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EUTHANASIA

Lynne Bowyer

In this article I consider the impact of euthanasia/physician-assisted suicide on the way we live and the relationships we have. I argue that embracing the practice of assisted dying is a deficient form of care that will erode the respectful and responsible human bonds that hold us all well in community.

Euthanasia

The word 'euthanasia' comes from the Greek *eu*, meaning 'well', and *thanatos*, meaning 'death'. *Euthanasia* was concerned with dying well, as the person departing was leaving their relationships and all their worldly affairs in harmony. In our current age euthanasia has come to mean having choice and control over when and how you die.

Why Might People Want To Have Choice and Control Over When and How They Die?

It is argued that nobody should have to live a life of pain and suffering, so if a person finds their condition intolerable then they should have the option of terminating their life. After all, the saying goes, 'It is my body – my choice'. Terminating one's life in such circumstances could be undertaken by one's own hand, in which case we call it 'suicide'. Requesting euthanasia requires another person, usually a medical practitioner, to deliberately end the life of someone at that person's request. Physician-assisted suicide is a version of euthanasia, whereby the medical practitioner provides the means to end a life, in the form of

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a lethal dose of a drug, and the person administers this themselves.

It is easy to make a case for euthanasia/physician-assisted suicide if the argument is based at the emotive level and framed in terms of 'individual choice'. All one needs is a narrative of an individual in tragic circumstances, what we might call a 'hard case', so that we would appear to lack compassion if we were to deny the person a way to end their life. For example, in New Zealand, where I live, we recently had the life and terminal condition of lawyer Lecretia Seales to consider. In 2011, Lecretia was diagnosed with brain cancer – a grade 2 oligoastrocytoma. Grade 2 is on a spectrum of 1 to 4, in which 4 is the fastest growing. At the time of diagnosis, the tumour had already infiltrated a quarter of her brain. Her tumour had a diffuse shape, making surgical removal impossible. Between 2011 and 2014 Lecretia underwent surgery to 'debulk' the tumour, followed by radiotherapy and two rounds of chemotherapy. However, her condition was terminal and in 2015 she began to decline. On 20 March 2015, Lecretia, via her lawyers, filed a statement with the New Zealand High Court, seeking permission for her GP to be able to administer a lethal dose of drugs, without prosecution, should she wish them to do so.[1]

We would be callous if we did not feel for Lecretia and her family in these circumstances. If thinking stops here it becomes difficult to say why ending someone's life under such conditions is the wrong thing to do. However, our lives are not lived and our choices are not made in isolation. We are all embedded in relationships with others, which are informed and sustained by the social, political and economic structures of our time. When we consider the complexity and interconnectedness of human life, we are able to see why euthanasia and physician-assisted suicide are problematic.

We must first, however, clarify a number of things that often get confused or conflated when euthanasia/physician-assisted suicide is being discussed.

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Understanding the Terrain in Which Euthanasia/ Physician-Assisted Suicide is Being Discussed

A good deal of the discussion around euthanasia/physician-assisted suicide conflates the ideas of pain and suffering. There is a difference between pain and suffering, and each must be handled carefully, but differently. Many people are afraid of being in excruciating pain leading up to their death and think that euthanasia is a way of avoiding this. But pain, if it is unbearable, can be alleviated through appropriate medication and palliative care, which includes palliative sedation if needed. It is not inevitable that death will be painful, but if pain is part of someone's dying then we need to ensure that they have access to good pain management and hospice or palliative care. Lobbying for these to be available to everyone if needed is a priority.

Suffering is different from pain; suffering is existential. It is concerned with a person's value, their place in the world, and the significance of their existence. Suffering can be alleviated through social practices that value all people, regardless of their situation. Too often in our current society people are only valued if they are 'productive', which usually requires them to be youthful, well, and relatively fit and healthy, so they can be harnessed to a productive task. Our society can be considered a 'functionalist society', as it emanates from a world-view in which 'productivity' and 'usefulness' are valued over other forms of social engagement. If people perceive themselves as 'unproductive' or 'useless', and as a corollary, a 'burden' on society, due to disability, age or frailty, which are messages that circulate in the media and in policy discussions, it is difficult to conceive of oneself as valued and hence valuable. A change in the way that we think of and speak about people would ameliorate the suffering of those we currently marginalize. If we can convey instead that it is enough to have simply lived as someone's son/daughter, brother/sister, mother/father, aunt/uncle, cousin, friend, neighbour and so forth, recognizing that a person is valuable for just

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being who they are, then we are holding well the significance and value of someone's existence. The fact that someone is struggling to breathe, or eat, or communicate, or use a toilet should not diminish their value, and it is up to the rest of us to uphold this important message.

It is also critical to understand that there are a number of practices currently available to people who are on a dying trajectory, and these practices are *not* euthanasia. When any of these things happen, we are not actively terminating someone's life; we are allowing them to return to their dying. Neither are these practices included under the idea of euthanasia. We can refuse treatment or choose to discontinue treatment once it has begun, if that treatment is futile. By doing so, we allow people to return to their dying. Food and fluids can be stopped if they are onerous for people to take on board, and there is no benefit to be gained from their continuation. Often, keeping people hydrated and fed interferes with the dying process and can contribute to their pain. Recognizing the time when food and fluid is no longer needed is an important part of caring well for someone. People can have a 'do not resuscitate' request, so that if they are on a dying trajectory and go into cardiac arrest, they are not revived. Often, medical practitioners try to see what they can do in a situation, and resuscitation may be on that list. For some people, being resuscitated would add a further complication to their terminal condition and may not be something they want to go through. As mentioned above, rigorous pain management and palliative sedation can be given as needed. Sometimes the side-effects of pain medication may hasten death. However, such medication is not given to *cause* death; the intention is to alleviate pain. This is known as the 'Doctrine of Double Effect' (DDE). DDE holds that there are circumstances in which the meaning of an intended action also has foreseeable, but unintended, consequences. However, all things considered, if the intended action is considered necessary in the circumstances, we may have to go ahead and accept the unintended consequences of that action. For

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example, when death is confronting someone and they are in severe pain, frequent high doses of morphine to subdue their pain and keep them comfortable may be required. Frequent high doses of morphine may suppress respiration and could bring about death a little sooner. However, causing the person's death is not the motivation for, or the meaning behind, giving the morphine; relieving pain and keeping them comfortable is. In the messy activity of caring for people towards the end of life these sorts of difficult decisions have to be weighed up and balanced and will be taken after discussion between professionals and with family members.

In a western healthcare system, all of the practices discussed above are available to people who are approaching the end of life. None of these practices constitute euthanasia or physician-assisted suicide.

So Why Is Euthanasia/Assisted-Suicide Problematic?

As noted above, advocates of euthanasia/physician-assisted suicide argue that people should have choice and control over how they die: 'My life, my choice'. However, what this individualistic, choice-oriented framing of things conceals, is that with choice comes responsibility. All of our choices have repercussions that ripple out and affect the world in a myriad of ways. We are not isolated individuals; we live in communities of others, in particular places, within particular contexts. Our fundamental communal way of being means that when we make choices, we must make responsible choices, that is choices that will enhance the lives of others, or which will have no undesirable outcomes for others.

If we normalize and expand our repertoire of 'choices' to include euthanasia/physician-assisted suicide there will be a change in societal values and the nature of relationships, and the ripple out effects of these are formidable. These ripple out effects include: the intimidating social messages

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we are conveying when we legalize euthanasia/physician-assisted suicide as a 'choice'; the gradual and problematic creep in the scope and application of acts of termination; the damaging changes to relationships that are required if euthanasia/physician-assisted suicide is legally sanctioned.

We will begin by considering the social messages we are conveying when we legalize euthanasia/physician-assisted suicide as a 'choice'. In jurisdictions that prohibit euthanasia/physician-assisted suicide it is a criminal offence to aid someone to end their own life. For euthanasia/physician-assisted suicide to become legal it means that those who assist someone to die must be immune from criminal prosecution. In order to provide such immunity, euthanasia/physician-assisted suicide requires us to decide on a point at which someone's life ceases to have any ethical and juridical value, either for the individual or for society, so that a person can be killed by another without the charge of homicide being laid. Ordinarily we talk in terms of 'murder', or 'manslaughter' when someone takes the life of another person, and except in extenuating circumstances, such as proportionate self-defence, these acts carry with them criminal convictions.

Legalizing euthanasia/physician-assisted suicide therefore undermines an enduring principle at the heart of the law, a prohibition on taking the life of another person, a principle that has been instantiated to protect everyone. As this enduring legal principle is based on the idea that everyone deserves to live, a move to legitimize euthanasia/physician-assisted suicide puts our very existence as a living being into question. When we expand people's 'freedom of choice' to have assistance in terminating their life, we undermine the freedom to remain alive without having to justify – both to ourselves and to others – our continued existence. This is because legalization doesn't just frame an idea in legal form; 'enabling' laws have a tendency to encourage the acts they enable because they sanction the law's underlying social message. As terminating life becomes normalized and part of our repertoire of

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'choices', there will be a change in societal values and the nature of relationships. We already have the concept of 'burden' in our lexicon, and many of our elders, along with people with 'disabilities' and those with mental health issues, are already made to feel that they are a burden on others. This is because we have a society that is 'ageist' and 'ableist', in which optimum functioning and productivity are prized. As we get older, or if we live with some sort of disability, it is not always possible to be the 'productive social unit' that is valued. As a consequence, increasing pressure will be placed on these vulnerable people to avail themselves of termination, so as not to burden family, friends and social institutions with their continued presence.

When we look closely at what is happening in jurisdictions that have legalized euthanasia and/or physician-assisted suicide we can see that such normalization has led to a significant creep in the scope and application of the practice. What we see in the Netherlands and Belgium, as well as in Oregon and now Canada, is a dramatic year-upon-year statistical increase in the numbers of people whose lives are actively terminated by others. This increase in the scope and application of a practice is sometimes referred to as a 'slippery slope', but it is actually a logical progression. Once the clear line that prohibits someone ending the life of another has been eroded, and euthanasia and/or physician-assisted suicide become accepted practice, it becomes more and more difficult to justify why the arbitrary criteria put in place in regard to who qualifies for legalized termination are the only situations in which it should hold. The literature is replete with examples that show how what is left of that line is pushed in all directions to include people who are younger than initially proposed when the legislation went through, and conditions that are different from those initially proposed. As there will always be another 'hard case' just outside the boundaries of the initial eligibility criteria, this logical progression is inevitable.

Another problem with euthanasia/physician-assisted suicide is that it requires fundamental relationship changes

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with medical practitioners who are tasked with caring for us when we are at our most vulnerable. In order to give terminating someone's life the cloak of medical legitimacy, salient changes are required to the nature of medicine and the doctor–patient therapeutic relationship. The lethal drugs that are administered in order to kill someone are often termed 'medication'. This is a misuse of the word 'medication', which stems from the Latin *medicari*, and is something given to alleviate, heal or cure someone's illness condition, not to end their very possibility of being in a condition at all. Medications have therapeutic efficacy, and once terminating someone's life is regarded as a 'therapeutic' option, how doctors conceive of themselves, and how patients relate to their doctors will be altered considerably. What a person tells a doctor about their symptoms, feelings, needs and so forth will be tempered by knowing that assisted termination is in the medical tool kit. We should not be comfortable with doctors who are content with conflating care and killing.

Baroness Finlay of Llandaff, a professor of palliative medicine, argues that the reality of working with people towards the end of life is very different from the clear-cut, neat and tidy, high-profile scenarios that proponents of 'assisted dying' use in their arguments. She points out that euthanasia/assisted-suicide proponents assume:

> a world in which all doctors know their patients well enough to understand their underlying fears and anxieties and to assess whether a request for euthanasia stems from firm conviction, rather than from a sense of hopelessness or obligation to others. They assume a world in which all terminally ill people know their minds clearly, are never vulnerable to any pressures, never have depressed thinking that has gone undiagnosed and that the information they have about their prognosis and future is always completely accurate. Anyone who works, day in and day out, with dying people knows that this idealised picture simply does not reflect reality.[2]

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Medical practitioners are human too and will have to carry the burden of terminating people's lives in complex circumstances, based on the opacity of our human situation. Such work will take its toll on them and their families.

Another Way

The idea of euthanasia in its present form stems from a particular world-view, in which order and control dominate the way of approaching the world. As discussed above, this world-view shapes our current westernized society, and it takes the isolated individual as the basic functional, productive social unit, concealing the complexity and interconnectedness of human life. Other ways of living and thinking are marginalized by this dominant narrative. However, in New Zealand, our indigenous Māori people take a more nurturing, thoughtful approach to those who are approaching the end of life. They do not give in easily to death and *whānau* (extended family) do whatever they can to ensure that a person lives well for as long as they can, and that their life remains comfortable, meaningful and worthwhile. In traditional Māori culture, a place is found for people regardless of the situation they find themselves in, so that those with mental illness, disability and so forth are supported appropriately and are valued for their part in the interrelational, intergenerational whole, as someone's brother, sister, mother, grandfather, forebear and so on. This takes collective work and it makes for a culture of assisted living, not assisted dying. If we are to live well together it would be better if we can all care enough for others so that we can convey to them that their lives are always of value, whatever 'slings and arrows of outrageous fortune' they may face. Then we could return *eu-thanasia* to its true meaning, whereby those who are departing are leaving their relationships and their worldly affairs in harmony.

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Notes

[1] Lecretia died peacefully aged 42 on 5 June 2015, the same day that the *Seales vs Attorney General* ruling declining her application for euthanasia was released to the public. Lecretia was not assisted to die. However, Lecretia's high-profile case has led to a binding referendum to legalize euthanasia in New Zealand. This referendum was held on 17 October 2020 and asked the question 'Do you support the End of Life Choice Act 2019 coming into force?'. In order to make an informed, considered decision on the matter, voters should have made sure that they had read and understood what the 'End of Life Choice Act 2019' entailed. The outcome of the referendum was that 65.1 per cent of voters said 'yes', which will make euthanasia legal under the terms of the Act from 6 November 2021.

[2] George Pilcher, *A Time to Live: The Case against Euthanasia and Assisted Suicide* (Oxford: Monarch Books, 2010), 13.

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