

Euthanasia: Some Critical Remarks

Adejumobi Olatidoye Ayodele
University of Alberta
Department of Philosophy
ayodele@ualberta.ca

ABSTRACT

Euthanasia is generally regarded as killing in order to put an end to the unrelieved pain and suffering of a patient. Most terminal diseases are often associated with unrelieved pain and suffering, as a result advocates of euthanasia have argued for the legalization of euthanasia on the ground of compassion for the patients' suffering. However advancement in medicine has made it possible for modern medicine to reduce pain and suffering to the barest minimum. The questions that arise from this are, given the advancement in medicine; is there any necessity for euthanasia? Is the relief of pain the same as the relief of suffering? Do the physiological treatment of pain and its symptoms treat the psychological and emotional effect of pain and suffering? This paper shall attempt to answer these questions and argue that though issues and fears raised by the anti-euthanasia movements are very legitimate, the problems are resolvable by a well regulated medical system. I will attempt to explain what a well regulated system entails and how it can take care of the concerns of the anti euthanasia movement.

1. *Introduction*

Euthanasia is generally regarded as killing in order to put an end to the unrelieved pain and suffering of a patient. Most terminal diseases are often associated with unrelieved pain and suffering, as a result advocates of euthanasia have argued for the legalization of euthanasia on the ground of compassion for the patients' suffering. However advancement in medicine has made it possible for modern medicine to reduce pain and suffering to the barest minimum. The questions that arise from this are, given the advancement in medicine; is there any necessity for euthanasia? Is the relief of pain the same as the relief of suffering? Do the physiological treatment of pain and its symptoms treat the psychological and emotional effect of pain and suffering?

It is against this background and questions that I shall examine the debate between pro-euthanasians and anti-euthanasians. I shall start by discussing the various forms of euthanasia focusing on voluntary euthanasia.

I will also attempt a critical analysis of Kass' argument against euthanasia.¹ I shall argue that though issues and fears raised by the anti-euthanasia movements are very legitimate, however the problems are resolvable by a well regulated medical system. I will attempt to explain what a well regulated system entails and how it can take care of the concerns of the anti euthanasia movement.

2. *Euthanasia: An Overview*

Euthanasia takes place when a person (a physician or a medical personnel) takes the life of another (the patient) for the sake of the patient. Proponents of euthanasia are of the view that euthanasia does not deny the terminally ill their right to life but only to substitute a painful death for a painless death. Euthanasia is therefore the deliberate taking of life of a terminally ill patient for her sake, that is, to relief her suffering. Euthanasia is different from other forms of killing because it is act of mercy and compassion, in which the victim's suffering from an incurable or terminal disease is relieved by a painless death.

Euthanasia can occur either by act of commission or omission, It is an act of commission when the action is done deliberately and it is an act of omission when killing happens by not deliberately taking action. However, euthanasia is different from the cessation of treatment or a case when treatment is not even started because it is useless or will not be effective, i.e. when the suffering that the sickness would cause will be more than the benefits that will be derived from the treatment. It should also be noted that death that occurs as a result of the patient's refusal of treatment is not euthanasia because the physician cannot force the patient to take any treatment against her will.

3. *Types of Euthanasia*

There are two types of euthanasia namely voluntary and involuntary euthanasia. But we shall only deal extensively with voluntary euthanasia, which is our main concern in this paper. Voluntary Euthanasia (mercy

¹ Kass, L.R, (2002), "I Will Give No Deadly Drug: Why Doctors Must Not Kill", in *The Case Against Assisted Suicide: For The Right to End-of-life Care*, Foley, K and Hendin, H. (eds.), Baltimore, The John Hopkins University Press, pp17-40.

killing) is the killing of a person or assisting the suffering person to kill him/herself. This must be carried out strictly at the request of and for the sake of the person killed. It is sometimes called assisted suicide. Voluntary euthanasia presupposes the determination of the patient to take control of the extent of medical intervention in his or her terminal illness. Voluntary euthanasia still holds even when the suffering person is no longer competent to assert his or her wish to die. An example is when a person informs her doctor the desire to die when an incurable disease hopelessly endangers her life. Since the decision was taken with full knowledge and consent, anyone who ends the person's life at the appropriate circumstances simply executes the wishes of the sick person and the act is simply voluntary euthanasia. In voluntary euthanasia, it does not matter whether at the time of taking the person's life, he or she was competent or not to revise his or her wishes.

Voluntary Euthanasia can either be active or passive, it is active when acts done on a patient are intended to kill .It involves some positive actions that are intended to bring about the death of a patient and which actually results to his/her death. While passive euthanasia on the other hand is the idea is that it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient. The moral significance of this distinction between passive and active euthanasia is a highly controversial issue. For example, James Rachels² is of the view that the distinction has no moral significance because killing is as good or as bad as letting die, while Tom Beauchamp is of the view that they are different and morally significant. In defending the distinction between active and passive euthanasia Beauchamp³ argues that it should play an important role in our moral reasoning. However, he agrees with Rachels that the active and passive distinction is sometimes morally insignificant, but it does not follow that the distinction is always morally irrelevant in our moral thinking about euthanasia.

4. Arguments against Active Voluntary Euthanasia, Autonomy and Self Determination

The opponents of euthanasia typically reject arguments for euthanasia based on the right of the patient to autonomy and self-determination. Autonomy is

2 Rachels, J. "Active and Passive Euthanasia" in *Contemporary Issues in Biomedical* (4th ed.), *Ethics*, Beauchamp T.L& Walters L, (eds), U.S.A, Thomson Publishers, 1995.

3 Beauchamp T.L, in Beauchamp, T.L, 1995, p. 449.

a central notion in medical ethics, as it is in ethics generally. It is the ability to direct one's own life and to make one's own decisions. It involves the control of one's own actions, that is, the absence of constraints and the capacity for rational deliberation. The argument is that competent patients have the right both ethically and legally to exercise a significant degree of control over their own health care and life. The autonomy and self-determination argument is therefore anchored on the belief that human is a free being and a self-autonomous rational animal that is capable of freely making the best decision for herself/himself at any given time, that is, each person has the capacity for self-governance or self-determination and no one should interfere with a person's control over his/her own life and (perhaps) taking active steps to facilitate such control. The proponents of euthanasia are of the view that denying people their choice of euthanasia is tantamount to forcing them to act against their will, which may prolong their suffering and also lead to loss of dignity. For example, Brock is of the view that: "Self-determination is valuable because it permits people to form and to live in accordance with their own conception of good life, at least within the bounds of justice and consistency with not preventing others from doing so as well. In exercising self-determination people exercise significant control over their lives and thereby take responsibility for their lives and for the kinds of persons they become, a central aspect of human dignity and the moral worth of persons lies in individuals' capacity to direct their lives in this way."⁴

The point Brock is making is that self-determination enables the patient to take charge and determine the type of death they want, this helps to alleviate the fear and concern about the last stage of their life and the fear of pain and abandonment by relatives and friends, this also helps them retain their dignity and enable them have control over their lives as they prepare for death.

In response to this argument, Kass argues that when mercy killing is requested as a result of the free choice of the patients who cannot on their own carry out the 'suicide' such request must not be honoured.⁵ Kass contends that such choice cannot be free and informed when made under such debilitated conditions, such choices can also be manipulated. Kass' conclusion on this is that "rational autonomy rarely obtains in actual medical practice".⁶

4 Brock, D.W "Physician Assisted Suicide is Sometimes Morally Justified" in *The Morality OF Physician Assisted Suicide, Law, Medicine And Health Care*, Weir, R.F, (ed.), Indiana University Press, 1992.

5 Kass, L.R, (2002), "I Will Give No Deadly Drug: Why Doctors Must Not Kill", p. 24.

6 Ibid. p. 25.

For Kass, the ideal of rational autonomy is a theoretical construct that does not obtain in practice, this is so because the relationship between the physician and the patient is not egalitarian, the patient is dependent on the physician, she relies on the physician for advice and when the patient is terminally ill, the rate of dependence is increased and case for mercy killing can be easily engineered. Kass claims that: “In the great majority of medical situations, the idealistic assumptions of doctor-patient equality and of patient’s autonomy are in fact false, even when the patient is in relatively good health and where there is intimate doctor- patient relationship of long standing. But with those who are seriously ill, or hospitalized, and, even more with the vast majority of patients who are treated by physicians who know them little or not at all, many choices for death by the so called autonomous patient will not be truly free and fully informed. Physicians hold a monopoly on the necessary information; prognosis, alternative treatments, and their costs and burdens.”⁷

I quite agree with Kass that the patient depends on the physician but the question that arises is that, is the picture of the doctor-patient relationship painted by Kass the whole picture. The picture he painted is that the physician is a sort of almighty, who cannot be controlled and checked. The picture is extremely paternalistic, he did not take cognizance of the fact that there are some check and balances that is in the power of the patients, for example, the patient is not bound to accept the advice of the physician, she can seek a second opinion from another physician. This paternalistic approach of Kass is one sided, he did not consider the fact that modern medicine has moved from the paternalistic approach of physician-patient relationship to that of the fiduciary approach, in which there is a shared decision making such that both the physician and the patients make active and essential contribution. In this relationship: “Physicians bring their medical training, knowledge and expertise – including an understanding of the available treatment alternatives-to the diagnosis and management of patients’ conditions. Patients bring knowledge of their own subjective aims and values, through which the risks and benefits of various treatment options can be evaluated. With this approach, selecting the best treatment requires the contribution of both parties.”⁸

7 Kass, L.R, 2002 “I Will Give No Deadly Drug: Why Doctors Must Not Kill”, p. 25.

8 Brock, D. W and Wartman, S., “When Competent Patients Make Irrational Choices” in Beauchamp T.L& Walters L, (eds.), *Contemporary Issues in Biomedical Ethics*, (4th ed.), U.S.A, Thomson Publishers, 1995.

Kass may respond that this understanding of physician/ patient relationship and autonomy is based on the assumption that the patients are articulate, intelligent and accustomed to making decisions about the course of their lives and possess the resources necessary to allow them a range of options to choose among, then respect for autonomy in the clinical setting will require only that we adhere to the standard for informed consent. That standard requires that patients be suitably informed about their prognosis and options, and be allowed to choose among them. However most of the patients that request for assisted suicide are not in this type of position because they are not in a position to make an informed rational decision,⁹

A possible response to this is the principle of the non-abandonment.¹⁰ If the physician is committed to taking care of the patient in health and in sickness, most of the problems envisioned by Kass will be taken care of. I think part of the commitment to care and non abandonment will include efforts by the physician to understand the patients' demand and recognizing their individualistic orientation and seeing their experiences within the framework of their own idea of selfhood.¹¹ In the course of the relationship between the physician and the patients, the physician should seek to know what is important to the patient and her family, this would place the physician in a position to negotiate an ethical course of action that will as much as possible integrate the values of the patient, her family as well as the values of medicine.

5. *The Relief of Suffering Argument*

Another pro-euthanasia argument is that the pain of dying is sometimes uncontrollable and that showing mercy by taking the life of the suffering person is preferable. Proponents argue that it is not designed for human to suffer endlessly in misery and pain. There arises a situation where death becomes the most imperative solution to human suffering and pain.

9 Kass, L.R, 2002 "I Will Give No Deadly Drug: Why Doctors Must Not Kill", p. 2.

10 Quill T. E, Cassel, C. K, 2002. "Non-abandonment : A Central Obligation for Physicians", in *Physician- Assisted Dying: The Case for Palliative Care and Patient Choice*, Quill, T. E. and Battin, M. P. (eds.), Baltimore, The John Hopkins University Press, pp. 24-38.

11 Rodney, 2004, "Our Theoretical Landscape: Complimentary Approaches to Health Care Ethics" in *Towards A Moral Horizon: Nursing Ethics for Leadership and Practice*, Rodney, p etal (eds.), Toronto: Pearson Prentice Hall, p. 79.

Opponents of voluntary euthanasia argue that suffering can be controlled by medication, but advocates of voluntary euthanasia and assisted suicide maintains that this makes no sense; they argue that if dying people are suffering terrible intolerable pain and want to die, it is more humane to honour requests for euthanasia than to induce somnolence or sleep by drugs while waiting for inevitable death. This argument seems to hold water, because it is based on two of the noblest human feelings, compassion and mercy. And since good physicians are always eager to alleviate pain, for some, this is reason enough to argue that they respond to the pleas for euthanasia or assistance in suicide. If a suffering patient believes with good reason(s) that she will be better off dead, then the physician refusing to help in assisted suicide can appear to lack mercy and compassion.

Kass is of the view that though, we all feel for people that are suffering as a result of terminal diseases and we would want to see that such suffering is quickly terminated even if it involves mercy killing but according to him, the aggregate and the adverse consequences of being governed solely by mercy and compassion may far outweigh the aggregate benefits of trying to relieve agonal or terminal distress by direct medical killing. Kass is of the view that the people that are most often regarded as needing mercy killing are those suffering from incurable and fatal illnesses, with intractable pain. This people are very few and such pains are most of the time controllable.¹²

Kass further went on to argue that proponents of mercy killing often shift their position and argue that when patients are given large doses of pain reliever it induces drowsiness and blunts awareness and these cannot be a desired outcome of treatment, that is, the effect of large doses of analgesic is not what we desire when patients are treated. Such life may no longer be valued. Kass argues that a shift from argument from suffering to argument from the valued life also leaves room for the argument to the effect that people in all sorts of greatly reduced state can also request that their sufferings be mercifully terminated. There are two troubles for this position: first, most of the people in this reduced state can no longer request on their own for mercy killing. Second, it will be difficult if not impossible to define the threshold necessary for ending life. This criticism raises an important issue regarding the control of pain and suffering. The questions that arise are, is pain and suffering the same? Does the control of pain necessarily lead to the control of suffering?

Cassell is of the view that suffering goes beyond pain alone; it includes the meaning associated with the symptoms and future expectation about the

¹² Kass, L.R, 2002 "I Will Give No Deadly Drug: Why Doctors Must Not Kill", p. 23.

symptoms. This explains why in some cases if two people have the same symptoms, one may be suffering while the other is not suffering. I shall now examine Cassell's argument against the view that most sufferings are controllable.

According to Cassell, the hallmark of suffering is related to the specific nature of that person.¹³ Once suffering has set in the cause of the suffering is no longer the main problem but the suffering itself. Some sufferings are also not relievable because the sources within the patient are inaccessible. For Cassell, the belief that suffering can be relieved in all or virtually all cases displays an ignorance of what suffering is and how it comes about. A possible problem for Cassell is that his account of suffering seems to go against how we ordinarily think about the relation between cause and effect, such that if the cause is controlled, then the effect too is controlled. However Cassell may respond that there is no necessary connection between cause and effect, so it is possible that the cause may be removed and the effect still be there.

For Cassell, suffering goes beyond pain, this is so because pain is often caused by tissue damage, but not all those that are suffering or those who request assistance in dying have tissue damage. Physiology does not address the whole of a person because personhood goes beyond the physiological, hence, physiological explanation of pain cannot solve the problem of suffering.¹⁴ There is no direct correspondence between pain stimulants and pain itself. Pain is not a function of the body alone but also the nature of the person experiencing the pain. According to Cassell, physiological and psychological understanding of pain is not enough to show why suffering is personal. It cannot explain why the same symptoms cause suffering in one person but not in another. Cassell therefore identified suffering with the meaning attached to the pain the individual is feeling and the meaning is "the medium through which thought flows into the body and body flows into thought"¹⁵

For Cassell, "the content of meaning is dynamic and not static or fixed".¹⁶ Symptoms are not simple brute facts of nature; they are actively influenced by the person in whom they occur because they are affected by that person.

13 Cassell, E. J., 2002. "When Suffering Patients Seek Death", in *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, Quill, T. E. and Battin, M. P. (eds.), Baltimore, The John Hopkins University Press, p. 79.

14 Ibid. pp. 80-81.

15 Ibid. p. 83.

16 Cassell, E. J., 2002. "When Suffering Patients Seek Death", in *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, Quill, T. E. and Battin, M. P. (eds.), Baltimore, The John Hopkins University Press, p. 83.

The personalized nature of symptoms is such that it is the meaning/value that one places on a given symptom that will determine whether the symptom amounts to suffering for one or not. This, I think, is what accounts for the reason why people with the same symptom may react differently to the symptoms. For Cassell, when people suffer as a result of pain, it is as a result of the meaning they attach with the symptoms and the future, that is, what they think will or might happen.

A question that arises for Cassell is, can the sufferers' meaning and view of the future not be changed or affected by education? If this is possible, it then means that suffering can in principle be eradicated. It will appear that some pain can be so intense that they seem unbearable notwithstanding the meaning one attaches to them. My point is that suffering may not necessarily be as a result of meaning and fear of future. What about those terminally ill children who are suffering but do not have the ability to attach meaning to their symptoms or even able to think about the future? If we go by Cassell's argument, such children cannot be regarded as suffering. This seems to show that it may not be completely accurate to reduce all pains and suffering to the meaning one attaches to them.

Cassell's argument that suffering cannot be controlled because it goes beyond pain to the meaning the individual attaches to the pain, does not hold because a good relationship between the physician and patient will place the physician in a position to educate the patient, especially if the meaning attached to a symptom is faulty and the perception of the future is wrong. However, this does not mean that all sufferings are controllable, the opponents of euthanasia concedes this much. The question then is, in the case of the few people whose suffering is uncontrollable; can we on the basis of beneficence and compassion morally justify euthanasia?

Kass' response to this question is that the aggregate and the adverse consequences of being governed solely by mercy and compassion may far outweigh the aggregate benefits of trying to relieve agonal or terminal distress by direct medical killing. Kass argues that if euthanasia is accepted on the basis of mercy, then mercy killing can be allowed for those that are in a greatly reduced state, whether it is their choice or not, that is, there is the possibility of the abuse of mercy killing because the line between voluntary euthanasia and involuntary euthanasia cannot hold.¹⁷ Kass also argues that if euthanasia is legalized, there is the likelihood that it would be abused and voluntary euthanasia can easily lead to involuntary euthanasia. He is of the view that doctors and the next of kin of the terminally ill who cannot make

¹⁷ Kass, L.R, 2002 "I Will Give No Deadly Drug: Why Doctors Must Not Kill", p. 26.

decision on their own will on the guise of mercy killing get rid of those they deem no longer worth living. The point being made by Kass is that legalizing euthanasia in any form will lead to terrible social and legal consequences. There is the possibility of abuse, such that voluntary euthanasia may lead to involuntary euthanasia. A person's life may be snuffed out against her wish for a motive other than mercy.

The question that arises from this is that what would be the gain of a doctor, if she kills a patient against the patient's wish? Are there financial gains? Is there professional honour or prestige that a physician can gain from the death of a patient? Generally Doctors are known to preserve lives and they don't like their patients to die, it does not bring professional prestige to them. Furthermore, there is no economic gain in the death of a patient because the fees the doctors get depend on treating patients who are alive, except those whose work is to diagnose causes of death.

Kass may respond by arguing that there is economic gain in the death of a patient that is terminally ill for the doctor because it relieves the pressure on the budget of the health institution they work for and the institutions may give incentives (financial and other material benefits) that will encourage physicians to abuse euthanasia. Brock is of the view that there is little firm evidence to support the claim that if euthanasia is legalized there would an abuse and erosion in the care of terminally ill patients, these fears cannot be ruled out however, if we go by the experience, so far with passive euthanasia, there has been no significant abuse or erosion in the care of dying patients.

A possible response to this would be that there is a possibility of abuse in passive euthanasia, it can be argued that there exists the possibility of passive voluntary euthanasia slipping into passive involuntary euthanasia. For example, let us consider the case of a child born with anencephaly (a baby formed without a forebrain), the general practice in medicine is that at birth the umbilical cord is not clamped, and the baby is allowed to bleed to death, the argument is that even if the cord is clamped the baby will die the next six to twelve hours and they don't need consent from the mother to do this. However, this line of objection is not open to Kass and other anti euthanasia authors because they are of the view that passive euthanasia is legally and morally permissible. Furthermore, the proportion of deaths that would occur as the result of euthanasia would be relatively very small. Therefore, any potential side effect from the legalization of euthanasia would be very small as well. Kass and most of the opponents of euthanasia accept the practice of passive euthanasia but they never consider the possibility of the abuse of passive euthanasia or is it the case that passive euthanasia cannot be abused.

In fact the line between voluntary passive euthanasia and involuntary passive euthanasia is thinner than they think.

Another negative consequence of legalized practice of assisted suicide is that it will damage the doctor /patient relationship, a patient that lack a close relationship with a trusted doctor will rightly be suspicious because it will be difficult to trust a stranger doctor who has license to kill.¹⁸ Trust is very necessary and important in doctor-patient relationship but legalizing assisted suicide will negatively affect the relationship of trust.

A possible response to Kass is to appeal to the principle of non-abandonment, that is, if physician stand by their commitment and obligation not to desert there patients at the end of their lives, by empathising with them. It is very important that physician do not distance themselves from their patients when there is nothing more that can be done to relieve their sufferings. When patients see such commitments on the part of their physicians, there will be a close bond and trust, which will not be affected even if euthanasia is legalized. In such a situation it would not be uncommon to hear a patient say, "I trust my physician, he can never do such a thing".

For Kass, the autonomy/freedom of the patient and the physician's compassion are not sufficient to override the duty not to kill. This is so because physicians have sworn to the oath of the purity of life.¹⁹ The goal of medicine is to benefit the sick through the activity of healing; assisted suicide will therefore be against medical tradition. For him, there is no benefit without the beneficiary, so what benefit is there for a dead person. The point being made by Kass is that the core of medicine is to save life and you cannot save a life by killing it, in other word you don't kill to relieve.

The problem here is that Kass' argument is too individualistic. Can we in actual fact divorce the patient from her family, culture and worldview? Though the claim that there is no benefit without a beneficiary seems true enough. But in the case of the terminally ill who is going through an intractable and unbearable pain and suffering, the loved ones of the patient also bear the pain with the patient, in such a situation, assisted suicide puts an end to the suffering of the patient and also to the pain of loved ones. Kass seems to assume that there is only one beneficiary (the patient) but this is not always the case, there are the loved one's who can benefit too.

Kass response is that a true physician serves only the sick; he does not serve the relatives or the hospital or government. Thus the true physician will never sacrifice the well being of the sick for convenience or feelings of the

18 Kass, L.R, 2002 "I Will Give No Deadly Drug: Why Doctors Must Not Kill, p.38.

19 Kass, L.R, 2002 "I Will Give No Deadly Drug: Why Doctors Must Not Kill, p.32.

relatives or society. This is however debatable; is it really the case that allowing someone to suffer is equal to maintaining the well being of the person? Is it possible to isolate all these when dealing with a patient and can the goal of medicine be achieved if we divorce the patient from her families and culture? Another important question that arises in connection with the claim that assisted suicide is against medical tradition is, is medical tradition expected to be static? Given the fact that medicine is progressing on a daily basis, a tradition that does not reflect and accommodate the new realities of the advancement will become obsolete. Present day medicine has in some important ways departed from some of the tradition handed down in the Hippocratic Oath. An example is the case of abortion; the Hippocratic Oath says “I will not give to a woman an abortive remedy”²⁰ My reading of this is that it is wrong for a physician to perform abortion, but this is not the case in most places. Even in places where abortion is not allowed, the law is not absolute, there are exceptions and this is a radical departure from part of medical tradition. The point about the non-static nature of medical tradition was well made by Beauchamp. According to him: “Even though medical tradition has emphatically condemned physician killing, it is conceptually and morally open to physicians and (society) to reverse tradition and come to conclusion that medicine and the social context have changed and that it is time to permit certain forms of physician assisted death that involve killing. Medical morality has never been self justifying, and traditional practices and standards in medicine may, in the face of social change, turn out to be indefensible limits on the liberty to chose.”²¹

Another related question is, are those purported goals of medicine absolute? The problem with Kass’ argument is that it fails to take cognisance of the context or circumstances surrounding the request for euthanasia. The implication of their die-hard stance is that the context is irrelevant to determining whether euthanasia is morally justified or not. For example, we know that killing is wrong but there are contexts in which killing is justified, such as in the case of self-defence.

20 Beauchamp T.L. and Walters, L, 1982, “Hippocratic Oath” in *Contemporary Issues In Bioethics* (2nd editon). California: Wadsworth Inc. p. 121.

21 Beauchamp T.L. “When Hastened Death Is Neither Killing Nor letting Die” in *Physician- Assisted Dying: The Case for Palliative Care and Patient Choice*, Quill, T. E. and Battin, M. P. (eds.), Baltimore, The John Hopkins University Press, p. 118.

6. Conclusion: *Euthanasia the Way Forward*

Having critically examined some of the arguments put forward by Kass against euthanasia, the questions and concerns raised by Kass seems more than just trivial. For example, is the alleged destructive impact of legalizing assisted suicide not real? Is the negative effect of euthanasia on the trust relationship between physician and patient not possible? All these are genuine concerns and if euthanasia is not well regulated all those concerns will become real. How then can euthanasia be regulated to forestall such abuses? My take on this issue is that all physicians are not to be allowed to practice euthanasia. There should be medical practitioners who should be trained in that area (specialists). To be a specialist in this area, the following requirements should be met: the specialist must be well versed in the field of medicine and pain management, a good medical track record and taunt moral profile, that is, she must be at the level of a fully virtuous agent or almost attaining that level. When such requirements are met, the fear of abuse of euthanasia will be greatly reduced, if not totally eliminated. Another requirement is that the specialist must be trained to be a good communicator, and they must also have good knowledge of prudential and ethical theory and how to apply it to issues surrounding euthanasia.²²

This approach will help solve a lot of problems, for instance, the fear that the trust relationship between the physician and patient will not arise because the personal physicians of the patients will not be the people responsible for carrying out euthanasia. The best the physician can do is to recommend euthanasia at the request of the patient that is going through intractable pain and suffering.

Another problem that will be solved is the problem of abuse, the specialist as I mentioned would be at the level of a fully virtuous agent or almost attaining that level. This will ensure that the rate of abuse will be highly reduced. A possible objection to this position is that, it can be argued that there are no fully virtuous agents? Even if it is conceded that there are, what is the guarantee that they will be in the medical practitioners? Even if we find them among medical practitioners, they will be very few?

A possible solution to this problem is that we can identify physicians with taunt moral profiles, who are at the peak of their careers. This group of people will more than likely want to preserve their reputation and the good name they have built over their lifetime as practicing physicians. On the point that these specialists will be few, my response is that other younger physicians

22 Crisp, R. "A Good Death: Who Best To Bring It" in *Bioethics*, Vol. 1:1, 1987, p. 79.

might be allowed to understudy and learn from them and in the course their interaction, these specialist because of the fact that they are virtuous will be able to identify students who have dispositions to be virtuous, these ones will be retained. A rebuttal here could take the following form: that such specialist will be very few and they will not be enough of them to attend to the request for euthanasia. However, since part of the argument against euthanasia is that most sufferings are controllable and those that are uncontrollable are very few we can argue that the few virtuous specialists should be able to take care of them. What will actually be needed is a good hospice and palliative care system.

This approach is similar to Crisp's proposal that "care for terminally ill become an area of medical specialization, in which euthanasia will play an important part".²³ These specialists (he calls them 'telostriicians'), will be responsible for making life worth living for the terminally ill and they will be "ready to end the life when it is no longer worth living, if seriously requested".²⁴ The 'telostriicians' would be required to have good communication skills, good knowledge of prudential and ethical theory and how to apply it to issues surrounding euthanasia. This would enable them to easily determine when euthanasia is justified and also to explain and convince those that request for it when it is not justified.

However, my approach is different from Crisp's in one important respect; Crisp is of the view that 'telostriicians' should be an area of specialization in medicine that would be studied at the university, but my own view is that, they should be recruited from practicing physician with proven track record and good moral profile. The possible advantage of my view over that of Crisp is that the problem of abuse, which was a major concern of the opponents of euthanasia still remains (if we take Crisp's view) because the moral standing of the student that will be trained is not known, but in the case of my own proposal, the specialists are virtuous and the risk of abuse will be very slim.

23 Crisp, R. "A Good Death: Who Best To Bring It" in *Bioethics*, Vol. 1:1, 1987, p.78.

24 Crisp, R. "A Good Death: Who Best To Bring It" in *Bioethics*, Vol. 1:1, 1987, p. 78-79.