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REVIEW

Euthanasia and assisted suicide: a physician's and ethicist's perspectives

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Video abstract

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Abstract: The debate on legalizing euthanasia and assisted suicide has a broad range of participants including physicians, scholars in ethics and health law, politicians, and the general public. It is conflictual, and despite its importance, participants are often poorly informed or confused. It is essential that health care practitioners are not among the latter. This review responds to the need for an up-to-date and comprehensive survey of salient ethical issues. Written in a narrative style, it is intended to impart basic information and review foundational principles helpful in ethical decision-making in relation to end-of-life medical care. The authors, a physician and an ethicist, provide complementary perspectives. They examine the standard arguments advanced by both proponents and opponents of legalizing euthanasia and note some recent legal developments in the matter. They consider an aspect of the debate often underappreciated; that is, the wider consequences that legalizing euthanasia might have on the medical profession, the institutions of law and medicine, and society as a whole. The line of argument that connects this narrative and supports their rejection of euthanasia is the belief that intentionally inflicting death on another human being is inherently wrong. Even if it were not, the risks and harms of legalizing euthanasia outweigh any benefits. Ethical alternatives to euthanasia are available, or should be, and euthanasia is absolutely incompatible with physicians' primary mandate of healing.

Keywords: euthanasia, physician assisted-suicide, healing, suffering, palliative care, palliative sedation

Introduction

One of us (JDB) was recently attending on a clinical service where a situation arose that prompted a discussion concerning assisted suicide. It revealed a surprising lack of consensus among physicians regarding the difference between assisted suicide and euthanasia, as well as an appalling level of confusion about basic facts. Such a situation is disconcerting, given that good ethical decision-making requires "getting the facts straight" as an essential first step. It may be understandable that personal perspectives will vary on matters such as physician-assisted suicide (PAS) and euthanasia, particularly in our pluralistic societies. However, it is unacceptable that conversations of a professional nature would proceed in the absence of agreement on relevant first principles and without a shared knowledge base. It would be akin to a cadre of interventional cardiologists, equipped with a shaky grasp of the vascular anatomy of the myocardium, debating the merits of an innovative approach to intracoronary stenting.

This article addresses such lacunae in relation to euthanasia and PAS. (We will use the word euthanasia to include PAS except where we state otherwise or it is clear we

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are dealing with the issues separately). We define euthanasia and assisted suicide, reveal common misconceptions in this regard, and expose euphemisms that, regrettably, often serve to confuse and deceive. We review the main arguments advanced by proponents and opponents of legalizing euthanasia. The philosophical assumptions guiding our perspectives are laid out. We consider the effect of legalization on patients and their families, physicians (as individuals and a collectivity), hospitals, the law, and society at large. Our goal is to provide a vade mecum useful in end-of-life care and ethical decision-making in that context.

Definitions

Euthanasia

Euthanasia is an emotionally charged word, and definitional confusion has been fermented by characterizations such as passive versus active euthanasia. Some have suggested avoiding using the word altogether.[1,2] We believe it would be a mistake to abandon the word, but we need to clarify it.

The word's etymology is straightforward: eu means good and Thanatos means death. Originally, euthanasia meant the condition of a good, gentle, and easy death. Later, it took on aspects of performativity; that is, helping someone die gently. An 1826 Latin manuscript referred to medical euthanasia as the "skillful alleviation of suffering", in which the physician was expected to provide conditions that would facilitate a gentle death but "least of all should he be permitted, prompted either by other people's request or his own sense of mercy, to end the patient's pitiful condition by purposefully and deliberately hastening death".[3] This understanding of euthanasia is closely mirrored in the philosophy and practice of contemporary palliative care. Its practitioners have strongly rejected euthanasia.[4]

Recently, the noun has morphed into the transitive verb "to euthanize". The sense in which physicians encounter it today, as a request for the active and intentional hastening of a patient's demise, is a modern phenomenon; the first sample sentence given by the Oxford English Dictionary to illustrate the use of the verb is dated 1975.[5] The notion of inducing, causing, or delivering a (good) death, so thoroughly ensconced in our contemporary, so-called "progressive values" cultural ethos, is a new reality. That fact should raise the question: "Why now?" The causes go well beyond responding to the suffering person who seeks euthanasia, are broad and varied, and result from major institutional and societal changes.[6]

Physicians need a clear definition of euthanasia. We recommend the one used by the Canadian Senate in its 1995 report: "The deliberate act undertaken by one person with the intention of ending the life of another person in order to relieve that person's suffering."[7]

Terms such as active and passive euthanasia should be banished from our vocabulary. An action either is or is not euthanasia, and these qualifying adjectives only serve to confuse. When a patient has given informed consent to a lethal injection, the term "voluntary euthanasia" is often used; when they have not done so, it is characterized as "involuntary euthanasia". As our discussion of "slippery slopes" later explains, jurisdictions that start by restricting legalized euthanasia to its voluntary form find that it expands into the involuntary procedure, whether through legalizing the latter or because of abuse of the permitted procedure.

In the Netherlands, Belgium, and Lichtenstein, physicians are legally authorized, subject to certain conditions, to administer euthanasia. For the sake of clarity, we note here that outside those jurisdictions, for a physician to administer euthanasia would be first-degree murder, whether or not the patient had consented to it.

Assisted suicide

Assisted suicide has the same goal as euthanasia: causing the death of a person. The distinction resides in how that end is achieved. In PAS, a physician, at the request of a competent patient, prescribes a lethal quantity of medication, intending that the patient will use the chemicals to commit suicide. In short, in assisted suicide, the person takes the death-inducing product; in euthanasia, another individual administers it. Both are self-willed deaths. The former is self-willed and self-inflicted; the latter is self-willed and other-inflicted. Although the means vary, the intention to cause death is present in both cases.

Some will argue that agency is different in assisted suicide and euthanasia; in the former, the physician is somewhat removed from the actual act. To further this goal, two ethicists from Harvard Medical School in Boston, Massachusetts, USA, have proposed strategies for limiting physician involvement in an active death-causing role.[8] It is, indeed, the case that patients provided with the necessary medication have ultimate control over if, when, and how to proceed to use it; they may change their mind and never resort to employing it. However, in prescribing the means to commit suicide, the physician's complicity in causing death is still present. There are, however, some limits on that complicity, even in the jurisdictions where it has been legalized. For instance, even supporters of PAS in those jurisdictions agree it is unethical for physicians to raise the topic with individuals, as that might constitute subtle coercion or undue influence, whether or not intended.

PAS has been decriminalized in Oregon, Washington State, Montana, and Vermont, and absent a "selfish motive", assisted suicide is not a crime in Switzerland.[9] Even in these jurisdictions, however, one cannot legitimately speak of a "right" to suicide because no person has the obligation to assist in the suicide. Rather, assisting suicide has been decriminalized for physicians in the American states listed and for any person in Switzerland; that is, it is not a criminal offence for those who comply with the applicable laws and regulations.

Terminal sedation and palliative sedation

A lethal injection can be classified as "fast euthanasia". Deeply sedating the patient and withholding food and fluids, with the primary intention of causing death, is "slow euthanasia". The use of "deep sedation" at the end of life has become a more common practice in the last decade and has been the focus of controversy and conflict, especially because of its probable abuse.

Certain terminology, such as "palliative terminal sedation", creates confusion between sedation that is not euthanasia and sedation that is euthanasia. It was used, for example, by the Quebec Legislative Assembly in drafting a bill to legalize euthanasia.[10] We note that creating such confusion might constitute an intentional strategy to promote the legalization of euthanasia. In the amended bill, the term "palliative terminal sedation" was replaced by "continuous palliative sedation", which the patient must be told is irreversible, clearly indicating the legislature's intention to authorize "slow euthanasia", although many people might not understand that is what it means. The bill died on the order paper when a provincial election was called before it was passed. Immediately after the election the bill was reintroduced at third reading stage by unanimous consent of all parties and passed by a large majority. This new law allowing euthanasia in Quebec, the only jurisdiction in North America to do so, remains the focus of intense disagreement and is now being challenged as ultra vires the constitutional jurisdiction of Quebec.

"Palliative sedation", which is relatively rarely indicated as an appropriate medical treatment for dying people, is used when it is the only reasonable way to control pain and suffering and is given with that intention. It is not euthanasia. "Terminal sedation" refers to a situation in which the patient's death is not imminent and the patient is sedated with the primary intention of precipitating their death. This is euthanasia. The terms palliative terminal sedation and continuous palliative sedation confound these two ethically and legally different situations.

Euthanasia advocates have been arguing that we cannot distinguish the intention with which these interventions are undertaken, and therefore, this distinction is unworkable. But the circumstances in which such an intervention is used and its precise nature allow us to do so. For instance, if a patient's symptoms can be controlled without sedation, yet they are sedated, and especially if the patient is not otherwise dying and food and fluids are withheld with the intention of causing death, this is clearly euthanasia. Needing to discern the intention with which an act is carried out is not unusual. For instance, because intention is central to determining culpability in criminal law, judges must do so on a daily basis. We note, also, that intention is often central in determining the ethical and moral acceptability of conduct, in general.

Within the realm of decision-making in a medical context, withdrawal of artificial hydration and nutrition has continued to be a very contentious issue in situations in which persons are not competent to decide for themselves about continuing or withdrawing this treatment. The questions raised include: When does its withdrawal constitute allowing a person to die as the natural outcome of their disease (when it is not euthanasia)? And when does its withdrawal constitute starving and dehydrating a person to death (when it is euthanasia)?

Our key assumptions

In discussing an issue as contentious as euthanasia, which has a foundational base in values as well as facts and knowledge, it is incumbent on us to identify our underlying philosophical beliefs and assumptions. This will orient the reader to the line of logic that links the ensuing arguments.

People undertaking an ethical analysis belong in one or other of two main camps: principle-based (or deontological) ethics or utilitarian ethics. We belong to the first group. We believe there exists a universal morality and that, at the very least, there is significant intercultural agreement on core concepts of ethics. It is important to recognize that agreement when it exists, because we should try to start our ethical debates from where we agree, not from our disagreements. Doing so allows an experience of a shared morality, which gives a different tone to both the debate and our disagreements.

It is beyond the scope of this article to discuss in depth the putative origins of this human moral sense. For religious people, it is to be found in their religious beliefs. Perhaps it is a result of Darwinian natural selection and has come to be written in our genetic code and reflected in our common neurobiological apparatus. Perhaps it is a product of the powerful reasoning capabilities of *Homo sapiens*, culminating in a rationalization process that recognizes the survival and other

advantages of cultivating virtues such as altruism and fairness over greed and injustice. Perhaps its origins will forever elude us and we must be content with describing it through concepts such as moral intuition. Perhaps it is some combination of all of these factors and others. Regardless, it has often been said that even in secular societies, close to 100% of its citizens adhere to moral codes, whether implicit (eg, the ethical "yuck" factor) or explicit (eg, the Ten Commandments).

As a consequence, we endorse the view that the practice of medicine is necessarily constrained by moral absolutes. In other words, we categorically reject moral relativism, the utilitarian view that what is right or wrong depends just on weighing whether benefits outweigh risks and harms, and in particular, that this is only a matter of personal judgment. Some things ought never to be done to patients by their physicians. In relation to euthanasia, physician–philosopher Edmund Pellegrino states it well: "Physicians must never kill. Nothing is more fundamental or uncompromising".[11] We strongly agree, and this central tenet informs our entire line of argument.

We believe that future generations looking back on the twenty-first century euthanasia debate (which is taking place in most Western democracies) will see it as the major values debate of the century and determinative of the most important foundational values of the world they will have inherited.

Basic concepts related to euthanasia and PAS

The right to die

The "right to die" terminology is used in the euthanasia debate to propose there is a right to have death inflicted. Death is inherent to the human body, vulnerable and inexorably aging; death can be accelerated or temporarily delayed, but never thwarted. The inevitability of death is an explicit, necessary, noncontingent, and universalizable phenomenon true for all living beings. There is no "right to die". In contradistinction, there are fundamental human rights to "life, liberty and security of the person".

Where there is a right, there is an obligation; therefore, were a "right to die" to exist, a logical consequence would be that some other person or agent would have a duty to inflict death (especially if the requisitioner were physically incapable of accomplishing the act themselves). Pro-euthanasia advocates rely heavily on this line of logic and have used it to impose responsibility for carrying out euthanasia onto the medical profession.

The claim to a right to die must be distinguished from a "right to be allowed to die"; for instance, by refusing life-support treatment. The right to permit the dying process to unfold unimpeded flows from and is a consequence of persons' exercise of their right to inviolability, the right not to be touched without their informed consent. It does not establish any right to die in the sense of a "right to be killed".

A recent case from British Columbia, *Carter v. Canada (Attorney General)*,[12] illustrates the arguments that emerge between those arguing for a right to die (legalized euthanasia) and those opposing it. Gloria Taylor, a woman with amyotrophic lateral sclerosis who was one of the plaintiffs, challenged the constitutional validity of the prohibition on assisted suicide in the Canadian Criminal Code.[13] Suicide and attempted suicide used to be crimes under the code, but these crimes were repealed by the Canadian Parliament in 1972. However, the crime of assisting suicide was not repealed. The trial judge in the Carter case, Justice Lynn Smith, considered the reasons for that repeal. She accepted that it was not done to give a personal choice to die priority over "the state interest in protecting the lives of citizens; rather, it was to recognize that attempted suicide did not mandate a legal remedy".[12] With respect, we propose an alternative explanation: The designation of those acts as crimes was abolished to try to save the lives of suicidal people. It was hoped that if society removed the threat of possibly being charged with a criminal offence, they and their families would be more likely to seek medical assistance.

In coming to her conclusions that PAS can be ethically acceptable and ought to be legally allowed in certain circumstances, Justice Smith relied heavily on the fact that it is no longer a crime to commit or attempt to commit suicide and asked, why, then, is it a crime to assist it? "What is the difference between suicide and assisted suicide that justifies making the one lawful and the other a crime, that justifies allowing some this choice, while denying it to others?"[12]

The answer is that decriminalizing suicide and attempted suicide is intended to protect life; decriminalizing assisted suicide does the opposite. As explained earlier, intentions are often central in deciding what is and is not ethical.

Society tries to prevent suicide. Notwithstanding the influence of pro-euthanasia advocates, the preponderant societal view is that suicide, at least outside the context of terminal illness, must not be tolerated. Suicide is generally considered a failure of sorts: the manifestation of inadequately treated depression, a lapse in community support, a personal shortcoming, societal disgrace, or a combination thereof. Even if in certain societies in ancient times suicide was not illegal, it was generally frowned upon.[14]

Importantly, the decriminalization of suicide does not establish any right to die by suicide. Furthermore, if there were such a right, we would have a duty not to treat people

who attempt suicide. In other words, if there were a right to choose suicide, it would mean that we have correlative obligations (perhaps subject to certain conditions such as ensuring the absence of coercion) not to prevent people from making that choice. Hospital emergency rooms and health care professionals faced with a patient who has attempted suicide do not, at present, act on that basis. Psychiatrists who fail to take reasonable care that their patients do not commit suicide, including by failing to order their involuntary hospitalization to prevent them committing suicide, when a reasonably careful psychiatrist would not have failed to do so, can be liable for medical malpractice, unprofessional conduct, and even, in extreme cases, criminal negligence.

Another distinguishing feature between suicide and assisted suicide must be underlined. Suicide is a solitary act carried out by an individual (usually in despair). PAS is a social act in which medical personnel licensed and compensated by society are involved in the termination of the life of a person. It asks not that we attempt to preserve life, the normal role of medicine and the state, but that we accept and act communally on a person's judgment that his or her life is unworthy of continuance. (We are indebted to Canadian bioethicist Dr Tom Koch for this particular formulation of the issue.)

Autonomy

Advocates of euthanasia rely heavily on giving priority to the value of respect for individuals' rights to autonomy and self-determination. Respect for autonomy is the first requirement listed in the principlism approach to biomedical ethics, known as the "Georgetown mantra", which strongly influenced the early development of applied ethics in the 1980s.[15] It refers to a person's right to self-determination, to the inherent right of individuals to make decisions based on their constructions of what is good and right for themselves. The autonomous personal self is seen to rule supreme. It washes over the relational self, the self that is in connection with others in the family and community. Autonomy is often treated as an "uber" right trumping all other rights. It renders moot many obligations, commitments, and considerations beyond the risks, harms, and benefits to the individual involved. The inclination to attribute primary importance to autonomy may be alluring at first glance; clearly, no physician educated in today's ethical zeitgeist (patient-centered, partnership-seeking, and consent-venerating) would want to be seen to be violating someone's autonomy by disrespecting their right to make personal choices. That would smack of paternalism or authoritarianism, which are seen by "progressives" as heinous wrongs.

The way in which respect for autonomy is implemented in practice and in law is through the doctrine of informed consent. Among many requirements, it demands that the patient be fully informed of all risks, harms, benefits, and potential benefits of the proposed procedure and its reasonable alternatives. As a consequence, to obtain legally valid informed consent to euthanasia, the patient must be offered fully adequate palliative care. As well, the patient must be legally and factually mentally competent, and their consent must be voluntary: free of coercion, duress, or undue influence. We question whether these conditions can be fulfilled, at least with respect to many terminally ill patients.

Individual autonomy and perspectives from the individual's family

It is useful to consider the historical roots of individual autonomy and its possible links to the movement to legalize euthanasia. The belief that one has the right to die at the time, place, and in the conditions of one's choosing is based on the conviction that one owns one's body and that one can do with it as one pleases. It is an idea deeply rooted in the humanist worldview.

The notion of a personal self emerged in the Renaissance, where it was thought that the personal self could be worked on and perfected. It was quite distinct from more ancient concepts of humans as part of a greater and unified whole. Pica della Mirandola (quoted in Proctor 1988)[16] captures the sentiment: "We have made thee neither of heaven nor of earth, neither mortal nor immortal, so that with freedom of choice and with honor, as though the maker and molder of thyself, thou mayest fashion thyself in whatever shape thou shalt prefer." It does not require a huge conceptual leap to appreciate that if the self can be created, the process should be reversible: self-making balanced with self-annihilation. Self-determinationism is a type of solipsism discernible at the very core of most philosophical arguments in favor of euthanasia.

The concept of autonomy can be problematized. It is, as ethicist Alfred Tauber has suggested, two-faced.[17] He describes two conceptions of autonomy: one that is dependent on radical self-direction and human separateness and another that is other-entwined and constitutive of social identities. He places interdependence, interpersonal responsibility, and mutual trust as counterpoints to free choice. He argues that both are necessary for society to thrive and for medicine to fulfill its moral imperative. Autonomy is also being rethought by some feminist scholars through a concept called "relational autonomy".[18] This recognizes that, hermits

aside, we do not live as solitary individuals but, rather, in a web of relationships that influence our decisions, and that these must be taken into account in assessing whether or not our decisions are autonomous. The role that respect for autonomy should play in relation to the decision whether to legalize euthanasia must be examined not only from the perspective of the patient but also from the perspective of the patient's relations. In the current debate, the latter have often been neglected.

It is ethically necessary to consider the effects on a person's loved ones of that person's decision to request euthanasia. We illustrate this by making reference to the BBC television program "Coronation Street", the longest-running television soap opera in history. It recently focused on a character named Hayley Cropper. In a series of episodes in early 2014, Hayley was diagnosed with pancreatic cancer and subsequently resorted to suicide in the presence of her husband, Roy Cropper. The producers of the show succeeded in plucking at heart strings and eliciting empathic responses from the audience. The character had a complex personal narrative that permitted one to appreciate why she might have wanted to hasten her own death: she was a transsexual woman who feared reverting to her previous male identity as her dying process progressed. The producers, always attuned to contemporary societal issues, made sure to balance Hayley's suffering with a reciprocal harm, wrought on her husband Roy and another character, Fiona (Fiz) Brown. Roy became tormented with guilt by association, and Fiz was seriously traumatized because she was deprived of the opportunity to say goodbye to Hayley, her foster mother. The point made was that self-willed death may be merciful to oneself and simultaneously cruel to others. There is an essential reciprocity in human life. We are neither islands in the seas nor autonomous, self-sufficient planets in the skies.

We must also examine the effect of legalizing euthanasia from the perspective of physicians' and other health care professionals' autonomy with respect to freedom of conscience and belief, and the effect it would have on institutions and society as a whole. The overwhelming thrust of the euthanasia debate in the public square has been at the level of individual persons who desire euthanasia. Although that perspective is an essential consideration, it is not sufficient. Even if euthanasia could be justified at the level of an individual person who wants it (a stance with which we do not agree), the harm it would do to the institutions of medicine and law and to important societal values, not just in the present but in the future, when euthanasia might become the norm, means it cannot be justified.

Loss of autonomy, experienced or anticipated, is one of the reasons that might prompt a patient to request death from their physician. Other reasons include pain, but it is not the most important. Thankfully, modern medicine is, with few exceptions, effective at relieving physical symptoms, particularly pain. These other sources of suffering are largely in the psychosocial domain, as the recent annual report by Oregon's Public Health Division (released on January 28, 2014) demonstrates. During a 14-year period (1998–2012), the three most frequently mentioned end-of-life concerns were loss of autonomy (91.4%), decreasing ability to participate in activities that made life enjoyable (88.9%), and loss of dignity (80.9%).[19] A loss in bodily function is linked to the fear of becoming a burden on loved ones and is often experienced as an assault on human dignity. It is important to note that depression can represent either an indication or a contraindication for euthanasia. A list of end-of-life concerns that can be linked to requesting euthanasia is presented in Table 1.

We turn now to another critically important value, respect for life, which, in the context of euthanasia, is in conflict with respect for autonomy. In discussing euthanasia, the one cannot be properly considered in isolation from the other.

Respect for human life

Respect for human life must be maintained at two levels: respect for each individual human life and respect for human life in general. Even if it were correct, as pro-euthanasia advocates argue, that when a competent adult person gives

Table 1 List of common reasons for requested death

Reason
Loss of autonomy and independence (eg, loss of control over decisions, inability to make decisions, loss of self-care abilities)
Less able to engage in activities making life enjoyable
Perceived loss of human dignity; this is often related to an impairment of physiological functions in basic body systems (eg, bowel functioning, swallowing, speech, reproduction) or preoccupations with bodily appearance
A fear of becoming a burden on family, friends, and community
Cognitive impairment or fear of cognitive impairment
Depression, hopelessness (nothing to look forward to), or demoralization*
Feeling useless, unwanted, or unloved; social isolation
Inadequate pain control or concern about it
Existentialist angst or terror, mortality salience, fear of the unknown
Intractable symptoms other than pain (eg, pruritus, seizures, paresthesias, nausea, dyspnea)
Financial implications of treatment

Notes: This list is not presented in the order of frequency. *Some experts deny that demoralization actually exists as a mental disorder separate from clinical depression.

informed consent to euthanasia there is no breach of respect for human life at the level of the individual, there is still a breach of respect for human life in general. If euthanasia is involved, how one person dies affects more than just that person; it affects how we all will die.

Respect for life is implemented through establishing a right to life. We return to the trial judgment in the Carter case because it illustrates how such a right can be distorted and co-opted in the service of legalizing PAS or even euthanasia. In applying the right to life in section 7 of the *Canadian Charter of Rights and Freedoms*[20] to Ms Taylor's situation, Justice Smith says:

> [T]he [Criminal Code] legislation [prohibiting assisted suicide] affects her right to life because it may shorten her life. Ms Taylor's reduced lifespan would occur if she concludes that she needs to take her own life while she is still physically able to do so, at an earlier date than she would find necessary if she could be assisted.[12]

What is astonishing is the novel, to say the least, way in which Justice Smith constructs a breach of Ms Taylor's *Charter* right to life. In effect, Justice Smith's reasoning converts the right to life to a right to death by PAS or euthanasia. Justice Smith's judgment was overturned by a two to one majority in the British Columbia Court of Appeal, as contrary to a Supreme Court of Canada precedent ruling that the prohibition of assisted suicide is constitutionally valid.[21] It is now on appeal to the Supreme Court of Canada; we note its liberty to override its previous precedents.

Obfuscations and the main arguments of proponents and opponents

Proponents of euthanasia often use rhetorical devices to foster agreement with their stance by making it more palatable. One of these is to eliminate the use of words that have a negative emotional valance. As mentioned previously, "suicide" has been a taboo for many cultures and across time. Some commentators have described concepts such as suicide clusters, suicidal contagion, and suicide scripting; none of these are considered beneficial to society. As a consequence, there have been efforts at replacing the terminology of assisted suicide with assisted dying. A former editor of the *New England Journal of Medicine*, Marcia Angell, has stated that the latter expression is more appropriate because it describes someone "who is near death from natural causes anyway while the former refers to something occurring in someone with a normal life expectancy".[22] We doubt that she was actually meaning to imply that human lives have less intrinsic worth as persons approach death; however, that interpretation is logical and inevitable.

Another strategy to whitewash "death talk" is to figuratively wrap it within the white coat of medicine. Cloaking these acts in medical terms softens them and confers legitimacy. This has spawned a host of euphemisms such as "medically assisted death", "medical-aid-in-dying", and "death with dignity". After all, we all want good medical care when we are dying. A strategy that may escape scrutiny is to link assisted suicide with physicians; that is, PAS. However, assisted suicide and euthanasia are not necessarily glued to physicians. Nurses could perform these procedures, although most recoil at the prospect. In theory, almost anyone (ambulance drivers, veterinarians, pharmacists, lawyers) could be empowered and trained to euthanize. We have argued elsewhere that if society is going to legalize euthanasia (which we oppose it doing), it could equip itself with a new occupation of euthanology,[23] thereby relieving physicians of having to contravene their ancient guiding principle of primum non nocere.

One must also be wary of euphemisms because they dull our moral intuitions and emotional responses that warn us of unethical conduct. In our world of desktops, laptops, and smartphones, where one's existence is proclaimed and validated on computer screens and intersubjectivity is channelled in cyberspace, we would not be surprised to see some enterprising euthanologist of the future advertise a gentle "logging-off". Although fanciful, this prediction is well aligned with a conception of the world that views persons as reducible to bodies with complex networks of neurological circuits wherein the entire range of human experiences can be created, recorded, interpreted, and terminated.

This conception of human existence can also breed rather extreme points of view, such as the one that considers the failing body as "unwanted life support". David Shaw has suggested that, "if a patient is mentally competent and wants to die, his body itself constitutes unwarranted life support unfairly prolonging his or her mental life".[24]

Many current attitudes and values could affect how terminally ill, dying, and vulnerable people are treated. For example, if materialism and consumerism are priority values, euthanasia fits with the idea that, as one pro-euthanasia Australian politician put it: "When you are past your 'use by' or 'best before' date, you should be checked out as quickly, cheaply and efficiently as possible." But we are not products to be checked out of the supermarket of life. As this shows, some who advocate in favor of euthanasia resort to intense reductionism in buttressing their arguments. If one thinks of

a human being as having an essence comprised of more than bodily tissues, then the intellectual, emotional, and social barriers to euthanasia come to the fore.

Euphemizing euthanasia through choice of language is not the only "legalizing euthanasia through confusion" strategy.[25] Another is the "no difference" argument. The reasoning goes as follows: refusals of treatment that result in a shortening of the patient's life are ethical and legal; this is tantamount to recognizing a right to die. Euthanasia is no different from them, and it's just another way to implement the right to die. Therefore, if we are to act consistently, that too should be seen as ethical and legal. The further, related, argument is that euthanasia is simply another form of medical treatment. However, as explained previously, the right to refuse treatment is not based on a right to die, and both the intention of the physician and the causation of death are radically different in those cases compared with euthanasia.

The main arguments in favor of and in opposition to euthanasia are presented in Table 2. Prominent on the yea side are the autonomy principle and the belief that putting an end to suffering through euthanasia is merciful and justifies euthanasia. Prominent on the nay side are the corrosive consequences for upholding society's respect for life, the risks of abuse of vulnerable people, and the corruption of the physician's role in the healing process.

Table 2 Main arguments advanced by proponents and opponents of euthanasia

Arguments
Arguments in favor of euthanasia
Persons have an inalienable right to self-determination; that is, patients can decide how, where, and when they are going to die.
Euthanasia is a profoundly humane, merciful, and noble humanitarian gesture because it relieves suffering.
Assistance in dying is a logical and reasonable extension to end-of-life care and involves only an incremental expansion of practices that are legal and seen as ethical.
It bypasses physicians' reluctance to accept patients' advanced directives and their requests to limit interventions.
It can be carried out humanely and effectively, with negligible risk of slippery slopes.
Arguments against euthanasia
Intentionally taking a human life, other than to save innocent human life, is inherently wrong and a violation of a universal moral code.
The value of respect for autonomy must be balanced by other values, particularly respect for individual human life and respect for human life in general.
It is different in kind from other palliative care interventions aimed at relieving suffering, such as pain management, and from respect for patients' refusals of life support treatment.
Slippery slopes are unavoidable.
It introduces an unacceptable potential for miscommunication within the doctor–patient relationship.
It is incompatible with the role of the physician as healer and would erode the character of the hospital as a safe refuge.

The role of the physician: "doctor as healer"

An absolute barrier to physicians becoming involved with acts that intentionally inflict death is that doing so would be incompatible with their healer role. This statement requires unpacking. The concept of "healing" is a challenging one to define, and it is nearly impossible to explain it in reductionist and objectivist terms. By its very nature, healing is holistic and intersubjective. Balfour Mount, the physician who created the first palliative care unit in North America, has defined it as "a relational process involving movement towards an experience of integrity and wholeness".[26] Such a description does not entirely clarify the situation; Dr Mount once admitted: "When I try to explain what is healing I invariably end up invoking notions such as 'wholeness' or 'soul' and, in the process, I often lose the attention of my colleagues who have been enculturated in the positivist paradigm of scientific methodology." A formulation that may provide a more robust understanding of medicine's healing mandate is the notion that healing amounts to caring for the whole person.

The historical roots that link medicine to healing run deep. In ancient times, a physician's training was represented as an initiation into sacred rites: Asclepius was the healing god. Healers have existed across time and cultures; this is an important focus of interest for medical anthropologists. The Old French and Anglo-Norman word "fisicien" derives from "fisique", which denoted a practitioner of the art of healing. Healing is inseparable from the need of humans to cope with the bafflement, fear, and suffering brought on by sickness. The problems of sickness, accidents, unjustness, and evil are all central concerns of professions with a pastoral function: the ministry and medicine.

Some physicians may attempt to distance themselves and their clinical method from any priestly role and religion as a whole. That resistance is understandable to some extent. However, it has been argued that physicians, by the nature of the clinical encounter, even if they are not necessarily metaphorical shepherds tending their sheep, cannot be considered to be morally neutral technicians.[27] A fascinating commentary on this aspect of medicine comes from an unexpected source. The renowned Canadian novelist Robertson Davies, a self-declared expert on magic, in

describing the characteristics of a physician, once stated to a medical audience at Johns Hopkins University:

> [...] to the wretch who sits in the chair on the other side of your desk. You look like a god [...] the detection and identification of gods in modern life is mine, and I assure you that you look like a god.[28]

We are not trying to suggest that physicians are priests, let alone gods; we are merely pointing out that, whether or not we are religious, the healing function requires attention to notions of transcendence, and if they have them, patients' theistic beliefs and their spiritual life. Not surprisingly, indeed insightfully, healing has been described as the relief of "soul sickness".[29] The late Dame Cicely Saunders, founder of the modern hospice movement, has equated it to recognizing, reaching, and alleviating "soul pain". Although it is beyond the scope of this article to consider the full breadth of healing as a human phenomenon, a few additional points are in order.

Healing is a journey, rather than a destination, and it is a process more than an epiphany. Recent work by Mount and his collaborators has attempted to characterize healing by contrasting it with wounding. On a quality-of-life continuum, being in a healed state is at a pole marked by an experience of wholeness and personal integrity. Being wounded is situated at the opposite pole and represents an experience of suffering and anguish. Healing is associated with the following perspectives: a sense of connection to self, others, and a phenomenal world (ie, a world experienced through the senses); an ability to derive meaning in the context of suffering; a capacity to find peace in the present moment; a nonadversarial connection to the disease process; and the ability to relinquish the need for control. Wounding is a movement in opposite directions. Suffering is fundamentally a sense of one's own disintegration, of loss of control to prevent that, and an experience of meaninglessness.[30] By counteracting those perceptions, a person can be helped on a healing trajectory, even as death approaches. Healing interventions are always possible. One can die healed. As a consequence, the phrase, "There is nothing more that I can do for you," has no place in medicine.

What does healing look like at the bedside? The following characteristics are frequently emphasized. Healing requires recognizing, listening to, and responding to a patient's story, especially listening for trauma, shame, suffering, lament, and listening in a way that generates "earned trust": "Trust me because I will show that you can trust me." It occurs in the moment, in the present tense, in a series of "nows". There needs to be a profound recognition of and an attempt to mitigate the power differential. There is a duty to nurture hope, a deep sort of hope, and one that is understood as "having agency to discover meaning".[31] Hope has been described as "the oxygen of the human spirit. Without it, our spirit dies. With it we can overcome even seemingly insurmountable obstacles."[32]

Alternatives to euthanasia

There are two great traditions in medicine: the prolongation of life and the relief of suffering. The concept of suffering, the fact that it is an affliction of whole persons, rather than bodies only, was explicated several decades ago by the American physician Eric Cassel in his seminal paper: "The Nature of Suffering and the Goals of Medicine."[33] This understanding represents one of the central tenets of palliative care medicine. The provision of high-quality care by individuals who share in this belief and are able to act to address the full range of human suffering is the most important goal with respect to terminally ill patients. It also constitutes the obvious and necessary alternative to euthanasia.

A specific approach to palliative care, with conceptual anchors in the concept of healing, has recently been described and used by Canadian psychiatrist Harvey Max Chochinov and colleagues; it is called "dignity therapy".[34] Although we prefer the original term, "dignity-conserving care", because it implies somewhat more modest goals and suggests less of a transfer of agency from patient to physician, this approach holds great promise for assisting patients at the end of life. It provides an entry for a deep exploration of dignity: How does the individual patient conceive of it? How is it threatened? How does it link to vulnerability or a sense of "control"? Where does one get the idea that we are ever in control? It is focused on issues such as "intimate dependencies" (eg, eating, bathing, and toileting) and "role preservation". Chochinov has described one's social roles and their associated responsibilities as "the bricks and mortar" of self.[34] The therapeutic approach described aims to preserve persons' inherent dignity, in part by helping them to see that their intimate dependencies can be attended to without their losing self-respect and that they can continue to play meaningful roles.

Consequences

A major disagreement between euthanasia advocates and opponents revolves around the existence of slippery slopes. There are two types: the logical slippery slope, the extension of the circumstances in which euthanasia may be legally used, and the practical slippery slope, its abuse (see Table 3). The evidence during the last decade demonstrates that neither slope can be avoided.[35,36] For example, although access to

euthanasia in the Netherlands has never required people to be terminally ill, since its introduction it has been extended to include people with mental, but not physical, illness, as well as to newborns with disabilities and older children. In Belgium, euthanasia has recently been extended to children, it is being considered whether to do the same for people with dementia, and organs are being taken from euthanized people for transplantation.[37] The logical and practical slippery slopes are unavoidable because once we cross the clear line that we must not intentionally kill another human being, there is no logical stopping point.

When euthanasia is first legalized, the usual justification for stepping over the "do not kill" line is a conjunctive one composed of respect for individual autonomy and the relief of suffering. This justification is taken as both necessary and sufficient for euthanasia. But as people and physicians become accustomed to euthanasia, the question arises, "Why not just relief of suffering or respect for autonomy alone?" and they become alternative justifications.

As a lone justification, relief of suffering allows euthanasia of those unable to consent for themselves according to this reasoning: If allowing euthanasia is to do good to those mentally competent people who suffer, denying it to suffering people unable to consent for themselves is wrong; it is discriminating against them on the basis of mental handicap. So, suffering people with dementia or newborns with disabilities should have access to euthanasia.

If one owns one's own life, and no one else has the right to interfere with what one decides for oneself in that regard (as pro-euthanasia advocates claim), then respect for the person's autonomy as a sufficient justification means that the person need not be suffering to access euthanasia. That approach is manifested in the proposal in the Netherlands that euthanasia should be available to those "over 70 and tired of life".[38]

Once the initial justification for euthanasia is expanded, the question arises, "Why not some other justification, for instance, saving on health care costs, especially with an aging population?" Now, in stark contrast to the past when saving health care costs through euthanasia was unspeakable, it is a consideration being raised.

Familiarity with inflicting death causes us to lose the awesomeness of what euthanasia entails; namely, inflicting death. The same is true in making euthanasia a medical act. And both familiarity with inflicting death and making euthanasia a medical act make its extension, and probably abuse, much more likely, indeed, we believe inevitable, were it to be legalized. We need to stay firmly behind the clear line that establishes that we must not intentionally kill one another.

Those most at risk from the abuse of euthanasia are vulnerable people: those who are old and frail or people with mental or physical disabilities. We have obligations to protect them, and euthanasia does the opposite, it places them in danger. We need, also, to consider the cumulative effect of how we treat vulnerable people. What would be the effect of that on the shared values that bind us as a society and in setting its "ethical tone"? As one of us (MAS) has repeatedly pointed out, we should not judge the ethical tone of a society by how it treats its strongest, most privileged, most powerful members, but rather by how it treats its weakest, most vulnerable and most in need. Dying people belong to the latter group.

Among the most dangerous aspects of legalizing euthanasia are the unintended boomerang effects it will have on the medical profession. The concept of "unanticipated consequences of purposive social action" is a well-described phenomenon in sociology.[39] In his classic paper, American sociologist Robert Merton distinguishes between the consequences of purposive actions that are exclusively the result of the action and those, unpredictable and often unintended, that are mediated by social structures, changing conditions, chance, and error. For example, with respect to euthanasia, there is really no guarantee that the legal and administrative policies erected today, even if currently they functioned as intended, which is doubtful, will be as effective in a different cultural context decades hence.

Then there are the insidious changes induced by the force of habit: the unexamined and autonomic modes of

Table 3 Slippery slopes

Slopes
The practical slippery slope
Performing euthanasia without informed consent or any consent
Persons administering euthanasia who are not legally authorized to do so
Failure of reporting euthanasia or physician assisted suicide as required
Misclassifying euthanasia as "palliative sedation"
Noncompliance with safeguard protocols (eg, not obtaining psychiatric evaluations of competence, circumventing policies for mandatory second opinions, functioning as "willing providers" without having had a previous clinical relationship with the patient)
The logical slippery slope
Euthanasia offered to those with existentialist angst, mental illness, anorexia nervosa, depression
Euthanasia expanded to include patients with dementia
Euthanasia expanded to persons who are neither physically nor mentally ill: "over 70 and tired of life"
Extending legislation to include children
Euthanasia becomes accepted as medical care, as a sort of "therapeutic homicide"

human behavior. How will the legitimatization of euthanasia and its insertion in the everyday professional vernacular and practice alter the ethos of medicine? The risks are of a grave nature and are immeasurable. How will the involvement of physicians in inflicting death affect their thinking, decisions, and day-to-day practice? Given that euthanasia may be routinized and expedient, there is a distinct possibility that death will become trivialized and that avenues for dignity-preserving care will remain unexplored. What are the potential corrosive effects on hospitals of accepting the language of euthanasia and in implementing that mandate? The language we use not only reflects reality but constructs reality. As German philosopher Martin Heidegger has said, "Language is the house of Being. In its home man dwells".[40] One can imagine that "H", currently a symbol of hospice and hope, will become conflated with an "H" that stands for hollowness and hastened death. We have little doubt that the slippery slopes include a language of abandonment, generating medical practices that will vitiate hope, and a profession that will struggle to identify a true north on its moral compass.

Conclusion

We have introduced an ethical issue that is frequently overlooked in the euthanasia debate: the effects and unintended consequences of legalizing it on the medical profession and on the institutions of law and medicine. Religion used to be the principal carrier of the value of respect for life for society, but in secular societies, that role has fallen to law and medicine, which are "value-creating, value-carrying and consensus-forming for society as a whole".[41] The law prohibits killing another person, and physicians take an oath not to inflict death. These imperatives must never be abrogated, which legalizing euthanasia, accepting the notion of "therapeutic homicide",[42] would necessarily do.

This article is the product of two individuals who bring complementary modes of thinking to the issues raised by euthanasia. One (JDB), a specialist physician, has developed his practical knowledge from years of accompanying patients throughout the trajectory of illness, including at the end of life. The other (MAS), an ethicist and lawyer, has fine-tuned her epistemic logic through considered deliberation, during a 35 year academic career, of the issues raised by euthanasia in light of accepted first principles. The former has acquired knowledge through "reflection in action", the latter out of purposeful "reflection on action".

A dual conception of reflective thought has recently been expanded to include two additional elements. Occupational therapist and education theorist Anne Kinsella[43] has argued that there is a "pre-reflective and receptive" stance in which one human, unconstrained by the means of language, recognizes another human affectively and precognitively, and, as well, a stance of "reflexivity". Reflexivity involves "the act of interrogating interpretive systems"; it assumes that meaning-making is a collective endeavor influenced by historical conditions and contexts. This is more far-reaching than the internal and individual contemplation usually equated with reflective thought. In a spirit of reflexivity, we have considered and analyzed the phenomenon of euthanasia.

Our analyses and investigations of both practical and theoretical issues raised by euthanasia, have culminated in a profound belief that euthanasia is harmful to individuals, especially vulnerable people, physicians, the institutions of law and medicine, and society, and that the healing role of physicians and euthanasia are simply not miscible; indeed, they are antithetical.

Further information

Readers who require more detailed information concerning the reference list and cited texts should contact the corresponding author by email.

Disclosure

The authors report no conflict of interest in this work.

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