morale and other conditioners. (Skevington, 2002). In spite of the fact that the current pain therapy can provide continuous pain relief up to the very end of life in more than 90% of cases, these new therapeutic tools are not yet widely known and practiced by physicians. In addition, suffering is much more difficult to treat than physical pain. Severe pain can lead to suffering which cannot be easily controlled. Paradoxically a patient whose pain is managed well may still suffer. The suffering, as an individual sensation of discomfort and malaise, may continue for a very long period of time without any specific correlation to the physical pain. Heavy suffering can violate one's integrity as a person; the self may become unravelled, fragmented, and disintegrated by massive suffering (Ben Mitchell, 2010). There are feelings such as hopelessness, loneliness, alienation, pointlessness or unworthiness which may occur even if pain is being relieved properly, making suffering intolerable and unbearable.

While pain is more related to a physical condition, suffering can be caused by both physical and non-physical factors. There is no consonant approach to pain and suffering. While some authors sharply distinguish suffering from physically caused pain, other authors regard physically caused pain as one of the many forms of suffering. Some people believe that suffering is person-centric (Cassell, 2004a). That suffering, dissimilar to the physical symptoms, is a personal phenomenon which cannot be accessed by a third-person view; suffering as the personal (subjective) phenomenon cannot be objectified. Other people believe that suffering has different forms which, in addition, can be objectively described. Since there is no consensus about the nature of suffering, diverse hermeneutics of suffering would have diverse consequences in an assessment of suffering.

Within the biological model, suffering can result from disease; where pain is the source of the suffering. Suffering can also arise from the impact disease is having on the person's life. This type of the suffering will depend on the attitudes and objectives of the suffering person – to what extent the person is able to modify attitudes and to adjust objectives to the new situation. Finally suffering can also be found on the existential level; some people reduce the existential level to spirituality (Peck, 1997), however it should be noted that not only religious persons have their existential needs- more precisely "non-believers" can have existential questions as well and do not call them "spirituality".

It is important in arguments based on suffering to distinguish between physical, psychological, social and existential (which includes spiritual) suffering. With regard to unbearable suffering it is important to distinguish if suffering is understood as a personal phenomenon (that only the person concerned is able to determine the level of "unbearable suffering") or as an objective phenomenon (then "unbearable suffering" can be assessed by external criteria and by other persons). It is important to define "unbearable suffering". Dutch law states as a criterion merely "unbearable suffering", while Belgian law holds it to be "unbearable physical or mental suffering". Besides suffering, similar specifications of other conditions related to suffering but distinct, such as being in a terminal stage of disease are relevant to warranting euthanasia.

2.3.4 Presuppositions

The basic presupposition of the suffering argument can be found in the following axiom: unbearable suffering founds the (moral) right to ask for euthanasia. Justification of such a right can be found for instance in the European Charter of Fundamental Rights (2000), where Article 4 states that no one shall be subjected to torture or to inhuman or degrading treatment or punishment. It could be argued that to subject a terminally ill person to medical treatment which produces horrible suffering goes against the aforementioned article. The suffering argument usually assumes that unbearable suffering is the only condition required for euthanasia. So unbearable suffering is simultaneously a sufficient condition for euthanasia.[18] The person intolerably suffering induces compassion in the other person who then kills out of mercy.

2.3.5 Analysis

Suffering can be considered both an objective and subjective phenomenon. However the unbearableness of suffering is rather a personal phenomenon and therefore a subjective criterion. Once the suffering has become "unbearable" for an individual then this suffering is intolerable, insupportable and insufferable and only the suffering person can know at what point or when this state has been realised. No one acting as an external (and "objective") observer can assign the unbearably suffering person to tolerate such suffering. If we would regard the unbearableness of suffering as an objective criterion then this threshold could only be determined after a palliative care trial or after a committee or inquiry, after which some group would have authority to say "You are entitled to die" or "You are not allowed to die", which would be in contradiction both to autonomy and the right to die arguments. It seems that the praxis in the Netherlands tends to assume that the unbearableness of suffering is a subjective criterion which is validated by a longstanding declared wish to die rather than by some exact empirical tools. Furthermore it remains unclear if for instance the mental torment as documented in the Dr. Chabot case is included in unbearable suffering (Sheldon, 1994) or if suffering would also cover situations like "tired of life" which can be existential and very afflictive but not necessary qualifying as grounds for a euthanasia request (Sheldon, 2003). Surely it is easier to medically measure pain than suffering. The level of both pain and suffering can be measured – albeit such assessment is problematic if pain is not reduced to the physical entity and if suffering is taken in its complexity – while it can be taken for granted that "unbearable" suffering can be assessed by the individual concerned solely. Even two accounts of very heavy and awful suffering, which according to an external evaluation would be graded as almost the same could be perceived as "unbearable" for one person and as "bearable" by another person.

Proponents of euthanasia argue that unbearable suffering is more that sufficient reason to request euthanasia. Their other supportive arguments are compassion, respect for human dignity, the patient's best interest, quality of life, autonomy and the right to die.

Opponents of euthanasia refuse the suffering argument as such, saying that suffering, even "unbearable ", is not sufficient grounds for killing a person. Their counter-objections mostly refer to compassion in the sense of psychological support, efficacious relieve of suffering,

[18] "Suffering as a criterion for access to euthanasia is based on an approach that is taken for granted and regarded as self-evident" (The Danish Council of Ethics, 2006).

good palliative care and human proximity; to care in the sense of avoiding alienation, shame, helplessness, emotional and social burdens and dealing with needs, such as worthiness and being treated as a person- not as a non-person or as a no person anymore.

Some authors argue that the desire for euthanasia cannot be interpreted at face value. The meaning of the desire for euthanasia is not related to the reality of physical disintegration or physical and psychological suffering from the effects of disease such as cancer, but includes anxiety, fears, existential concerns and desires for respect, care, and connectedness interpreted within the context of the patients' whole lived experience. (Mak & Elvyn, 2005).

For some adherents of euthanasia, unbearable suffering is a necessary but not the sufficient condition for a patient's eligibility to request euthanasia. They argue that unbearable suffering is the minimal requirement and some objective criteria of the patient's conditions must have been met before the desire to die can be fulfilled. Such additional and more objective criteria, such as being in the terminal stage of an illness, can be medically assessed more exactly than the subjective evaluation of unbearable suffering.

Opponents of euthanasia point out the ambiguity of pain and suffering: "If the pain and suffering are by definition unbearable, then it seems clear enough that the decision to die is not freely chosen but is compelled by the pain. […] Under the conditions of unbearable pain and suffering, then, if the concern of the agent is to alleviate the pain it seems to be a mistake to speak of voluntary choices. The natural conclusion to draw from this is that there can be no such thing as voluntary euthanasia, or, at the very least, that we have no means to ensure that the patient's request to die was not compelled." (Campbell, 1999, p. 243). Thus in situations where the decision to terminate one's own life is made while experiencing unbearable suffering, the possibility that such a choice was not made freely has to be taken seriously. Opponents also argue that effective pain control can alleviate the suffering. The counter-objection is focused on the fact that not all pain is manageable in terminally ill patients, stressing the difference between pain and suffering. Suffering is inevitably a solitary condition and always involves self-conflict, since, among others, the meaning is essential to suffering. (Cassell, 2004a). In addition, in cases where the disease is progressing and state of health worsening, even the best pain therapy can prove to be unsatisfactory, leaving the person suffering to an intensity that the other person, imagining such suffering, neither has suffered nor could possibly imagine suffering.

Proponents argue that it is more in accordance with human dignity to relieve suffering by termination of life then to incapacitate the patient with high doses of drugs (analgesics and sedatives) and to keep the patient in a state of unconsciousness so that he/she does not have to consciously suffer (palliative sedation, terminal sedation). Then if there is an option between existence with suffering and unconsciousness without suffering, it is more appropriate to choose death instead of continuing such an unconscious existence (or choose life alternating between suffering and sleep). They conclude that such a way of living (caused by medical intervention) is pointless, harmful and inhuman and such "medical suffering" should be avoided.

Some people, with reference to the fact that the full autonomy of a person requesting euthanasia may be doubtful, propose the use of a similar framework as the ones we use in other areas of end-of-life decision making, such as the withholding or withdrawing life support treatment for incompetent patients, in particular in the context where there is doubt as to the genuine autonomous choice of the terminally ill patient. This would involve a cascading process of assessment. Then the first condition would be a clear wish to die expressed in a qualified and authentic way repeatedly. The next condition would be the

assessment of the patient's unbearable suffering as a reason for choosing death. Then the external social controls would apply (medical evaluation done by the therapeutic team, proxy evaluation). When all relevant facts and circumstances are weighted and assessed and all persons involved agree then choosing death at a chosen time is better option than continuing unbearable suffering.

2.3.6 Evaluation

Suffering is an ambiguous phenomenon in our contemporary world. On the one hand there is a strong tendency not only to avoid suffering but also to negate it as such since suffering does not fit into the picture of a young, healthy, wealthy and successful person. In current Western culture, pain and suffering as symptoms of disease and illness, are perceived as contrary to a healthy life, corporeal performance and the cult of youth. On the other hand suffering is glorified by some popular (and in fact unorthodox) versions of Christianity which can be characterized as "dolorous Christianity" (Christ has suffered, therefore you have to suffer; the more you suffer the more you are loved by God). Suffering, denied or glorified, overlooks the positive aspects of suffering as part of our personal development. However it is neither easy nor appropriate to say to the person suffering unbearably, who does not see any sense of such terrible suffering and of her destroyed life, that suffering has its place in the process of personal development. Whatever the case, a lack and/or superficiality of analysis from the patient's perspective should temper calls to make euthanasia legal (Mak & Elvyn, 2005).

The argument "unbearable suffering" should not be taken in its "simplified version": they suffer unbearably, therefore let us legalize euthanasia. There are many hidden existential concerns of the terminally ill and horribly suffering patient's that should be addressed and discussed. And the patient's personal perspective has to be taken more into account.

Some authors are hesitant to address suffering as a determiner for eligibility to euthanasia as they criticize the medical world's objectification of patients. They believe our dominant biomedical model should be modified, improved and re-oriented to the patient's personhood (Mak & Elvyn, 2005). It is not only the patient's mental competency that is at the stake but also a new professional moral competency of health care personnel; such professional competency, not entirely fitting into the biomedical model, would ensure appropriate existential care, exploring the covert meaning of "a good death" and dealing with the authentic desires of patients rather than mechanically applying arguments of autonomy or suffering. As many studies demonstrate, the desire to die (due to unbearable suffering or due to personal preference not to have to go through the final, painful, hopeless and possibly meaningless passage of own life), in many situations, is not so much a request for death as a request for help (Lesley, 2006).

With regard to the medical practice of euthanasia in the Netherlands, "the ethical justification has been shifting from *respect for autonomy* to *relief of suffering*. But this has created a tension within the justificatory strategies regarding euthanasia. The two arguments are mutually exclusive. It only makes sense to talk about respect for autonomy if a physician *refrains* from making judgements about the patient's benefits." (ten Have, 2001, p. 477).

Another question which has to be clarified is about "suffering" and "unbearable suffering" as the only criterion for euthanasia (the autonomy argument is very problematic in a situation of terrible suffering). There are two approaches to this question: either unbearable

suffering as a purely subjective phenomenon is understood in a broad sense, as any physical, psychological, social or existential suffering, and, once claimed as "unbearable" (and only the patient can decide whether his/her suffering has become unbearable) becomes the necessary and sufficient grounds for euthanasia (and any patient including psychiatric ones would have the right to euthanasia on the grounds of "unbearable suffering") or "unbearable suffering" is a necessary but not self-standing condition and some additional criteria such as terminal stage illness or consent of all persons concerned would need to apply.

2.3.7 Conclusion

The unbearable suffering argument is based on the patient's perspective and perception. Many feel that only the patient can assess his/her intolerable suffering. Unbearable suffering is in line with the right to die and with (one of the interpretations of) human dignity to ask for euthanasia in such a humanly devastating situation assessed as unbearable suffering. Regardless of whether one is able to determine where the suffering threshold is, and if that is therefore grounds for euthanasia, the issue of whether it serves as the sole ground for such also serves to divide opinion.

2.4 Compassion

2.4.1 Introduction

While the suffering argument stems from the patient's perspective, the compassion argument comes from the other person's perspective. Compassion is a kind of external response to that devastating suffering. One feels morally obliged to help, to relieve such suffering and to save the intolerably suffering person (Begley, 2008).

2.4.2 Description

The compassion argument is usually used in euthanasia debates as "mercy killing". Under the presupposition that no person should be obliged to endure interminable suffering perceived as pointless, and supposed that the intolerable suffering cannot be relieved by medical tools and the only way to avoid such suffering is by death of the patient, then such a death may be brought about as an act of mercy. (Battin, 2003). From this perspective, euthanasia is not to be applied based on an evaluation of the suffering by a second or third person (in order to determinate if the suffering is unbearable) but about the response of the health care professionals and family members, who draw attention to the suffering person and to the distress and misery of such a situation. As an act of humanity and showing mercy they terminate the life of the suffering person. The counter-argument is based on false interpretation of compassion and mercy: killing is not compassion. To show compassion in such a situation would mean to take care of the suffering person, but not to kill him/her (Schotsmans & Gastmans, 2009).

2.4.3 Contextualization

In animals it would be regarded as inhuman to allow a dog or horse to suffer not just a terminal illness but also conditions such as a broken leg in the wild. As such, one could use animal euthanasia as an argument, making it an *a fortiori* argument: if we euthanize animals on the grounds of compassion, all the more so we have to act with compassion towards

suffering humans by providing a merciful death. As such, euthanasia is an expression of humanity.

2.4.4 Presuppositions

The compassion argument comes from the general belief that the desire to relieve suffering and feeling compassion are highly regarded human values which also include volitional elements. Compassion by definition motivates one to action. Another presupposition is based on the old medical tradition of beneficence. At present the utilitarian arguments similarly presume beneficence as the justification for euthanasia (Kohl, 1975; Rosenblatt, 1992). Compassion can also be a condition for legal assisted dying (Kay, 2006).

2.4.5 Analysis

Under the condition that there exist no effective means to relieve (unbearable) suffering, euthanasia may be justified as the only remaining option available, or even required by the principle of beneficence. The commitment to act with regard to the benefit of the patient is still one of the most relevant principles in medical ethics. Thus on such grounds of beneficence physicians would have to ensure that a peaceful and painless death is offered to patients who are suffering while dying in a horrible way. On such grounds physicians may be even obliged to administrate euthanasia due to the virtue of compassion, which seeks beneficence rather than to observe impassively and inactively as a patient dies in a horrible way with his/her painful death prolonged (Van Zyl, 2000). Such an "omission" could be qualified as contrary to basic human values such as sympathy and mercifulness.

The beneficence argument can be reinforced by utilitarianism. The killing of a patient may be contrary to the sanctity of life doctrine but as such is morally good because the consequence of such an action is good: suffering has been eliminated and the death has been achieved in a desirable way (painless and peaceful). Naturally this moral assessment of an action in accordance with its good or bad consequences can be applied not solely to physical pain and suffering but also to mental suffering such as feelings of unworthiness, loss of self-control and self-sufficiency or complete dependence on others for their assistance in daily activities starting with hygiene and food. Utilitarians argue "that frustration of being unable to perform everyday tasks for oneself, and the erosion of dignity as personal and previously private tasks have to be performed by someone else as one reverts to behaviour not experienced since infancy." (Draper, 1998, p. 184). The utilitarian argument of beneficence will be potentiated in situations where no alternative exists to the miserable death the patient is experiencing, when the suffering is ceaseless and increasing by its protraction and death is imminent. Then compassion would override that little of (very miserable) life which is lost by the act of euthanasia. The utilitarian argument of beneficence caused by compassion is an external criterion for euthanasia: the autonomous patient is not making the decision to die but another person, on grounds of sym-pathy (etymologically to suffer with), decides about the death of the suffering patient. By this argument euthanasia of incompetent patients (both of adults and children) can be justified. The common utilitarian argument would not usually justify involuntary euthanasia of a competent person. Once liberty is granted as one of the basic values, then the autonomy of individuals has to be respected. However, once the patient is no longer able to express his/her autonomy and freedom, his/her way of dying can be determined by feelings of compassion. It is very valuable if a person, moved by compassion, is seeking to act and to defeat suffering and if the sense of compassion is not limited to feeling alone. (Ramsey, 1997).

A specific target of the relief of suffering is that of terminal suffering. It could be argued that since virtually all pain can be treated pharmaceutically, compassion is not an applicable issue. However, 'virtually all' pain is not 'all'. Thus some pain and suffering remain to be treated though it cannot be treated medically and the usage of terminal sedation is justified. However terminal sedation as complete sedation is complete obtundation as well (the patient can no longer perceive and communicate) being almost the same as causing death, thus making their use questionable. Some people argue that pain and suffering as part of the dying process can be a valuable, positive and transformative experience leading to personal and spiritual growth. Nevertheless it should be said that there is no guarantee of such a positive, valuable and transformative experience. (Battin, 2003). Moreover experience of such terminal suffering is far more likely to become a very negative, horrifying experience.

2.4.6 Evaluation

Once compassion is taken as the competence which decides for the good of the patient, then the competence of the patient concerned doesn't necessarily have to be taken into account, thus compassion becomes the normative upon which decisions are made and for the incompetent patient, even in some cases for the competent one, more for the other person's self-esteem and peace of mind than for the good of the suffering patient, who did not express his/her wish to be terminated. Here the compassion argument is attacked by the slippery slope argument: from autonomous euthanasia to non-autonomous mercy killing. "The ethical acceptability of one person taking the life of another at the latter's request and based on a feeling of compassion will depend, as a minimum, on the situation involved being one of extraordinary suffering and agony that cannot be relieved" (The Danish Council of Ethics, 2006).

The ethical evaluation of compassion directly depends on the understanding of the moral significance of compassion. If compassion is ranked as a primary human virtue then the compassion argument plays a different role in the euthanasia debate than when compassion, with a focus on its unsteady and non-rational nature, is ranked as a secondary moral faculty.

2.4.7 Conclusion

The compassion argument is surrounded by many emotions which place it between compassion as the response to unbearable suffering (only the suffering person can say what suffering is not bearable) and mercy killing based not on the patient's perspective and request but on the feelings of mercy of the person who is providing a "good death"; the "good death" being interpreted exclusively by that other person.

2.5 Human dignity

2.5.1 Introduction

Human dignity[19] is an argument commonly used by both proponents and opponents in euthanasia debates. Its proponents use human dignity and the possible harm to dignity as an argument for euthanasia, mainly as a secondary argument next to the suffering and compassion arguments as the primary ones. For some people euthanasia coincides with human dignity in the sense that the administration of euthanasia is an expression of the respect for human dignity. (Humphry, 1992; Biggs, 2001). Consequently the law which

[19] For the meaning and history of dignity see Meyer, 1995.

specifies provisions for physician assisted suicide in the state Oregon is called the "Death with Dignity Act". Opponents argue that human dignity is contrary to euthanasia because it undermines human dignity, especially of elderly, disabled and dying persons. Obviously there is a diverse interpretation of human dignity beyond these controversies.

2.5.2 Description

The human dignity argument in euthanasia debates can be articulated in two simple but contradictory theses:

a. Euthanasia is in line with human dignity.
b. Euthanasia is a violation of human dignity.

The first thesis supposes that human dignity has to be protected and harm to dignity should be avoided. Since the enormous suffering of a dying person would wound the dignity of that person, it is justified to protect human dignity by the act of euthanasia – either on grounds of autonomy and right to die (voluntary euthanasia) or on grounds of compassion (non-voluntary/involuntary euthanasia).

The second thesis is similarly based on the preservation of human dignity, using a contrary argument: euthanasia is contrary to human dignity; euthanasia cannot be performed because not only the dignity of the person requesting euthanasia would be violated but also the dignity of the person who performs euthanasia (regardless of whether it was requested or not).

2.5.3 Contextualization

Human dignity is usually given as the philosophico-anthropological essence of human rights (Schachter, 1983). Thus one of the goals of human rights is to protect human dignity (respect for the inherent dignity of the human person). Consequently the right to die is not only a positive or negative right of self-determination but also a tool by which human dignity is protected. (Swarup, 2009; Cohen-Almagor, 2001). Once a person reaches the conclusion that his/her dignity would be affected by great (or unbearable) suffering and inhumane dying then the person has to take steps to protect his/her human dignity. There are plenty of historical examples of such scenarios starting with Stoa (*autothanatos*), when the person suffering in an indignant way was obliged to avoid or to end such a devaluing and dehumanizing situation by suicide.

This becomes contextualized in the form of medical futility, whereby clinical situations arise in the form of reduced therapy such as withdrawing and withholding life-sustaining treatment or termination of artificial hydration and nutrition and the relevant decision-making processes. It creates a paradigm of medically futile treatment which technically can be administrated and continued but also, from the patient perspective, such reduced treatment is justified by the respect for human dignity: it would be against human dignity (and against the patient's best interest) to produce suffering and to prolong dying if there is no other perspective than the imminent death of the patient. Since there are areas within medical practice that are already governed by measures for the protection of human dignity (e.g. advance directives) (Cantor, 1993), this protection has to be extended to other areas of end-of-life decisions such as voluntary euthanasia (Hillyard& Dombrink, 2001).

2.5.4 Presuppositions

There are two completely different philosophical presuppositions in euthanasia debates about human dignity which are very rarely revealed and addressed. One presupposition

assumes that human dignity is by its nature a changeable faculty which can be developed during the life of human being. Thus human dignity is an empirical entity which can be assessed and measured by external criteria such as level of consciousness. So while for some people human dignity is given by birth (or even before); the newborn child already has its human dignity, other people assume that human dignity has to be acquired in the course of a lifetime (after birth), when the person has developed abilities of perception, awareness, self-interest etc. As an example of this philosophical assumption Peter Singer and his approach can be given. Within this understanding, human dignity is something what we gradually acquire, develop and lose. Thus the human dignity of a terminally ill or terribly suffering person who is devastated by his/her biological and physiological condition is "on retreat" because the person is in the process of loosing his/her dignity or may have lost it to a various extent.

A different presupposition is grounded in the metaphysics of the person, which understands human dignity as a constant entity which human beings possess continuously: to be human means to have human dignity. So dignity does not belong to some aspect of a person but to the person as such, being that which is essential to the person (Ramsey, 1997). In this sense dignity is not what one has (diverse faculties and capacities) but what one *is*. Human dignity as a whole can be harmed (for instance by killing) but not taken away or lost. Thus both newborn child and dying person have the same human dignity which cannot be diminished or augmented.

2.5.5 Analysis

There is no doubt that as human beings are mortal, everybody wishes for a "death with dignity". However there are huge controversies about the meaning of dignity and its implication for dying. So for one group, "death with dignity" means legal reform which accommodates active voluntary euthanasia as an appropriate response to a perceived need for the option called "death with dignity" (Paust, 1995). While for the other group, "death with dignity" amalgamates with palliative care, hospice and spiritual care which have to replace the request for euthanasia; death with dignity seems a mutation of the original concept of human dignity and therefore euthanasia being indignant.

For the first group "being dignified is having a sense of the importance of one's life or achievements and appearing and behaving, before oneself and others, in the light of these. To lack this sense of importance or to fail to (or be unable to) present oneself in accordance with it is undignified. This lack of dignity is properly a humiliating thing for the subject, and connected to lack or loss of self-esteem, or even of the sense of self-worth." (Ramsey, 1997, p. 48). Then to live such a diminished life or to suffer such diminishment or impoverishment is sufficient to conclude that such life ought to be ended (Quill, 1993; Ramsey, 1997). Thus personal dignity is part of personal liberty which includes the ability to choose to die more or less quickly; dignity and self-determination are virtually interchangeable. It is matter of personal dignity to decide the time and way of one's death. As a supportive argument, quality of life is used: if the person decides that the quality of his/her life is too low and not acceptable to him/her then he/she has the right to choose death while one's dignity is still (relatively) intact. Some argue that dignity, being complex and unique to each person, includes not only physical and physiological aspects, but also emotional, intellectual, spiritual and existential ones (Quill, 1993).

For the second group, dignity belongs to human nature: we posses it in the mode which is not limited and therefore dignity cannot be denied or damaged. They argue that the (rational) nature of humankind cannot be attacked as such, only some aspect can be hidden: an incurable disease affects one's life but not one's nature. Dignity to them consists of the intrinsic worth of human nature (Ramsey, 1997). So despite pain and heavy suffering, there is dignity in such a case; human dignity cannot be undermined. It is obvious that such a hermeneutic of dignity is based on certain metaphysical presumptions which can be taken as granted or refused as false.

From a clinical point of view, contemporary medicine can impose medical technology on a dying person to the extent to which it can be seen as incompatible with and contradictory to human dignity. This has been recently described by an Iranian neurosurgeon in the following way: "Rob a human being of his dignity and you have robbed him of the essence of being human. Confine him, immobilize him, make him dependant, deprive him of hope and then inflict pain upon him and you have all the ingredients of the highest form of torture." (Nayernouri, 2011, p. 55)

2.5.6 Evaluation

On one hand a patient's choices, limited by existing legal constrains which do not allow a physician to comply with the patient's request for euthanasia as a deliberately hastened death, result in a violation and/or loss of dignity. On the other hand a patient's choices in many countries are limited by insufficient palliative care; this results in a violation of human dignity because persons have to die in indignant conditions.

2.5.7 Conclusion

Any conclusion regarding human dignity depends on the meaning given to the term "human dignity".

2.6 Patient's best interest

The argument of the patient's best interest is related to the argument of dignity. In the later case it was human dignity which demanded a dignified death; in some situations the respect for human dignity could justify termination of the life of a person suffering in a way which violates human dignity (when understood as a changeable feature of human beings). Here it is on the grounds of the patient's best interest that euthanasia is justified. It is either the patient self who is interpreting his/her best interest or another person (physician, nurse, relative) who is assessing the patient's best interest and who acts in the patient's best interest. Some people think that euthanasia does not go against the goals of medicine, considering it to be possibly in the patient's best overall interest. Some authors relate *euthanasia* to *eudaimonia* (living well, flourishing) of the Aristotelian tradition, arguing that in virtue ethics, euthanasia can be regarded as a continuation of *eudaimonia* insofar as euthanasia facilitates good dying (dying is a part of life), avoiding bad dying which would be frustrating and not a vibrant way to finish life. (Begley, 2008). Therefore medical and other health care professionals have to balance their own *integrity* with professional concerns and patients' interests. In this way they will recognize good and be able to realize it. Finally, helping another will lead, from a teleological perspective, to human flourishing. (Begley, 2008). So if euthanasia is understood as the upholding of a patient's best interest, then it is a catalyst to human flourishing.

The counter-argument points out that if a patient's best interest is interpreted by another person such as a health care professional, then such an interpretation will be paternalistic. Another objection does not deny the legitimacy of the patient's best interest, however in scenarios involving killing, it is not given precedence.

2.7 Quality of life

The quality of life argument is related to the patient's best interest argument in the way that it is the patient's best interest to live a life which has certain qualitative features, which are valuable and worthwhile. Quality of life is therefore an indicator as to how these qualitative features can be assessed by the patient. In contrast to the patient's best interest, quality of life is purely subjective and can be measured by the patient only. There is an affinity with the suffering argument: once suffering becomes unbearable, quality of life is very low, possibly so low that the patient does not want to live a life of such poor quality, giving euthanasia a role and upon the patient's evaluation of his/her life, a good death can be administrated.

Insofar as death is a part of life, quality of life can be referred to the quality of dying. As there has been an enormous emphasis on the quality of life in all areas of medicine in the last decades, the same impetus should be given to death and dying. (Hoffmann, 2009; Nordenfelt, 1994; Walter & Shannon, 1990). Quality of life can become a secondary argument of autonomy (as the primary argument): Once the quality of life or dying is too low and no longer acceptable or intolerable, the patient can express his/her autonomy by requesting euthanasia.

The counter-argument to the quality of life argument is based on a critique of the concept of quality of life in health care. This critique emphasizes life as a gift which is valuable as such and which should not be measured by subjective criteria of quality. In a comparable way as the dignity of life cannot be measured, the value of life cannot be assessed. Although quality of life is very important both individually and for society as a whole, quality of life in itself cannot be the reason to terminate those suffering low quality of life or life which is not deemed worthy of being lived. And this line of counter-argument could continue with references to the Nazi period (the killing of people with low quality of life and with unworthy life).

2.8 Health care costs

It is a trivial statement that health care resources are limited. Since some treatments (e.g. intensive care or in oncology) are very expensive, they should be used with good justification in order to prevent that health care resources are not used in an unfair and irresponsible way but in the ways in which the criteria of social justice are satisfied.

From an economic standpoint, one package of morphine costs a few Euros while one day in an Intensive Care Unit can cost thousands of Euros. On top of that if the treatment is futile anyway and the patient's prospect is one mainly of pain, suffering and dying then not only principles such as autonomy or dignity apply but also principles like justice, solidarity (which would not justify futile treatment) and health care costs as distribution of limited resources criteria have to be taken into account.

There are various scenarios for the economical calculation in this context; from very liberal ones to those based more on social coherence and social solidarity (which has its limits as well). Then euthanasia could become a smooth solution for generally expensive health care

and for health care systems suffering from financial deficiency. It should be mentioned that palliative care is much less expensive than many medically aggressive, technically advanced and economically costly treatments.
The counter-argument is based on the impropriety of a financial argument in the context of dying patients. The counter-objection stresses the fact of limited resources for health care and the validity of health care cost calculations. The middle-ground position argues that care for terminally ill and dying patient certainly cannot be limited to economic calculations however health care costs do have to be considered.

2.9 Regulation - legalization

The basic form of the regulation argument concerns the legalization of euthanasia. Proponents argue, while referring to autonomy, right to die, compassion and dignity, that euthanasia should be a legal right for everyone; the criminalization of euthanasia is contrary to the many arguments for which euthanasia should be decriminalized. The fear of decriminalization of euthanasia has the consequence that euthanasia will be practised "in the shadows", beyond any social control. The legalization argument is more policy oriented, focusing more on social and legislative strategies than on morality as such.
Opponents argue that the right to die cannot be legally acknowledged since such a right does not exist, moreover such a legal provision would violate human rights, in particular the right to life. Even opponents who would otherwise condone legal voluntary euthanasia under certain conditions argue that once legalized, euthanasia would be abused. Referring to the Dutch practice where not all performed cases of euthanasia have been reported, they argue that there is a slippery slope from active voluntary euthanasia to involuntary euthanasia which, again, can be proven empirically. (Keown, 1995, 2002).
A pragmatic view on regulation appreciates a legal provision on euthanasia under the argument "regulation is better as no regulation at all". Once regulated, obligatory rules have been established and they provide an enforceable framework. The alternative scenario of no regulation is much worse because euthanasia will be performed anyway but in the chaotic and confused setting of a grey zone.
Those who hold euthanasia as wrong in principle argue that an immoral practice cannot be transformed into a moral one by legalization: immorality cannot be legalized.

2.10 Transparency

The transparency argument is associated with the regulation argument. As is generally known, euthanasia is being practiced in many countries in which it is illegal. So the transparency argument states as follows: let us be transparent, let us continue doing what we are doing anyway in the open and honest way, let us terminate hypocrisy (criticising euthanasia in Benelux, not being able to address the issue in our home countries, behaving as if euthanasia is not presently being practised in our cities).
The argument to the contrary holds that if euthanasia is completely wrong, then transparency only serves to corrupt existing morality. A similar objection as above would apply.

3. Conclusion

In the analysis of this chapter, it became clear that for any argumentation on euthanasia, regardless of whether for or against, the first crucial step is clarity in terminology: what

exactly do we mean by the term "euthanasia". So to avoid confusion, misunderstanding and frustration, it is crucial to start with clear semantics. Within this analytical study, euthanasia, having been distinguished from assisted suicide and from other instances of the end-of-life decisions such as withholding, withdrawing or terminal sedation, was defined as a deliberate act of termination of the life of *B* by *A* upon an explicit request of *B* for the sake of *B*. This means that the term euthanasia is understood to be so-called active voluntary euthanasia. Moreover, for a precise definition, some additional criteria apply such as terminal stage of the illness, unbearable suffering, enduring and voluntary wish to die (expressed repeatedly), and the act of euthanasia being performed by a physician.

In the discussions on euthanasia various numbers of arguments are listed. Similarly different types of argumentations can be identified which use different or the same arguments taken from different fields and contexts; so one and the same argument is used within diverse argumentations. In summary, philosophical, legal, religious and social types of argumentations on euthanasia should be distinguished. So if, for instance, an argument is made on the basis of a "right", while one argumentation uses the argument of "right" in the legal sense (e.g. human rights), another uses the argument of "right" in the sense of moral right (moral claim, not based on specific legislation). The next one uses the argument of "right" in a theological way (God's right over life) or in a psychological way (one's right to an authentic expression of his/her self).

It became evident that there are no unequivocal arguments for or against euthanasia. Any list of arguments *for* euthanasia is, to a large extent, at the same time also a list of the arguments *against* euthanasia in the sense that another list of objections to these *pro* arguments has to be considered. Some of the *pro* arguments are simultaneously *contra* arguments and vice versa (e.g. dignity). Despite this fact, some arguments are prevalently arguments *pro* (e.g. autonomy) while the other ones are arguments *against* (e.g. slippery slope). If the argumentation is not to be biased, it has also to deal with the argument's contra position in an intellectually honest way.

The analysis demonstrated that some arguments which at first glance seemed quite convincing were found to be not so if questioned and analyzed critically, and once their weak points are also brought to light. So for instance the autonomy argument (autonomy of the dying person asking for euthanasia) is not as convincing as its proponents argue, being replaced or invalidated by the argument of compassion - unless there is clear evidence that euthanasia was the genuine choice and authentic option of the person concerned. While the autonomy argument has its justifications and explanatory powers, it is however diminished by other arguments such as competence or social pressure which affect the authenticity of an autonomous choice.

As an auxiliary tool, a matrix of arguments (Fig. 1) demonstrating the interconnectedness of the individual arguments was provided. The matrix shows both the prevalent dichotomy *"pro et contra"* and complementariness. As the main arguments *for* euthanasia, autonomy, the right to die, unbearable suffering, compassion, dignity, the patient's best interest, quality of life, health care costs, policy arguments of legalization (regulation) and transparency have been identified. By contrast, as the arguments *against* euthanasia, the following ones have been listed: competence, inviolability of human life, prohibition of killing, abuse, slippery slope, quality palliative care, physician's role, vulnerability, and social pressure. All these arguments have to be placed into the operational framework of the proposed matrix whose purpose is to illustrate the correlation of individual arguments. Some arguments can be

used simultaneously both ways, for or against euthanasia; each of them has its own different explanatory and justifying power; some of them remain mutually exclusive (e.g. autonomy, compassion).

There is an immense interrelation between the arguments which sometimes goes unnoticed but what can be described by comparative analysis based on the proposed matrix. Many arguments rely on specific meaning or interpretations, as derived by the semantics of a singular term, or by a specific philosophical approach upon which the argument is based (e.g. dignity); last but not least the arguments also rely on their use in a particular cultural and/or religious context.

Such an understanding of the backgrounds, mechanisms and strategies of the arguments on euthanasia contributes significantly to a meaningful and respectful discussion of the controversial issue of euthanasia, which will surely continue into the coming decades.

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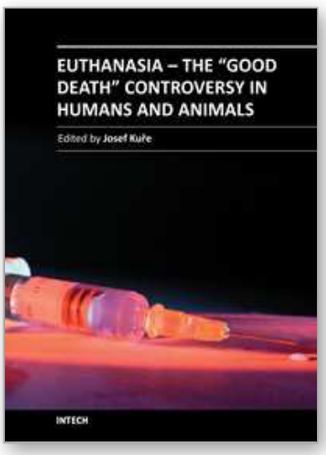

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No one really wants to die, or do they? From classical times to our post-modern era of medical high tech, societies have struggled with the thorny issue of euthanasia, and what it entails. Who shall be entitled to a "good death" and in what form shall it arrive? This book provides the reader with insight and enlightenment on the medical, philosophical, social, cultural and existential aspects of "good death" amid our digitized, individualized and ageing society, hampered by rising health care costs but unchained from one standardized level of care.

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