

We are IntechOpen, the world's leading publisher of Open Access books Built by scientists, for scientists

6,900

Open access books available

186,000

International authors and editors

200M

Downloads

Our authors are among the

154

Countries delivered to

TOP 1%

most cited scientists

12.2%

Contributors from top 500 universities



WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index
in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?
Contact book.department@intechopen.com

Numbers displayed above are based on latest data collected.
For more information visit www.intechopen.com



Euthanasia: Between Personal Moral and Civic Ethics

Begoña Román
University of Barcelona
Spain

1. Introduction

In this article we will focus primarily on the ethical debate on euthanasia and will not approach the subject from the legal field. We also do ethical reflection from civic ethics, from a secular ethics and from civic minimums that human rights are. Civic ethic is the framework of a transnational bioethics; it is the best framework to ensure the peaceful coexistence of plural morals in public sphere. In public sphere there are morals for euthanasia and morals against euthanasia. So, if the ethics of public sphere, not of personal privacy, should be fair and respect the right to choose, both options are respectable and therefore a legal level should decriminalize euthanasia. We discuss that euthanasia is a matter of personal moral and that both options, for and against euthanasia, are ethical.

From civic ethics we merely talk about respect for the final decision of an autonomous person, because autonomy is the ethical basis that every moral has to respect.

“Euthanasia” is Greek word composed by two parts: *eu*, good, and *thanatos*, death. Thus, the word simply means peaceful death. In technological societies, due to the success of medicine, it is possible to live a long time with a disease but without quality of life; in these societies it is possible to keep *alive* the biological life of a person *while* his biographical life has finished. In these circumstances some people demand to die with dignity, because they do not want to live without quality of life. In such a context, doctors don’t only have to cure, heal suffering but also help to die.

2. On the right to die

2.1 What is and what is not euthanasia? About words, things and laws

There is a big confusion related to the end of live, so it is important to clarify what and what is not euthanasia. We must distinguish among five notions (Lorda et al; 2008):

- a. Euthanasia
- b. Assisted suicide
- c. Patient’s rejection of a treatment
- d. Physicians’ team withdrawal or withholding of a treatment
- e. Terminal sedation

a. Euthanasia

We speak about euthanasia when the following four conditions take place:

1. The patient clearly demands to die once the diagnostic and prognosis are known.
2. The patient is under great suffering due to an incurable disease that deprives from living with the quality of life he wants.
3. An action carried out by medical professionals that know the patient, respect his autonomy and accept his decision of dying.
4. This medical action is the direct and immediate cause of death.

So euthanasia is an action that directly affects two people, both professional and patient, but the patient is who has the last word. He is who, in total pain conditions with no hope of recovery, asks the doctor to help him to die. Nevertheless the patient's decision must be autonomous, i.e., with knowledge of his reality and his expectations, in coherence with his concept of quality of life, and his decision must be continuous and consistent. Certainly, to make a decision on euthanasia, the patient needs a good diagnosis and prognosis. The patient has to know the reality of his illness, because without good and understandable information, the patient can not be autonomous.

The patient has to keep his decision in a consistent, persistent manner during a reasonable time, to avoid both the precipitation (as result of a moment of disorientation), as also to be influenced (result of pressure from other heteronymous factors). In fact the decision to end one's life must be really one's decision and not caused by other pressures or influences. The Patient will need the physician to take this decision.

The physician's role is necessary before, during and after the patient's decision to die:

- *Before* the patient's decision, to know his physical conditions, to have true information about his diagnosis and prognosis:

In the case of certain diseases which causes a progressive lack of health and autonomy, the doctor has to assume a special intimate relationship with the patient, for the control of symptoms, to let the patient know all the available possibilities, from the paradigm of autonomy and informed consent, but also to inform that it will be the patient, who will set the pace and make decisions. At this moment it is very important that the doctor knows how to accompany the patient to accept reality.

- *During* the patient's decision, to be giving to the patient the dose of required information:

At this point it is crucial that the doctor asks before reporting, because there is a right to know and there is also a right to not to know. It is important the doctor respects the patient's silence, his doubts; it is important that the doctor and his team have not only good technical skills, pain management, but also communication skills and skills with the biopsychosocial model (Engel, 1980), because the "total pain" is everywhere, and not only in the body.

This means a deliberative process of the patient himself; it is an inner dialogue, very intimate and deep one: he must make probably the hardest decision of his life, his final decision.

Once the decision is taken, when the patient asks his doctor for euthanasia, is when a process of dialogue begins between them, in order that both following conditions are satisfied:

It is an autonomous decision that persists in the patient for a certain period of time

It is a decision consistent with the concept of quality of life of patient.

Once verified these conditions, the patient decides when and under what circumstances he wants to die.

- *After* the patient's decision, to carry out the euthanasia in coherence with the wishes of the patient:

Documents of advanced directives and informed consent should be signed; these documents are fundamental from an ethical point of view. These documents are the key to ensure, on one hand, that the process of dialogue between patient and doctor has taken place; on the other hand, that the patient's autonomous last decision has been observed. It is not euthanasia if the person is not competent and others decide for him. However, how important it is to have an advance directives document for ascertaining the wishes and the decisions that the patient would have made if he knew his circumstances in which he is due to illness.

b. Assisted suicide

The difference between euthanasia and assisted suicide is that the patient is who causes his death and the professional merely offers the lethal dose and other necessary means when the patient is physically incapacitated.

There is no right to die without a duty of the doctor to help to die. But in this case it is a matter of dignity of life and dignity of death. Because only the doctor has the relevant expertise to ensure a good death; and this expertise is knowledge but it also implies attitudes and values.

Doctors should have the following competences to help to die:

- a. Knowledge of diagnosis and prognosis.
- b. Knowledge of appropriate doses to ensure that the patient has no pain or suffering.
- c. Knowledge about the patient's competence in order to ensure that patient's decision is autonomous
- d. Knowledge of consistency of the arguments that patient gives with regard to his scale of values and his notion of quality of life.
- e. Attitude of respect and empathy to accompany the patients in their last moments, because the doctor can do many ethically things, when nothing technically can be done. In this aspect it is very important to look carefully what the patient can need, for example, religious needs, spiritual care, or care for the patient's family. It is also essential that the doctor and his team are friendly; they must make the patient feel that he has always dignity, and no a charge for anybody nobody.

To clarify names we avoid adjectives such as voluntary, involuntary, passive or active euthanasia etc. Euthanasia is always voluntary, because the patient wants it; and euthanasia is always active because doctor's act causes the patient's death in a direct manner. Euthanasia is not only a matter of private moral; to respect these personal moral we should focus the question of euthanasia on civic ethics that defends its legalization.

c. Patient's rejection of a treatment

Patient's rejection of a treatment is not euthanasia: in euthanasia is the doctor who causes the death in a direct manner, but in the refuse of treatment, because the patient does not want to continue with the recommended therapeutic measures by the doctor, it is the disease that runs its course, to finally cause death.

d. Physicians' withdrawal or withholding of treatment

Euthanasia is not either withdrawal or withholding of treatment. In this case we are talking of a medical decision, when doctors check the futility of the treatment and the great harm it can cause, to the patient violating the principle of non maleficence (*primum non nocere*).

e. Terminal sedation

Terminal sedation is not euthanasia either. Terminal sedation is consistent with the Hippocratic principle of non maleficence. When death is imminent, in order to avoid the pain and suffering, doctors give pharmacological doses (normally morphine), and the side effect of these high doses drugs is lethal. Doctors are not looking for to cause the death but to relieve pain.

Sooner or later the result is the same, the death of the person, but not the way. To cause death through euthanasia is different to allow deterioration. The patient has the last decision, and only he has it.

In many countries where euthanasia and assisted suicide are illegal, the rejection of treatment is legal, because to respect the refusal of treatment, even effective treatment, is the consequence of taking seriously the principle of patient autonomy. It is interesting to note that the result is always the same, the patient's death, but euthanasia and assisted suicide are looking directly to cause death, and in the rest of circumstances, the rejection of the treatment, withdrawal or withholding of treatment and terminal sedation, death is not searched, but a result of not acting. But in all these cases the ethical principles are the same, i.e., the principle to patient autonomy and the principle of non maleficence, of not harming or imposing life to the patient.

2.2 In the name of autonomy: Live and die in a plural society

Human rights are primary goods, in Kantian words, “transcendental” goods, i.e., the condition of possibility to choose other goods. Rights are the minimum goods that any person should be guaranteed in order to enjoy a decent life from which quality of life can be chosen.

We are defending a right to die from the principle of respect to patient's autonomy, because from autonomy the patient chooses his notion of quality of life.

We make the difference between quality and dignity of life: dignity is essential for choosing quality; it is the minimum choice from autonomy. Thereby dignity is the *conditio sine qua non* in order to be able to take decisions, while quality depends on subjective, personal preferences. Good life is a purpose, a personal and subjective goal, but human rights are the conditions to look for it. A fair life must make the search for good life possible.

People have the right to take decisions, among these, when to die, and this is a matter of dignity. Some people are for euthanasia and others are against euthanasia, this will depend on the meaning of their quality of life. Both options need the right to decide, and both options exist in a morally plural society. But a law against euthanasia doesn't respect the right to take decisions; because a law against euthanasia doesn't respect one of these options, it isn't respectful regarding the dignity and quality of life of a part of this plural society.

We can distinguish two concepts of autonomy:

On the one hand, the Kantian concept as stated in the formulations of Categorical Imperative, e.g, act only according to that maxim whereby you can, at the same time, will that it should become a universal law (Kant, 2002). Kant grounded dignity on the autonomy of person and autonomy is *the ratio essendi* of morality: our duty is to become autonomous.

On the other hand, the Anglo-Saxon notion of autonomy, as right to self determination of a moral agent who is an independent and rational human being. This is the notion of autonomy of J. Bentham or J.S. Mill (Mill, 1989): "The only freedom which deserves the

name is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it". This notion prevails in Bioethics. So the condition for being autonomous is having the ability to grasp reality and to have information in order to be able to take decisions, without obstacles or pressures (internal or external) and in coherence with the own scale of values (Beauchamps & Childress, 1989).

Nevertheless autonomy is always a degree on a continuum, a process during which we can become more or less autonomous. People tend to lose autonomy at the end of their lives; most of them will become dependent as they grow older. However vulnerability and fragility are not shameful conditions but human conditions. Therefore we can talk about the right to be cared for until the end, even includes euthanasia.

Bioethics has put too much stress on fostering and respecting autonomy, but it has not always outlined the kind of dignity that should be recognized for a person who is progressively losing autonomy (the elder, people with degenerative illness, etc.).

We are all educated to become autonomous, but not to accept our dependence, not even to treat a dependent person. Furthermore, the traditional ways of dealing with dying people can become obsolete and ethically reproachable because they are based on charity, beneficence, goodwill or paternalism.

Autonomy is hindered in elder persons. Precisely the people deserving care, like frail old people, have dignity but they are not autonomy, maybe they will be not it any more. Elder people with dementia, Alzheimer illness or people with serious intellectual disabilities are not autonomous but not due to that should they lack dignity and human rights.

We are suggesting that, further than Kant, Mill and Beauchamps & Childress, the concepts of dignity and human rights should be reconsidered in order to make a foundation of respect for people who are not autonomous in a great degree and who don't want to live longer. We should complete the concepts of autonomy and dignity with the concept of vulnerability.

Independently of if sick people are more or less autonomous; we are talking about dignity and rights: they are persons and they always have dignity. Most of them have finished their autonomous life project, most of them are at the end of their life; all of them are progressively losing degrees of autonomy; and some of them want to die because they consider that they do not have quality of life. But they want to die with dignity and they want quality of death.

Thus, we suggest distinguishing between dignity in *lax sense* and dignity in *strict sense*.

Dignity in *lax sense* is the dignity which everyone has as a person, someone that is an End in itself, an absolute value, the source of all other values. In Kantian words (Kant, 2000): "Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means". There is a great consensus in this meaning of dignity

Dignity in *strict sense* is the dignity that *only a moral agent* can have. Dignity in strict sense would be the kind of dignity that is object of personal achievement, the purpose of the human life searching a personal identity, an *ethos*. This is the meaning of true autonomy for Kant, and it is a duty: become autonomous to be worthy.

Thus, everybody all the people have dignity, also the most perverse murderer and the anencephalic child, but neither of them have dignity in the strict sense: the former because he abused his autonomy; the latter because he is unable to exercise his autonomy. But we, the ones who interact with them, gamble with our strict dignity if we, when treating them,

forget they are always people, despite the immorality of the former and the disability of the latter.

We should fight against *diagnostitis* and determinisms that dictate that if one cannot live a normal life (what is a normal life?) and make a useful function in society, life is no longer worth it. As long as there is someone who makes them feel, in their own way, they are worthy, they will find their quality of life.

Who has reasons to live, finds the way. V. Frankl said it better: whoever finds a ‘why’ can stand any ‘how’ (Frankl, 2000). A society that treats frail and dependent people as worthy, is giving them a ‘why’ so all of us (we all are inter/dependent people) can discover how to live in a better way.

Nevertheless the question of euthanasia is not antagonistic to that of palliative care. Euthanasia is not to kill people because it is cheaper than ensuring their care!. People who want more palliative care must be respected. But we must also respect the decision of competent, autonomous people who do not want more care and want to die with medical help. We must ensure that euthanasia is also included among palliative cares.

Kant always thinks in a rational and transcendental *human being* and this is not an embodied subject, mortal and vulnerable, as is the real subject. Autonomy is inseparable from vulnerability. Euthanasia is the unavoidable consequence of a society that has based its concept of dignity on autonomy of the individual, beyond the biological life or a religious sense of life. Beyond Kant and his concept of dignity based in autonomy, we try to maintain a normative level in making decisions. From Anglo-Saxon Notion of autonomy, everything is reduced to personal options, and all private options are respectful. However, we think, according with Kant and beyond Anglo-Saxon notion of autonomy that life is more than a preference; live is a duty as transcendental condition of searching of meaning.

How to respect the autonomy of a person who is aware he will lose it due to the disease; how to respect the autonomy of a person who knows that his fate is to gradually lose autonomy but certainly not lose his life. Correcting Kant and his rejection of suicide (because such act can not become universal law), we are arguing that we should respect the final decision, the decision of a person to die, who knows he will never more be autonomous.

On the other hand, two people should be taken into consideration concerning euthanasia, patient and doctor, one with a right to die, the other with a duty to help him to die. But the doctor also has his own autonomy, his own conception of quality of life; and there are doctors who do not agree with euthanasia. Two autonomies (self-determination) are at stake.

The right to conscientious objection means that the doctor thinks it is wrong to help to die. So, for this doctor, to respect patient autonomy is something maleficent from his personal conscience.

Society must respect all these decisions: the patient's right to die, the physician's duty to help, and the right to conscientious objection by doctor.

Two conditions are needed in order to exercise the right not to act against the conscience: Ensure the patient's right to die, that means that another doctor will do what a conscientious objector does not want to do.

Do not make any pressure on the patient (underestimating his autonomy) and do not make moral judgments about his decision.

This means that in morally plural societies, we must guarantee the rights of all, but the medicine is at the service of the autonomy of patients, and not at the service of the physicians; so, the right to conscientious objection has limits.

2.3 Personal moral, professional ethics and civic ethics: Happiness, assistance quality and justice

Civic ethics is world ethics, ethics of justice, because it has to promote respect to human rights (including future generations). The criterion for making decisions in this ambit is justice, which talks about the primary goods that everyone must have guaranteed, they are universal moral demands. This is a minimal ethics because it doesn't talk about full life, how or why we should live. This Ethics is neutral regarding the way or style of life. *Civic ethics* is world ethics; it has to promote respect for human rights. We need an ethics for global society, for a shared world with morally plural societies that don't share the concept of good and the meaning of quality of life.

We need minimal ethics for the global world that propose duties and rights for every person, including responsibilities for the other living beings or for planet Earth. In certain sense it is possible to defend not only a right to live and a right to die, but also a duty to die: because the Earth has limits and it can not support too many people. And this world ethics is civic ethics, ethics for every citizen in the world. It is also previous and a *sine qua non* condition for private Ethics. Personal Ethics has to cause happiness, not in any way, but in a legitimate and fair way.

So we are defending that human rights are the content of justice; they cannot be only conventions out of random or cultural, economical or political interests. They should be defended as universal exigencies that enable us to talk about justice and to take rights seriously.

The way a society treats its elder members says a lot of about the level of justice and solidarity in this society. J. Rawls in his work *A Theory of Justice* (1971) exposed the hypothesis of the veil of ignorance: if people are unaware of their biological-social lottery, they would choose to live in a fair society rather than a random society. In the former, each member is born equal in liberty, and the most fortunate ones in that lottery have to help minimize the disadvantages of the less fortunate ones. In contrast, the law of the jungle, an animal law, prevails in a random society. In that society natural selection is the only criterion, a survival instinct that doesn't depend on our liberty. In that society it is stupid to speak about ethics, human rights or dignity, because in ethics we talk about what depends on us, about what we owe to each other; and justice depends on our management.

Thus, we can conclude that the incidence of luck in a person is inversely proportional to the level of justice in the human society in which one lives. It is *bad luck* to become ill or disabled, but it is a good luck to live in a fair society that doesn't leave one at his luck. For instance, aging is an unavoidable fact, but it is a good luck to become old person living with dignity and quality of life until the end; living in a society that respects the last personal decision about when and how to live and die.

Civic ethics talks about two categories: truth and justice.

- a. We understand Truth as the validity of knowledge, a validity based on empirical proofs, on the evidence that we have at the moment.
- b. We speak about Justice considered as impartiality and as the consent of the affected parties by the decisions that must be taken.

We cannot take fair decisions without true knowledge, so we need science. From the same dignity for all, civic ethics is the frame in which dialogue takes place, with information, participation and deliberation of involved persons. Therefore we talk about the right to be informed, and that's the reason for implementing the informed consent in health organizations. Civic ethics doesn't talk about quality of life. We must be able to care with justice, the same for everybody (that is dignity), but from different approaches (that is quality). Physicians and caregivers should prioritize the civic values over their personal ones, because the patient has the last word (he has private, personal values) in decision making regarding his life. So we must ensure that in hospital or at home ill people eat, drink, bathe and take their medication, but depersonalization or homogenization must be avoided: every person has a private unique life and a personal ethics with his particular values. Thus, if a person has decided that his life is meaningless because of his loss of autonomy; if this person wants to die, we must conclude that he has right to die and a doctor must help him to die without pain and suffer. The goals of medicine are save, take care, also at the end of life, also helping to die. Physicians must be trained to help to die. To allow euthanasia the *physicians' curricula* should be improved, because physicians are trained to carry out actions against disease and death, to save lives, to care people: they must be trained also to attend dying people in a better manner, when nothing technically can be done, and to attend people who want to die.

The patient is the ultimate responsible person for his own life. Respecting the patient's autonomy also means respecting his values, also giving him the information of the process of his disease. Physicians and patients establish a moral contract. Physicians must inform patients about the time, the treatments, and expectations of recovery and future quality of life. This information process must be done with the adequate vocabulary according to the patient's capacity. The relationship between Physicians patients is so important that it would be recommendable for Physicians to learn communicative skills, which aren't taught at Universities.

Information and communication often fail because the doctor is not aware of the different levels of knowledge patients have about disease and their conception of death. Sometimes it is even a matter of different cultures. The physician must always take care of the patient's welfare and respect his customs. And here Physicians need pedagogical tools and, of course, ethical attitudes.

Physicians should be with the patient during the decision making process; it's not only a matter to respect the patient's decision: a good decision will need information about benefits, risks, processes. Autonomy is the capacity to make decisions and it requires knowledge and responsibility until the end of life.

As professionals in health organizations, with the leadership of civic ethics and its content (truth, justice, human rights and duties), we ought to make compatible the different ethics: the personal, the professional and the corporative ones. Dilemmas will surely arise: people have different interests, different cultures, and different scale of values; solutions will be found from the horizon of human rights. But if a person has good reasons, his reasons, to die, we should respect this decision and help him to carry out in the optimal conditions.

3. On duty to live

3.1 Autonomy: Personal preference or normative concept?

Who should decide the end of life? The same person who lives, only this person can decide about this subject because his life is a private property. The individual has the last word

about his life. He is the only moral authority in his life, also even for religious people: God is a moral authority because they want so. The choice of living or dying is a very personal decision that should be respected when person is competent, autonomous.

Our relation with life and death depends on our personal moral. Now we are discovering that it is possible to live without autonomy (Alzheimer, dementia, etc). It is our responsibility to guarantee that no people suffer and it is our obligation, if possible, to guarantee their quality of life. But if a person, before he loses his autonomy, decided not to live without autonomy, we have the duty to help him to die.

But it is not the same to take a decision from autonomy than from arbitrary preferences. If we are talking about ethics, we are talking about normative concepts, not about arbitrary elections. Autonomy is something more than mere preferences. In this sense, from our point of view, Kantian concept of autonomy is better than the Anglo-Saxon one in order to reach a normative foundation: life is more than quality of life; life is something more than choosing pleasures

We are talking about Ethics, not about morals. Ethics is moral philosophy, a critical and rational reflection about morals. Nowadays we need to engage in this reflection because we are living in a multicultural world, a morally plural world, where morals are changing depending on new technical challenges that evolves moral values. We must think which options are not respectful, which options are respectful and which among these are better because of their arguments.

Kant, the author who made the concept of autonomy fashionable, reminds us that everything has its price, while people have their dignity. And this dignity causes in us the moral feeling of respect, from the Latin *respicere*, that means watchful look (in German, *Achtung* means both attention and respect). To respect people means to pay attention to their needs. Kant reminds us that dignity should be something sacred: humanity is worthy of respect, because humanity is an End in itself and implies rational competence, self-determination and responsibility.

To allow euthanasia is a matter of law and ethics; so we should think about life and the duty of live, not only about the pleasure of life. If we are rational beings, we should give reasons to live and to die: We have responsibilities and duties to ourselves and to others. Legalizing euthanasia requires social pedagogy about these subjects.

Regarding the duty to live -we argue that ethics, as a philosophical discipline-, it makes sense to propose universal obligations. Ethics is the discipline that reminds us the duty to make life something valuable and worthy, that is, the duty to construct a character, a meaningful life plan, an *Ethos*.

To conceive life as a mere preference (as is the case for many utilitarian or hedonistic philosophers and from a negative concept of autonomy as self determination), misunderstands the concept of autonomy, because it deprives ethical, normative obligation. It is even difficult to understand the very existence of a discipline, ethics, dedicated to studying the criteria of what is a good, fair, decent life without a fundamental duty to live. If everything is a matter of mere choice, of mere preference, without having to give explanations for the decisions that someone makes, we talk of aesthetics, not of ethics, nor therefore, of bioethics.

Regarding the reduction of autonomy to mere personal preference (the Anglo-Saxon notion of autonomy) , we are insisting that, in the question about euthanasia, the person must be competent and make decisions about his life and death only in the context of a disease that progressively robs his autonomy. If everything is based on the Anglo-Saxon concept of

autonomy (as a right to self-determination), the decision making is reduced to mere preferences of an individual, the pleasure of living or not. But in that case, we could fall into "the slippery slope". Actually, an individual who has lost interest in life and wants to die, he could ask the doctor to help him die. In this case the ethical reason to end his life is an exercise of self-determination, but not precisely autonomy in Kantian sense, e.g. to continue to exercise autonomy and not finishing with it. In our opinion this is the fundamental argument from which we defend the ethical legitimacy of euthanasia. In this case, we find someone who despises life: is this also respectable from a normative Ethics?

From Kant, we said no; we think that there is a duty to live, to fight for life until the end. We can consider right the decision to die only in circumstances of progressive loss of the autonomy (Alzheimer, dementia, etc.) and in circumstances of a “total pain” caused by the disease. Thus, we want to go beyond Kant and his refusal to commit suicide and defend the possibility of the right to die, but we are precisely following Kant, that is, his concept of autonomy. So we agree with Kant's ethical foundation of the duty of living and his concept of autonomy: worthy life it is not a matter of preferences.

The lack of interest in the life of a person because he is getting bored, or because his life has no meaning, but there is no disease or progressive loss of autonomy, undermines the principle of making one's life a meaningful project. It is a duty to live, we must seek a meaning, beyond the pleasure that life can generate. Beside the right to live and the right to die, there is also a duty to live with dignity until the end.

4. An agenda for the future

Euthanasia cannot be legalized without ethically thinking before what is at stake, and what is at stake in the issue of euthanasia is all of the following:

4.1 The dignity and quality of life of people. We need a social pedagogy to live and to die

The patient autonomy paradigm puts the person in the centre. To talk about of the principle of respect for the autonomy of the person means that he is the ultimate moral authority, he is who has the last word; he sets the pace, about his life and death. The use of advanced directives and informed consent documents must be enhanced. These tools are much more than documents and papers; they are the logical result of the dialogue between the patient and professionals. They will be the proof that the respect to patient's autonomy has taken place.

Euthanasia requires competences and legislative changes. Regarding competences, it must be reminded that professionals cannot infantilise either mature minors or the elderly, who, despite their years, have not necessarily lost their maturity and who may feel humiliated. Professionals must always ask his permission, and when necessary, forgiveness if they are not right. However, autonomy often remains only in the speech, in the theoretical level; but the unique "autonomous" are usually the physicians, they are not serving the patient's autonomy, but for best performance of the professionals or institutions at which they work. With regard to legislative changes, the citizens' participation in decision making must be improved, not only regarding their own individual health, but also on proposing public health policies.

Even though bioethics should be a civic, secular ethics which respects personal options, it is difficult for several governments to maintain neutrality in its view of the world, as it should in a morally pluralistic society. Sometimes it even goes from secularity to secularism.

If in the welfare state the criteria were the supply and demand law and the populist policies; in the justice state the criterion must be the consent of involved people, that is, the citizens and the professionals.

4.2 Credibility and confidence in the professionals and health organizations: Medical professionals to serve people

The quality of professional and organisational service must be in accordance with human rights, and the right to healthcare is one of them; but quality of this service will also depend on the citizens' use or abuse. It must be responsibly, in line with their needs, accepting that the system must satisfy rights, not individual preferences. And if a quality service is to be achieved, we all must feel part of a shared world. The four areas of ethics must be reconciled: civic ethics; organisational ethics; professional ethics; and the last, the personal ethics (ethics of professional and of the citizen whose service the professional is on). If professionals and organizations health services want to gain people's confidence, they will need to begin to re-classify their decisions in the corresponding areas. This means not giving priority to personal preferences or the preferences of the "clientele" when making professional or organisational decisions, and weighing before-hand whether they are in line with the civic, organisational, and professional values.

Healthcare professions must focus on the person: he is the subject of rights. It must be reminded again and again to those who are serving the professions and health organizations, what their mission is, their ultimate responsibility.

4.3 The kind of world that humans construct, and the reasons to live: A normative solidarity

Life cannot be underestimated; human life is the only chance on Earth: we must make with our lives something worthy. It is a matter of justice and solidarity to promote the research of a good life. Nevertheless, we are not talking about solidarity by compassion; we are not thinking in a utilitarian solidarity: "I should cooperate because maybe, one day, I could be in these circumstances". No: it is not a contract; it is not a convenience or a matter of selfish interest. It's a matter of normative solidarity; it is a matter of rights, justice and respect to humanity wherever and ever. Life is the most important moral resource to do something worthy with it, also at the end of life. Anyway, it is also a way of dignifying life to decide the circumstances of death (Thomasma et al, 1998), when someone is losing his autonomy, when to be able to decide is becoming more and more difficult.

5. Conclusions

This article has defended the following thesis on euthanasia:

1. The issue of euthanasia depends on personal moral. It is from the concept of quality of life where the person decides whether to continue living or not.
2. But it is a personal moral issue that must be supported by ethical reasons. This is not an aesthetic question of mere preferences, against the Anglo-Saxon concept of autonomy. We have therefore advocated a duty to live, to make life a meaningful project, from a Kantian concept of autonomy. It is in moments of loss of autonomy, not only of loss of pleasure, which it can be autonomously decided to not live longer. Precisely the autonomy that is being lost due to disease is the only cause that can legitimate to decide finishing life. This means that autonomy and ethics require biographical life beyond mere biological life.

3. Civic ethics does not speak of quality of life, which depends on personal moral, but of respect for the different options, and that's a matter of justice. It is fully consistent that an individual in his personal moral is against euthanasia and yet, from the civic ethic, the ethics of tolerance for morally pluralistic society, respects the choice by others with different personal moral in favor of euthanasia.
4. Medicine has its social legitimacy, its “raison d’être”, in assisting people, but from the paradigm of autonomy and not from the paternalistic paradigm. Once people have made their choices from personal moral, physicians should remind from civic ethics the duty of hospitality, the duty of care to people in their concept of quality of life.
5. The doctor can be a conscientious objector. Of course the doctor, from his personal moral, can be against euthanasia. But his objection has limits: the physician cannot impose his own personal choice and must ensure always the care of the patient. If the objector doctor does not want to help the patient to die, he must find other doctors to do so.
6. Open societies are free societies, that is its precious value; the price to pay is the greater complexity of its management. And our complex societies need more ethical reflection; they need more reflection on what we owe to each other and what we owe to ourselves.

6. References

- Aristotle (1934): *The nicomachian Ethics*, Cambridge, Mass (etc Harvard University Press.
- Beauchamps, T.L. & Childress, J (1989): *Principles of biomedical ethics*, New York.Oxford University Press.
- Engel, G (1980): The clinical application of the biopsychosocial model. *Am J Psychiatry*; 137: 535-544.
- Kant, I (2002): *Grundlegung zur Metaphysik der Sitten*. Kants Werke, Akademie Textausgabe, IV, Walter de Gruyter & Co, Berlin, 1968. English translation: *Groundwork for the metaphysics of morals*. New Haven: Yale University Press.
- Frankl, V (2000): *Man's Search for Meaning. An Introduction to Logotherapy*, Boston: Beacon; and Random House / Rider, London.
- Mill, J.S (1989): *On Liberty*, Cambridge University Press.
- Simón Lorda, P et alere (2008): Ética y muerte digna: propuesta de consenso sobre un uso correcto de las palabras, *Rev. Calidad asistencial*, 2008; 23 (6); pp. 271-285.
- Thomasma, D.C. et alere (1998): *Asking to Die*. Inside the Dutch Debate about Euthanasia, Dordrecht, Kluwer Academic Publishers.



Euthanasia - The "Good Death" Controversy in Humans and Animals

Edited by Prof. Josef KuÅ™e

ISBN 978-953-307-260-9

Hard cover, 248 pages

Publisher InTech

Published online 15, September, 2011

Published in print edition September, 2011

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.

How to reference

In order to correctly reference this scholarly work, feel free to copy and paste the following:

Begoña Román (2011). Euthanasia: Between Personal Moral and Civic Ethics, Euthanasia - The "Good Death" Controversy in Humans and Animals, Prof. Josef KuÅ™e (Ed.), ISBN: 978-953-307-260-9, InTech, Available from: <http://www.intechopen.com/books/euthanasia-the-good-death-controversy-in-humans-and-animals/euthanasia-between-personal-moral-and-civic-ethics>

INTECH
open science | open minds

InTech Europe

University Campus STeP Ri
Slavka Krautzeka 83/A
51000 Rijeka, Croatia
Phone: +385 (51) 770 447
Fax: +385 (51) 686 166
www.intechopen.com

InTech China

Unit 405, Office Block, Hotel Equatorial Shanghai
No.65, Yan An Road (West), Shanghai, 200040, China
中国上海市延安西路65号上海国际贵都大饭店办公楼405单元
Phone: +86-21-62489820
Fax: +86-21-62489821

© 2011 The Author(s). Licensee IntechOpen. This chapter is distributed under the terms of the [Creative Commons Attribution-NonCommercial-ShareAlike-3.0 License](https://creativecommons.org/licenses/by-nc-sa/3.0/), which permits use, distribution and reproduction for non-commercial purposes, provided the original is properly cited and derivative works building on this content are distributed under the same license.

IntechOpen

IntechOpen