

Opinion

Euthanasia, Terminal Illness and Quality of Life

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Euthanasia is a term derived from the Greek word meaning ‘good death’. The term has been loosely applied to all forms of death administered by a second party, implying ‘mercy killing’, not dissimilar in its connotation to the traditional shooting of a lame horse. The controversy with regards to euthanasia stems mainly from the vague application of the term to all methods of ending a person’s life by a physician, and according to his judgment, with the caveat that his judgment best serves the interest of his patient. There are two main categories in this form of euthanasia; voluntary and involuntary.

Involuntary euthanasia is when the patient is in such a condition that he or she is incapable of giving informed consent, including such states as severe dementia, mental incapacitation and imbalance, in coma or diagnosed by his/her physician as ‘brain dead’. On occasions when the attending care givers consider the patient’s condition beyond recovery, the physician can give written instructions that the patient ‘is not to be resuscitated’ in the event of a cardiac arrest, and this is a common and accepted procedure in the medical community. In cases of ‘brain death’, the medical and legal institutions have reached a consensus where assisted prolongation of vegetative life can be terminated by the physician, usually with the consent of relatives, and in some circumstances, the healthy organs of the patient can be harvested and donated to prolong the lives of others in need.

Neither of these forms of involuntary euthanasia will be considered in this essay.

What I do wish to consider, however, is the concept of ‘voluntary euthanasia’.

I shall define voluntary euthanasia as: ‘when a person is chronically or terminally ill, suffers from incapacitating pain or disability, who is *compos mentis* (i.e., possessing his/her full mental capacity) and *voluntarily* wishes to terminate his/her suffering by assisted suicide’. Notice that the operative word in euthanasia is ‘assisted suicide’, usually administered by a qualified medical practitioner.

Suicide, *per se*, can be committed by any person who is physically able to do so and usually need no accomplice. The words ‘commit’ and ‘accomplice’ denote legal terms as

both suicide and attempted suicide are considered a crime or a felony in many countries (although in some countries such as the U.K. suicide is no longer considered a crime),¹ yet the accomplice is liable to be prosecuted irrespective of whether the act of suicide is considered a crime or not.

Again, suicide as such, is not the subject of this essay and I shall not pursue this matter further.

The law notwithstanding, the major opposition to any form of suicide, including euthanasia, stems from religious institutions; including Christianity, Islam and Judaism.

The Catholic Church is vehemently against abortion, contraception, and suicide (including euthanasia in any form) on the grounds of the sanctity of God given life, yet it condones capital punishment and the waging of wars whether holy or mundane.

Surprisingly, both Judaism and Islam reiterate the same edicts as the Catholic Church with regards to suicide as well as euthanasia.

The pro-life advocates are a vociferous and extremist group that wail against any form of termination of life, including contraception, abortion, euthanasia, and even withdrawal of life support systems from a brain dead patient even though the Catholic Church has condoned this last practice.²

The main objections to euthanasia, from the medical community, are that the two major factors that prompt patients to request physician assisted suicide are pain and depression and that both of these symptoms are treatable by modern therapeutic interventions. The American Medical Association (AMA), despite their pro contraception and abortion policies, has taken a stance against euthanasia based on these presumptions.³

The pro-life advocates insist that it is ‘unethical’ to steal the last precious moments of these patients’ lives and the Catholic Church considers that alleviation of pain would rob these patients of their last opportunity of salvation inherent in their suffering and the AMA has pronounced that modern therapeutics and surgery can relieve their pain and depression.

To me, at least, this situation presents a conundrum. To help or not to help, to relieve or not to relieve; and is that relief substantial or is it only to assuage the physician’s guilt are questions that assail the thoughtful mind.

As a Neurosurgeon who has been involved in pain alleviation, I am fully aware of the shortcomings, the pitfalls and the failures of this line of treatment. Opioids and anti-

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depressant cocktails reduce the patient to a zombie if they are to be effective and the invasive and costly neurosurgical procedures are not always the panacea that they are hoped for.

Surely, all these considerations must seem minor and pale before the concept of human dignity.

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. Both in medieval and in modern times we have witnessed such indignancies perpetrated in order to destroy a human being by robbing him of his dignity. These were the methods of the inquisition, medieval or modern, and have always been condemned by human free thinkers. Under such circumstances, all confess and welcome a swift end. Perhaps that end is freedom from suffering.

Let us now return to the definition of euthanasia once again. 'When a person is chronically or terminally ill'.

As examples for these conditions, let us consider first; quadriplegia due to motor neuron disease (e.g., amyotrophic lateral sclerosis), multiple sclerosis or cervical spinal trauma, rendering the patient totally paralyzed in all four limbs, with or without any sensation below the neck, who are often unable to breathe without mechanical assisted respiration and secondly; the terminally ill patients with disseminated metastatic carcinoma.

In the cases of quadriplegia, the patients are totally dependent on care givers for their most basic needs such as feeding, cleaning, turning, or even swatting the fly that may be crawling into their eye. They may be unable to swallow and thus will need a gastric tube, and will also need regular suctioning of their saliva or phlegm lest they choke, and those unable to breathe are dependent on constant and permanent mechanical respiration.

If such are the last 'precious moments of life', or days, or weeks, or months, or years...and if thus any human is "reduced to this little measure", stripped of all dignity, then all the antidepressants in the world will not restore the essence of life nor will all the love or care or faith in Heaven or on Earth help to regain the quintessence of being human.

The possibilities of cure for cancer or spinal diseases with genetic intervention or stem cell therapy lie so far in the future that the only hope of a cure at present must lie in the realm of the miraculous.

As a center for miraculous cures, Lourdes, in France is a famous example as a complete and detailed list of miracles, attested by an expert medical panel and approved by the Vatican is available. In the 150 years of its establishment since the apparition of the Virgin Mary in the grotto at Lourdes, 200 million pilgrims have visited the sanctuary, 12 million of which (80,000 each year) has been by those afflicted by 'incurable' or 'terminal' illness. Of these 12

million supplicants, the Vatican has only approved a total of 65 miraculous cures. The majority of these cures were for tuberculosis, ophthalmitis, impetigo, bronchitis, intestinal or 'nervous' disorders. Only three of the 12 million sufferers were miraculously cured of cancer and none for quadriplegia.⁴ It is well established in the medical literature that a small number of all cancers regress spontaneously without treatment but the rate of these regressions is difficult to assess accurately and it is estimated that one in ten thousand to one in one hundred thousand of all cancers may remit spontaneously.

Under these circumstances, it is not encouraging to hope for either a miracle or a remission, and so until that time when realistic therapeutic measures become available for spinal cord damage or cancer, what hope for the afflicted and what recompense?

Resilience and compromise are essential attributes of human nature which allow realistic decisions to be made in the face of extreme adversity. The desire for cessation of pain and suffering, when no alternative presents itself, is the essence of basic human rights to freedom of choice and in the words of that great bard, "To be or not to be", becomes the quintessential question.

Concluding remarks

In this essay I have attempted to present the plight of those people suffering from pain or paralysis, where no hope or dignity remains, as well as that of those who love and care for them.

I have tried to make no moral or value judgments, but only ethical ones.

Since 2000 years B.C.E., social mores, customs, and the law were adjudicated by local elders and judges of the land in the Levant which were later codified by Hammurabi in his famous stele before they became codes of practice in Judaism, Christianity, or Islam.

The laws of the land are arbitrary judgments laid down by law givers to preserve harmony within a society, when faced with a social dilemma.

Euthanasia is such a dilemma and only a few states in the world have embraced this human problem. My plea is for others to follow suit.

References

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