An appraisal of life’s terminal phases and euthanasia and the right to die

KEY WORDS
Advance directive, active, death, euthanasia, judgments, life, pain, palliative, passive, rights, right-to-die, suicide

The Editor,
Current Oncology
January 27, 2011

Euthanasia allows inevitable death, ideally embracing minimized, moderated, or eliminated pain, anxiety, suffering, loss of dignity, or distress. Euthanasia may be active or passive, with life termination accelerated or allowed. Active euthanasia demands action to hasten death, whereas with passive euthanasia, there is no technological intervention, and death obtains naturally. Freedom, responsibility, and accountability are interlinked in life and death. Everyone is free to perform personal actions, provided that they accept responsibility and are accountable for those actions. Discrepancies between religious and secular protocols may cause conflicts. For example, many religious terminally ill patients retain pre-ordained iso-gender roles for personal hygiene duties.

Control and use of a subject’s own body is the sole purview of that subject. Passive euthanasia is moderated suicide when subjects choose to facilitate death and to pass naturally but comfortably, without technology prolonging onset of death. There are differences between active euthanasia and suicide. In the latter, the person killed and the person killing are the same; in the former, the person killing and the person killed are different. Accordingly, euthanasia is what one person does for or to another (sometimes with and sometimes without the other’s consent); suicide is what a person does to the self. Exercising the right to control one’s body allows subjects to choose passive euthanasia and the right to die. This freedom to choose accounts to collective responsibility. Active euthanasia promotes accelerated unnatural death; passive euthanasia allows non-interference in natural death. For palliative medicine practitioners, responsibility rests on the shoulders of people who determine the protocols implemented. Their decisions must be in the best interests of the patient. Others who introduce conflicts of interest should be expunged from decision-taking. Faced with death, most people experience emotions ranging from denial, anger, and bargaining to resolution and acceptance. “Death, a necessary end, will come when it will come.” The only certainty people must and will experience in life is death.

Besides preventing and curing disease or promoting health, doctoring is charged with maintaining and retaining life as long as possible. At the time of writing, mechanochemical technologies allow for the resuscitation of failing functions, even though a person may be “brain-dead,” with no electrocardiography trace or reactions, and live only if fed artificially. Antibiotics for opportunistic infections in terminal cases may prolong physiologic signs, but whether such technology prolongs life is dubious.

A person’s informed directive about their own body—as to whether they wish to live or die—is supreme. Just as someone may will their body after death for medical use, so too can they influence how their body should be managed terminally before death. Ante-mortem desires are called “advance directives.”

Accordingly, when sound in body and mind, people should think about finite life and about what their end-management should be. Before falling ill, they should write down directives for end-of-life management. With death imminent, do they want sole responsibility for their bodily care, or do they wish others to decide? This decision is intensely private, subjective, and personal. Should regrets surface, the decision should be rescinded. With all interests satisfied, a definitive advance directive demands respect. “Commune with your heart upon your bed and be still” (Psalms 4.4 AV).

If no advance directives are enunciated, conflicts can arise, and life-sustaining policies are left to the judgments of caregivers. Some invoke religion... but, for many, belief in a superior force starts where their
understanding stops. Certain religions dictate that any life-sign demands resuscitation, regardless. Those accepting “life after death” question poignantly, “If you believe totally in G–d and heaven, why are you afraid to die?” Should “Nature run its course”? Or should medical resources be used to maintain life? Consequently, conflicted situations materialize. Many religious choose DNR and don’t fear passing.

Some claim a right to die on demand, with hastened termination. Others disagree and invoke optimism in spite of clear advance instructions for terminal management. Reality, experience, and insights become judgment calls, and although many situations resolve, alas, too many produce recriminations and litigation. Vast differences exist between elective advance instructions and intuitive policies, just as differences exist between active and passive euthanasia. Active euthanasia should not be the default policy of choice, but the right to die naturally—or with active or passive euthanasia—should be a subjective option through advance directives.

Palliative medicine optimizes quality of life, dignifies pain-free survival, and satisfies a subject’s wishes; it should foster practices to alleviate, not accelerate, death. Precise instructions about life-support systems should be pre-recorded; resuscitation with technology or with only natural processes should be indicated.

Given that, by the 21st century, medicine had more than doubled life expectancy over that in the 19th century, there is now a demographic bulge of seniors challenging palliative geriatric and terminal medical practices. Terminal management should be part of medical training. Without advance directives, societal consciences dominate, but the right to die and passive euthanasia should not be in conflict. Active euthanasia as an elective policy remains spurious, just as committing suicide is murder.

L.Z.G. Touyz BDS MSc(Dent) MDent(Perio&oralMed)
Associate Professor, McGill Faculty of Dentistry
McGill University
Montreal, QC
E-mail: Louis.touyz@mcgill.ca

S.J.J. Touyz BSc
Graduate student in Biomedical Ethics
McGill University
Montreal, QC
E-mail: Sarah.touyz@mail.mcgill.ca

CONFLICT OF INTEREST DISCLOSURES
The authors have no conflict of interests to declare.

REFERENCES

— This abbreviation for “do not resuscitate.” is usually noted on medical records and bed-letters when written instructions have been received and noted.