Rationality, euthanasia, and the sanctity of life

Paul Jewell

Abstract

Debates concerning the issue of voluntary euthanasia often make reference to the ‘sanctity of life’ principle. For the purposes of this paper, euthanasia is taken to mean death brought about through medical means at the request of the patient, subject to prescribed safeguards and conditions. It is difficult to succinctly define the sanctity of life but, essentially, its proponents maintain that the taking of (human) life is intrinsically wrong, that this is a self-evident principle, and that this principle has a special and superior status compared to other ethical principles such as utility or respect for autonomy. Several arguments for the sanctity of life principle are analysed. Three asserted features of the principle are examined: the principle’s ethical primacy, its special application to euthanasia, and its merit as a basis for legislation and codes of ethics. Supporters of legalised euthanasia typically assume that it would be performed by doctors, after consultation with psychiatrists, so the codes of ethics of the Australian Medical Association and the Royal Australian and New Zealand College of Psychiatrists are cited. It is concluded that the arguments for the sanctity of life principle are inadequate. The principle is at odds with other key principles in the cited codes of ethics. Furthermore, it is plausible that the principle is not derived from rational deliberation. It should not be granted the status of an ethical principle but is more akin to a psychological state. As such it does not have merit as a basis for legislation or medical ethics.

The issue

The majority of citizens in Australia and New Zealand believe that voluntary euthanasia is ethical and should be legalised. Minor political parties, some individual politicians, and dedicated lobby groups continue to push for changes to the law, but meet considerable resistance, particularly from proponents of the sanctity of life principle, who maintain that the principle has ethical primacy [1] [2] [3] [4].

An analysis of the ethics of euthanasia is a daunting task. It requires the application of philosophical ethics, the consideration of the doctor–patient relationship, arguments concerning the state’s responsibility and the limits thereof, and the interplay between these factors. The problem is exacerbated by the tragic consequences of getting it wrong. The axiom that one should preserve life above all else cuts the Gordian knot. Simple solutions to complex problems are attractive, and even more so if they appear to be self-evident axioms. It is not surprising, therefore, that the notion of the sanctity of life is promoted as an ethical principle, a guide to professional practice and a legislated requirement. Nonetheless, debate continues concerning the justification of exalting the sanctity of life above other ethical considerations, such as the welfare and wishes of the patient. The sanctity of life principle has an abstract, universal character, in contrast to an actual patient with particular wishes and individual needs. The Code of Ethics of the Royal Australian and New Zealand College of Psychiatrists begins with consideration of the patient’s autonomy and needs, as does the Code of Ethics of the Australian Medical Association [5] [6].
Indeed, if there is to be an axiom to guide the professional ethics and professional practice in medicine, it should surely be to promote the welfare and wishes of the patient. They are patients because their welfare is at stake, and if there were no patients there would be no medical profession [7].

Sometimes, to be sure, conflicts arise between the wishes of the patient and the professional’s judgement about the best way to promote the patient’s welfare [8]. It may be that the patient wishes to refuse a treatment the professional recommends. In such an instance it is accepted (and legally mandated) that the autonomy of the patient over-rules the professional’s judgement. It may be that the patient is unable to exercise autonomy, in which case a medical judgement is made. From time to time, court cases are needed to resolve disagreements, wherein expert advice will be called for concerning the competence of the patient and the benefits of the proposed treatment or procedure [9]. Despite the existence of some conflicts and difficulties around patient autonomy and medical benefit, some combination of a patient’s welfare and wishes determines the ethical (and legal) decision.

The exception is the matter of voluntary euthanasia. Proponents of ethical arguments against euthanasia maintain that, even if a competent rational patient requests euthanasia, and even if both the patient’s and doctor’s judgement is that any benefit from remaining alive is far outweighed by the actual distress of the illness, nonetheless, the doctor should not assist the patient to die. The argument for the primacy of the sanctity of life over the patient’s wishes and welfare has generally been supported by the law.

So consideration of the patient’s wishes and welfare provides the rationale for professional and ethical decisions. But this consideration is trumped by the sanctity of life principle, and only by the sanctity of life principle. It is worth considering, then, the status of sanctity of life as an ethical principle.

The Code of Ethics of the Australian Medical Association begins with a patient-centred approach. The first two principles are ‘Consider first the well-being of the patient’ and ‘Treat your patient with compassion and respect’ [6]. In the Code’s section 1.4 on the dying patient, the requirements are to remember the obligation to preserve life, but to temper that with respect for the patient’s autonomy and the relief of suffering. The Code of Ethics of the Royal Australian and New Zealand College of Psychiatrists states that it draws upon moral philosophy and it has in its first principle the admonition to respect autonomy and relieve suffering [5]. Neither code, then, asserts the primacy of the sanctity of life over patients’ autonomy or suffering. Both codes, though, operate within a society that endows the sanctity of life with considerable legal status. This is acknowledged by the psychiatrists’ code. Should the codes unequivocally define the status of the sanctity of life principle, or not? If society at large debates a change to the principle’s legal status, should the medical and psychiatric professions support the primacy of the principle, or support the primacy of their patients’ autonomy and medical condition?

Sometimes, discussions of professional ethics drift away from being patient-centred towards focusing on what a doctor should do, or refrain from doing, or on the ideal qualities of a professional. Discussing ethics in psychiatry, Crowden proposed that virtue ethics are useful to the professional and can ‘ground the character of good agents’ [10]. It is interesting that Crowden uses the word ‘agent’, contrasting, as it does, with the meaning of the word ‘patient’. Agents make decisions, patients are acted upon. In response, Radden discusses ethics in terms
of the particular sorts of demands that fall upon doctors and psychiatrists as professionals [11]. Debates about the ethics of euthanasia are similarly professional-centred. So it is argued that, if a doctor has the intention of ameliorating pain through the administration of morphine, then that is ethical (and in some jurisdictions legal), even if it also has the effect of shortening life [12]. Similarly, distinctions can be made between omission and commission. Withdrawing life support, it is argued, is different from applying a lethal medical intervention, even though the results are the same [13] [14] [15].

There is a worrying sophistry about the arguments concerning intentions, omission and commission. A patient-centred approach, though, can sidestep them. If it is wrong for a patient to request physician-assisted euthanasia, then presumably it would be wrong to provide the assistance. If it is ethical for a patient to request assisted euthanasia then, prima facie, it would be ethical to provide it.

What, then, are the arguments against voluntary euthanasia? Is it right or wrong to request it? Is it ethical or unethical to provide it? What is the status of the sanctity of life as an ethical principle and does it trump considerations of the patient’s wishes and welfare?

An axiom that is self-evident

One argument holds that the sanctity of life is an axiom, is self-evident, and hence needs no further justification [16]. Kant declared suicide as ‘wholly opposed to the supreme principle of all duty’ [17].

It should be noted, though, that the sanctity of life in this context does not mean the sanctity of all life, but rather the sanctity of human life. The necessity of preserving the life of, say, all plants is not being asserted, nor would it be possible. It follows, then, that there must be a relevant difference between human life and plant life. The difference, clearly, is that humans are capable of making decisions, of being self-determining, of practising autonomy. It is this difference that makes the debate about euthanasia possible, indeed makes possible all ethical considerations, as Kant readily admits. Autonomous decision making is the very stuff of ethics [18].

It is arguable that there are no axioms in ethics. If, for the sake of argument, we take the opposing view, that there can be ethical axioms, and the sanctity of life is one such, we confront a conundrum. We could similarly assert that respect for the autonomy of rational beings is a self-evident ethical axiom. In the issue of voluntary euthanasia, we now have two axioms in contradiction with each other: the sanctity of life and respect for autonomy. Denying a reasonable request for euthanasia is a breach of the self-evident value of autonomy. Acceding to the request is a breach of the sanctity of life. How can we decide whether one axiom trumps the other?

It could be argued that life should be preserved because death is the end of autonomy, of choice and decision making. One definition of death of a human is the cessation of brain activity, presumably because the brain is the locus of intention [19]. Thus the preservation of life is the preservation of autonomy. It would follow from this that there would be no point in preserving the life of someone in an irreversible coma, though. Similarly, there would be no value in palliative care that resulted in a drug-induced haze. Furthermore, the sanctity of life axiom could not logically be used to argue against non-voluntary euthanasia of the comatose,
nor in favour of many palliative care interventions [20]. Proponents of the sanctity of life do argue for the preservation of comatose patients, so sanctity of life is not about preservation of autonomy.

In summary, the sanctity of life principle refers to human life. A characteristic of humans is that they are capable of autonomy. An essential feature of ethical decision making is that it is the result of autonomous reflection and choice. If we were to assert that there are ethical axioms, then respect for autonomy would be a self-evident ethical axiom. Axioms cannot, by definition, contradict each other. The sanctity of life cannot be a self-evident axiom if it is contradicted by another self-evident axiom of respect for autonomy.

The sanctity of life is therefore not an irrefutable axiom.

Gift of God

It is sometimes argued that life is a gift from God and it is wrong to terminate it [14] [21]. This argument requires an unacceptable reading of the term ‘gift’. It needs to imply that a giver retains authority to dictate when and for how long the gift is employed by the recipient, even if the recipient neither requested nor acquiesced to the gift. Clearly, such a concept of ‘gift’ is unworkable.

The saying that ‘God gives and God takes away’ has further problems if it is to be taken as an ethical imperative. As the philosopher Hume pointed out, as well as requiring us to acquiesce to an injunction not to take life, it would also require us to refrain from attempting to prolong life [22]. Indeed, the very business of medicine is to intervene in natural processes.

Some religious leaders qualify the word ‘gift’ with the term ‘stewardship’ [23]. This does not seem to solve the problem, though, unless one is to abandon the normal conception of the word ‘steward’, which includes the assumption that one can resign the post. It would also need to be shown that religious convictions can provide a valid foundation for professional ethics. While Browning has argued for an alliance with psychiatry and religion, the suggestion seems at odds with an empirically based profession [24] [25]. It is also at odds with patient-centred ethics. In a multicultural society, a patient’s own religious or secular conviction may be that euthanasia is permissible. ‘Gift of God’ proponents would need to argue not only that religion has a place in medical ethics, but that a particular religious conviction does, applying even to those patients who hold other convictions. The RANZCP Code of Ethics first principle holds that psychiatrists must not impose their own values on their patients [5].

In summary, the ‘Gift of God’ argument can be used equally well against the preservation of life as for it, and so to use it in any consideration of medical ethics is futile. It is a particular religious conviction which may not be held by the patient, and which cannot be rationally or empirically demonstrated. It is therefore inappropriate as a principle of medical ethics.

Cessation of welfare

An undeniably striking feature of euthanasia is that it is so final. If medical ethics is to be driven by the welfare of the patient, can it ever be ethical to end the life of the patient?
Chappell argues that ‘death is never in anyone’s interests, indeed is the negation of all interests’ [26].

It is surely true that, in any person’s life, some experiences are positive, some are negative, and some have little significance either way. Some decisions result in a promotion of a person’s welfare, some operate against a person’s welfare, some have impacts that are balanced between the two. There are plusses, there are minuses, there are neither and there is a combination of both. People sensibly attempt to achieve happy outcomes and avoid miserable ones.

It is not the case that people’s lives are made up of only two types of experiences: those that have zero impact on their happiness and those that have positive effects. Clearly, in some people’s lives, the experience of distress far outweighs the experience of happiness. Such a person may sensibly calculate that an end to life will negate the misery. Such a calculation would be rational and, by utilitarian standards, ethical.

The argument that preservation of life should trump the welfare of the patient, because ending life ends welfare, is unconvincing.

**Rationality and the slippery slope**

It would be implausible to argue that preservation of life should always trump the patient’s wishes on the grounds that wishing to die is clearly irrational and a symptom of clinical depression. Nonetheless, the wish to die is sometimes, indeed often, associated with mental illness. It would make sense, then, to ascertain the mental health of a patient who requests euthanasia. The short-lived Northern Territory legislation had such a requirement [27]. Unfortunately, this is not a simple task [28] [29]. Because of the possibility for error, perhaps we should err on the side of caution and preserve life. There is also the slippery slope argument to consider. If we allow euthanasia for those whom we judge to be competent to request it, how long will it be before we start killing the vulnerable or incompetent?

However, the fact that some patients’ competency is in question does not justify the assumption that all euthanasia requests are irrational. Some clearly are not. Certainly diagnostic errors may occur, but that possibility is not unique to the euthanasia issue. To proceed on the assumption that every euthanasia request is irrational is to guarantee error, because some such requests are rational. The assumption is also inconsistent. Parker points out that a patient refusing life-prolonging treatment is not thereby assumed to be irrational, nor even required to be psychiatrically examined [13].

The slippery slope argument is a circular one. It argues that, if we allow voluntary euthanasia for competent patients, we may slide towards involuntary euthanasia for patients who are not competent. This, though, already assumes that preserving life is more important than respect for autonomy. The slope could just as easily be tilted the other way. If we refuse euthanasia for patients whose competency we doubt, we could slide towards refusing it for people who are competent and justified in requesting it. It would make more sense to increase the practical autonomy of the vulnerable, rather than constrain the wishes of the competent.
Rationality, intuition and instinct

The seminal political philosopher Mill argued that state coercion of an individual was legitimate only to protect other individuals [30]. With some exceptions, this principle has strongly influenced law making in democracies. Yet the prohibition of euthanasia appears to be based on accepting the sanctity of life as an over-riding ethical principle. Democratic governments do not usually enforce by law personal moral decisions, especially moral claims that are strongly contested. Arguments that the sanctity of life is an ethical principle that should over-ride other ethical considerations have been canvassed in this paper, and the examination has shown that they do not stand up well to logical scrutiny.

Yet sanctity of life remains a powerful influence, a deeply held intuition. Why is this? It may be instinctive.

Intuitions are beliefs that are deeply held, are difficult to shake off and are not a result of rational reflection. Instincts are responses that are deeply held, are difficult to shake off, and are not a result of rational reflection. If we consider the sanctity of life as an intuition that is a manifestation of preservation of one’s own life as an instinct, we have an explanation for its enduring success. Since rational reflection does not support the sanctity of life, then intuition/instinct becomes a plausible thesis.

Instincts, per se, have no ethical status. Some instincts can lead to commendable actions and results, such as the maternal instinct or the gregarious instinct. Hume proposed that sympathy is an instinct that forms the basis for ethics [31]. Clearly, though, deciding to overcome an instinct can be ethically commendable on occasion. One might overcome hunger pangs and give food to others who need it more.

The proponents of the sanctity of life offer it as a moral principle that is not contingent upon circumstances. The foremost champion of the morals-as-principles school of thought is the philosopher Immanuel Kant. Kant maintains that motives for action can be categorised into three types, and actions are a result of one of these motives or a combination thereof. One type of motive is a rational reflective decision to act according to a moral imperative. The second is a decision to aim for the satisfaction of one’s own desires and the promotion of one’s own happiness. The third is simply non-rational (or irrational) inclination. The first motive constitutes morality. The second and third do not. When the second and third influence the decision, then to that extent the action is not a moral one [32]. By this reasoning, if respecting the sanctity of life is driven by instinct or any other non-rational inclination, then it is not a moral position. (In this context, the terms ‘moral’ and ‘ethical’ are interchangeable.)

Recent political debates in the United States of America reveal apparently puzzling moral inconsistencies. The sanctity of life is championed in opposition to euthanasia, in a society that has a death penalty and wages a contentious war. However, if its citizens’ beliefs are viewed as a psychological response, rather than a moral position, they are not inconsistent. Psychologically, it makes sense to preserve the lives of kith and kin, and to destroy one’s enemies. An understandable psychological response, though, is not a moral principle.
Conclusion

Medical interventions are responses to the needs of patients, and as such are inextricable from ethical considerations. Some decisions have ethical implications that are complex or contentious. The medical profession is expected to operate in ways that conform to common social expectations and legal constraints. The prime consideration is some combination of the wishes and welfare of the patient. The consideration of this combination, though, is challenged in the issue of euthanasia by another consideration, that of the sanctity of life principle. When a patient’s wish is to die, when patient and practitioner agree it is in the patient’s interest to bring about a medically assisted death, proponents of the sanctity of life maintain that euthanasia is nonetheless unethical, and have managed to convince legislators of that position.

An examination of various arguments that sanctity of life should trump the welfare and wishes of the patient has shown that the arguments do not stand up well to logical scrutiny. If the arguments do not hold rationally, another explanation for their pervasiveness is called for. One possible explanation is that the sanctity of life principle is an intuition, which in turn is an expression of a psychological drive or instinct. As such, the sanctity of life does not merit overwhelming ethical status, either in professional ethics or democratic law.

References