Debates on euthanasia

Sinéad Donnelly

Recently I attended the Paediatric Palliative Care Conference in Wellington and was impressed by the compassion and dignity afforded to children who are dying in Starship Children’s Hospital, Auckland. The negatively phrased tick box “Do Not Resuscitate” (DNR) order while in hospital has been replaced by “Allow Natural Death” (AND). Even more dignified and compassionate is the Maori translation of AND: Te Wa Aroha.

Families are presented with the reality of their child dying and agree to engage with the palliative care team in “a time of love, a way of communication to prevent suffering, to promote comfort and dignity.” I was heartened and inspired to hear about Te Wa Aroha and the poignant stories of children dying and raw family grief.

In contrast I was deeply saddened on reading Malpas et al paper in this month’s NZMJ that healthy older people advocating euthanasia felt a burden, useless and an inconvenience in contemplating their future. I felt burdened by their distress. It read like a lament.

As a palliative medicine physician I find debates on euthanasia disturbing. Care of the person who is dying is not an issue for debate. It is not a dual, nor a contest to win or lose. It is more than that for me.

I have worked for 20 years caring for 400 people each year who die. That experience has taught me how complex each person is, how individual is their life and death, how again and again people respond to holistic care and attention. In Malpas et al’s paper I hear an urgent call for better medicine and care of the elderly, not for euthanasia.

The study participants’ fear seems to be of “institutionalised aging”. An aging person it is assumed will not be loved and will not receive care. I groan to read a study participant’s comment, “when I’m useless and have nothing to contribute”. Does fear of growing old justify euthanasia? Does fear of being a burden justify euthanasia? If so, what a cruel society we have created.

The inconvenient truth is that “being a burden” can happen at any age—infancy, childhood, teenagers included. This is the very reason not to legislate in favour of euthanasia. In the Court of Usefulness, who presides? How do we ensure that older people feel useful? What right have we to make older people feel useless?

Quotes from interviewees in this study are challenging, e.g. “old people are a drain on resources”. Is this the reason to legislate for euthanasia? There is no limit to the drains on resources—e.g alcoholics, drug addicts, depressed people. They see older people “getting little sympathy from caregivers frequently”. Is this the impression we are giving to older people? This is the challenging area.

The problem does not reside with the older people who request euthanasia. The real problem is that people in our midst feel they are a burden and feel or know we will not care enough. They are right.
The easy answer for us is to bury the problem. The more uncomfortable reality is to look at ourselves the carers, the able bodied and say “they are right, we do not care enough”. We must show our older people and our younger people that we know how to care for each other.

At times throughout our lives we are a burden to people. That is because we are human. Because we are all a trial or a burden, we create a community where there is give and take. But have we created community? Have some groups, e.g. Maori, Pacific People, held onto community? They are not in this self-selected pro euthanasia group. Why not? What have they got?

Agrich et al’s comment that “long-term care has become associated with images of frailty and despair, loneliness and destitution” rings true. People are afraid of getting old. One clear response to this fear is to create an excellent, integrated care of the elderly service. Our best and brightest young doctors should be vying with each other for advanced training positions to learn how to care for our specific needs when we are old.

Prior experiences with health care as a family member or friend was dying is an interesting influential factor in favouring legalisation of euthanasia. It highlights the needs of grieving family and friends—they, as much as the dying person, need great care and attention. Attention paid to them will help in their bereavement and future contact with dying and death. This is well recognised for bereaved children so why would it not also apply to bereaved vulnerable adults.

Euthanasia or assisted suicide, and sometimes both, have been legalised in a small number of countries and states. The Netherlands, Belgium and Luxembourg have legalised euthanasia.

In the United States, Oregon and Washington states legalised physician-assisted suicide (PAS) but euthanasia remains illegal. Switzerland allows non-physicians to assist suicide.

Legislators in several countries and jurisdictions have in the last year voted against legalising euthanasia and PAS. Those jurisdictions include France, Scotland, England, South Australia and New Hampshire. They have opted to improve palliative care services and to educate health professionals and the public.²

The World Medical Association³–⁵ and the New Zealand Medical Association⁶ are opposed to both the concept and practice of euthanasia and doctor-assisted suicide. Moreover, The Australian & New Zealand Society of Palliative Medicine⁷ believes that the discipline of palliative medicine does not include the practice of euthanasia or assisted suicide.

I disagree with Malpas et al saying euthanasia is legalised in “carefully qualified situations”. The Netherlands’ 30-year experience shows clearly the rapid expansion of what are seen as acceptable justifications for euthanasia—e.g. babies and children; non-consenting and depressed adults; an old man who wants to avoid a nursing home; suicidal middle-aged men.

According to Margaret Somerville—founding director of the McGill Centre for Medicine, Ethics and Law research—dying people request euthanasia far more frequently because of fear of social isolation and of being a burden on others.⁸
The medical authority of Oregon (where physician-assisted suicide is legal) seems to have accepted cost-saving as a justification: it has acknowledged that when it turns down an application to cover the cost of an expensive new drug, it simultaneously sends out a reminder that the state’s assisted-suicide programme is available at an affordable cost.

Somerville cites increasingly lax conditions around who can request assisted suicide in the Netherlands as proof of a “slippery slope” toward abuse. “When first allowed through a judicial decision, the conditions were that the person was an adult, terminally ill, in terrible pain and suffering ... competent, had given their informed consent and had asked for euthanasia over a considerable period of time,” she explains. “Not one of those conditions now applies”.

If the basic principle is autonomy and that's always the over-riding value, which is what they argue in the report, then if you’ve got a broken-hearted 18-year-old who wants euthanasia, how can you reject what she's asking for?” Somerville contends.

She adds that legalising euthanasia causes death and dying to lose their moral context. Maintaining a moral context is crucial in light of an aging population and scarce, expensive healthcare resources, which will face us with many difficult decisions about who lives and who dies.

Concerns were expressed in Canada about abuses that might occur if decriminalisation of assisted suicide and voluntary euthanasia was implemented.

“What about people who already feel like they're a burden? If it's very difficult for their families, it's a failure of our social services and health care system,” argued Rhonda Wiebe, Co-Chair of the Council of Canadians with Disabilities’ End-of-Life Ethics Committee. “They shouldn't be paying with their lives because health and social services can't step up to the plate”.

Legalisation of euthanasia creates societal pressure on vulnerable populations, such as people with disabilities, to end their lives. Wiebe adds “There's this continual apology for your own existence and when you start internalizing that, what happens when you go to a doctor who is supposed to be helping you negotiate life with a disability, and they're saying death is always an option?”

There is the burden some people (e.g. Malpas et al’s study participants) feel at the thought of being disabled. And there is the burden disabled people already feel in struggling to live in the society we have created. The latter will be compounded by legislating in favour of euthanasia.

People are asking not to be considered a burden. They are asking us “are we a burden?” We say yes when we legislate for euthanasia.

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Author information: Sinéad Donnelly, Consultant in Palliative Medicine, Capital & Coast District Health Board (CCDHB), Wellington—Adjunct Professor, School Biological Sciences, Victoria University, Wellington—Senior Clinical Lecturer, Otago School of Medicine, Wellington

Correspondence: Dr Sinéad Donnelly, Palliative Care Service, Level 6, Grace Neil Block, Wellington Hospital, Private Bag 7902, Wellington South, New Zealand.
Email: Sinead.Donnelly@ccdhb.org.nz
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