EUTHANASIA AND THE GOOD LIFE

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Introduction

In common parlance, it is often held that people die the way they live. The joker breathes his last with an ultimate gag. The violent robber gets killed during a hold-up, while a noble benefactor dies in peace at home with piously crossed hands. A less innocuous way of linking one's life with one's death is found in the moralistic association of certain deadly diseases with a specific lifestyle. Dying of AIDS, for example, has by some extremists been held to be people's own "choice," the result of a "morally wrong" lifestyle, and even God's punishment. The idea that our dying is always in accordance with the way we lived can of course easily be rebutted. Mahatma Gandhi was violently killed, while Stalin and Mengele died peaceful deaths. We also have to reject firmly the idea that disease, misery, or suffering is the normal pay-off for sins committed. What happens is that people easily find points of resemblance between one's lifestyle and one's death. The choice of our images for describing the way someone died is the result of the way we perceived the person's life to have been.

It is not only other people who describe the way we die on the basis of how they perceived our life. Indeed, we all in a way create our own ideal moment and mode of dying on the basis of our image of what constitutes a good life. In the following pages, I will situate the growing claim for legalizing euthanasia within this normative view of life. The demand for euthanasia reflects our image of the good life. This image is the result of a combination of what Clifford Geertz calls "spheres of
meaning": modes of thinking that are the result of historical-cultural processes; developments that have gained a particular meaning; our relations with others, with modern technology, and with everyday reality, and so on. It is a complex set of interactions, the result of an interplay between a specific, partly inherited approach to the world, and meaningful practices that we develop on the basis of this approach. In turn, these elements tend to reinforce our own particular view of life. The claim that euthanasia is morally acceptable or even required can be situated within this framework.

As often argued, developments in medical technology have indeed created specific problems related to aggressive and "blind" medical intervention. Confrontations between patient autonomy and the dynamics of science and medical progress are common place. But there is more than than. As Callahan argues, the demand for euthanasia is not so much the result of a confrontation between patients' desires and aggressive medical practice, but, on the contrary, fits perfectly within a medical mode of thinking [1].

I argue that there are also other conflicting elements that have influenced our view of euthanasia. On the one hand, there is hope and confidence that medicine will enable us to first understand and then control disease and aging processes. Scientific developments continue to pique our imagination. By attempting to preserve an optimal state of physical and mental health, medical research engenders a specific view of the desirable life. Medicine, itself the result of a particular approach to the world, thus accentuates the idea of the rational, self-determining free person, living his own, "ordinary" life. On the other hand, we are confronted with the obvious limits of technological progress and control of nature. In the context of medicine, the rapid expansion of knowledge has not enabled us to solve human suffering. Death's inevitability remains unchanged. Short-time successes in the prolongation of life lay the path to long-term ailments due to old age. The seeming impotence of science in the face of many diseases has clearly dampened our optimism in the medical enterprise. The last 30 years of research into cancer have failed to significantly impact on overall cancer deaths in our society [2]. Our experience with HIV/AIDS has also made clear that medicine can neither guarantee a particular lifespan nor a given quality of life. Weary from the devastation that AIDS has caused, the suggestion that medicine could eventually remove death as "the ultimate disease" strikes us now as ridiculous.

The support for euthanasia seems partly the result of these tendencies in our society. Medicine has provoked the dream of perfect control over disease and dying. Death, being the anithesis of modern medicine, has been neglected. The vanguard of life, medicine, cannot offer us a meaningful answer. The renewed attention to death, in particular in the med-
ical context, linked to clear examples of "loss of control" over disease, demands the creation of a new language. This new language offers the illusion of regaining control, which fits within the medical context.

It is important to unravel these dynamics of meaning. An understanding of them gives us the opportunity to choose within certain limits (within our cultural context) the path we wish to take. We should realize where the claim for legalization of euthanasia comes from. We should be aware that legalizing euthanasia might reinforce and stimulate a particular view of the good life. In assessing the consequences of such reinforcement, we may want to take into consideration the context in which such a claim is made. Legalizing euthanasia may lead to the development of a vision of the good life which is more limited than desirable.

The Classical Argument: Euthanasia as a Response to Technology Gone Wild

The demand for euthanasia is linked by most proponents with the artificial prolongation of life and the concomitant use of invasive medical technology. Medicine, it is argued, has been applied to save life at any price, without taking into consideration patients' "quality of life" [3]. As Burnell states,

[doctors sometimes feel that every symptom and every condition must be treated with all the measures that technology can provide. This attitude has led to the feeling that "Sometimes, we treat because we can, not because we should," and sometimes, the patient's feelings are left out of the discussion. [4]

It has been claimed that resuscitation and life-support systems have been used inappropriately. In the United States, there are approximately 10,000 patients in a persistent vegetative state [5], a condition in which the consciousness of an individual has been permanently ablated. Medical progress has occasionally allowed us to cure previously fatal diseases, but this often requires aggressive interventions, inflicting pain and suffering, which are frequently not adequately relieved [4]. It is sometimes questioned whether we respect people by keeping them alive in these circumstances. The very capacity of medicine to prolong life also puts a burden on the aged. Older people may be more dependent and may suffer uncomfortable ailments that are often perceived as degrading. By extending life, medicine allows people to grow old enough to possibly develop disease such as dementia, which may interfere with their capacity to live autonomously.

Some argue that euthanasia should be an option within our present-day medicine, precisely because of these changed circumstances. Fletcher thus claims that "[t]he whole armory of resuscitation and prolongation of life forces us to be responsible decision makers about death.

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as much as about birth” [6]. Even the financial burden of using sophisticated life prolonging technology—whether impacting on the family or the whole health care system—is invoked as an argument for allowing euthanasia [4, 7]. Most of these arguments suggest that euthanasia is a popular revolt against unfettered technology. Euthanasia becomes a compassionate solution in a time of technological violence. It is presented as a way of regaining what was taken away by technology.

**Euthanasia as the Result of Medicine's Responsibility over Dying**

For Callahan however, the claim for euthanasia fits perfectly within the development of our striving for medical prolongation of life. He argues that this claim is the result of the conjuncture of the quest for control over life and what he calls “technological monism.” By the latter is meant “the tendency to erase the difference between human action as a cause of what happens in the world, and independent, natural biological processes, those old-fashioned causes of disease and death” [1]. Medical science has thus created a new “reality,” in which nature is totally submitted to human domination. By the very terms of this “reality,” death can be prevented by appropriate medical intervention. Every death has a specific medical cause that is treatable. If medicine is not able to do so in a concrete case, there is always an identifiable reason: medical science is not sufficiently developed yet to treat this specific physical cause, or a mistake has been made.

The existence of a medical procedure that can “save” the life of a patient puts the full moral responsibility in the hands of the physician. If a medical procedure is not applied, it has become the physician who “causes” the death of the patient. In such strain of thought, even legislation can “cause” certain forms of death. For Canadian Supreme Court Judge Cory in the Sue Rodriguez case, for example, “State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity” [8, my italics]. In the same vein, pursuing medical progress becomes a moral obligation, as it might lead to the discovery of new life-saving interventions [9].

For Callahan, this creation of human responsibility over dying can go two ways. Some link the idea of human responsibility to the notion of the sanctity of life and thus claim that stopping every life-supporting treatment is murder. Taking somebody off a respirator is seen as the sole cause of death; the real cause—namely, the failure of the patient’s respiratory system—is forgotten. Others, on the contrary, defend euthanasia because technological monism obscures the difference between death as the result of human action and death from a natural cause. If every death involves human responsibility, then there is no difference between killing and letting die by cessation of treatment. The morality
of both acts is then determined by the intention that brings them about [7]. According to Callahan, this way of thinking repudiates the difference between physical causality and moral culpability [10].

Nevertheless, the driving force behind medical science remains the idea that all causes of death are, in principle, curable. Medical technology, while attaching human responsibility to dying and thereby removing the difference between killing and letting die, still tends to unfold its full panoply of possible interventions when confronted with dying patients. However, this intervention with respirators, heart monitors, parenteral nutrition, and dialysis comes into conflict with our notion of patient autonomy. Patients feel that they have no control over what happens to them and often feel estranged from frightening technology. For Callahan, the success of the euthanasia movement lies in the fact that it offers people a way out: "It seeks to reassure us we can die as we choose, and to provide a technically decisive solution to our dying" [1]. That euthanasia is an acceptable moral choice is the result of a medical ideology that places death within the sphere of human control.

The Dream of Total Control and the Good Life

While Callahan is convincing in his description of the link between medical technology and individual self-determination, there may be some other reasons for the success of the euthanasia movement. The claim for legalizing euthanasia is partly the result of the conflict between a view of the good life, as promoted by medicine, and the inevitability of death. Indeed, our view of the good life is challenged by death and by the process of dying, characterized by loss of control. By giving the illusion of control over dying, euthanasia offers us a solution to this conflict.

The Good Life as Promoted by Medicine

Knowledge and contemplation are not enough, friend Henry, if they are not translated into power, so the unschooled are right in judging us to be adepts of a white or a black magic. To make the ephemeral endure, to advance or retard the ordained hour, to master the secrets of death in order to battle against it, to avail oneself of natural remedies so as either to help or to thwart Nature, to dominate man and the world and to make them over, or perhaps even to create them . . . —Marguerite Yourcenar [11]

Medicine offers us more than ever before an expectation of grandiose control over nature. Medical progress gives us hope for ever-increased mastery over our bodies and minds. "Cosmetic psychopharmacology," such as Prozac, suggests the possibility of perfect mental stability. Genetic research claims to give insight into the purely biological causes of
physical and mental "problems," suggesting the possibility of prevention and "correction" of deviance. Genetics might also offer some understanding of, and in the future even therapy for, age-related illnesses such as Alzheimer's, thus removing another confrontation with the temporal limits of human existence.

The reduction of our mental and physical states to clearly identifiable biological processes allows for subtle control in the form of medical treatment. The development of this powerful knowledge of medical science is a result of our instrumental approach towards nature, but it reinforces at the same time an idea of the ideal person. Finding medical causes for deviancy—which then should be treated—requires (however implicit) an assessment of a standard of normality. In the same way, arguing that aging is a disease [12] implies a belief that there is an optimal moment in life that should be preserved. Not surprisingly, this optimal moment in life consists of a youthful physique and a sharp mind, the combination of which allows us to be masters of our environment. Medicine thereby reinforces our modern view of the good life and influences our self-perception.

It is important to make clear at this point how notions of rationality, freedom as self-determination, and our idea of the good life are interrelated, and how medicine functions in this context. The close connection between self-control as a rational agent and freedom can be traced back to Immanuel Kant. For Kant, "Being rational agents, that is possessing a capacity so much higher than nature, puts us under an obligation to live up to this status" [13]. Rationality requires that we be independent from nature, that we be guided solely by our own reason. Living in full accord with our rationality is what makes us fully moral, human agents. Rationality, then, is also the source of our fundamental freedom. It is a freedom "which rebels against nature as what is merely given, and demands that we find freedom in a life whose normative shape is somehow generated by rational activity" [14]. Rationality simultaneously defines the morality of our behavior and frees us from the captivity of the natural state. Freedom as self-determination is an obligation that encumbers us as rational beings.

Our culture at the same time developed a very specific view of the "ordinary life," "in which sober and disciplined production was given the central place" [14]. It is "the life of production and the family, of love and work" [15]. Being able to realize this good life requires certain capacities, which medicine helps to preserve or even creates. The notions of the "ordinary life" and "freedom as self-determination" are intertwined. Freedom as self-determination stresses rationality and self-mastery, both of which are essential in realizing a valuable "ordinary life." Being human implies being a rational agent, and places one above—thus separating one from—nature. It is with rationality that the
free person can understand and control nature, allowing him to work out a valuable, productive, "ordinary life." Being rational agents obliges us to be self-determining and to realize a productive life within society. Threats to rationality and self-determination are perceived as a threat to the very essence of our being human. The medical science's promise to promote mental and physical well-being is indeed seductive in this context. Medicine becomes the guardian of rationality and self-mastery, thus deciding on essential human conditions. The more this dream of complete mastery is realized, the more troubling it is to confront situations in which rationality and self-control are not preserved. Creating expectations about the preservation of physical control and rationality renders it difficult to accept that "to have a life is to be terra animata, a living body whose natural history has a trajectory" [16]. Medicine offers us the illusion of growing autonomy and creates the hope that we can freeze our life at one ideal point of perfect rationality and self-control [1, 16]. We have difficulty coping with situations in which our autonomy is lost.

The Conflict Between the Good Life and Death and Suffering

The process of aging and death bluntly confronts us with our inescapable destiny and our uncontrollable nature. As Jonas states, "[t]he approach of death may seem to mock our pretensions to autonomy; at the least, we are invited to wonder whether wisdom really consists in one last effort to assert our autonomy by taking control of the timing of death" [17]. While medicine and science in general can create at least the illusion that aging might be combated as a disease [12], by reducing it piecemeal into identifiable and treatable causes. death as such cannot be escaped.

The last two decades in medicine are not only characterized by hitherto unimaginable progress but also by extreme disenchantment in our struggle against other diseases. AIDS, for example, has not only proven to be a human disaster, poorly controlled by present-day medicine, AIDS was also instrumental in the resurgence of tuberculosis, a disease thought to be of mere historical importance in the developed world. It thereby puts into question the previous successes of medicine in combating epidemics. This has had a major effect on our confidence in medical science. Not only do those who are infected by the disease feel abandoned by medicine, but the incapacity to bring some epidemics under control more generally erodes our faith in medicine.

AIDS as "deadly disease" has confronted us anew with the ultimate failure of our dream of absolute control over nature. Our previous, nearly successful, attempts to hide death, by removing the dying process from the private homes to the hospital and the institutions for the el-
derly have been undone by AIDS. This time, it strikes particularly where it is the least expected: among young, productive members of society, among those who could reasonably believe to be at their optimal stage of life, an age of full physical and mental development, of expansion, discovery, and successful control over the environment through a productive, enjoyable life.

The painful characteristics of AIDS, entailing absolute loss of control, contribute also to the demand for euthanasia. That may be the reason for C. Levine's suggestion that "AIDS may change the boundaries to include serious considerations of euthanasia" [18]. Patients with AIDS go through different stages of physical decline. They become physically dependent and may suffer from diarrhea, vomiting, bleeding, and a variety of other painful and distressing ailments. In the "prime of their life," many persons are now confronted with forms of physical decline comparable to those caused by the plague, that "anticipated the horror of post-mortem decomposition" [19]. Apart from the physical deterioration, AIDS can also have an effect on the central nervous system, which may cause dementia and other mental disorders. The confrontation with these all-too-rapid developments in a young and previously healthy person is extremely traumatic both for the person with AIDS and those around him or her.

The use of the notion of "dignity" in the context of euthanasia highlights the influence of a specific perception of the good life on our attempts to deal with death and suffering. Dignity refers to our relation with others, more particularly the way we ought or want to be perceived by others [14, 20]. It is therefore not surprising that in the euthanasia debate dignity is related to loss of control, fear of becoming dependent on others, and fear of inhumane suffering. As Susan Songe states: "It is not suffering that is most feared, but suffering that degrades" [19]. We perceive ourselves as having dignity when we possess certain qualities that allow us to have an "ordinary," productive life. In order to accomplish this life, we need mental and physical mastery over our environment. Dignity, as a feeling of self-worth, is perceived to be lost when people become dependent, when they are biologically declining, and when they lose their rationality. Burnell suggests that becoming physically dependent on others, "even to the point of the most basic biological functions," makes people fear for a total loss of dignity [4]. He also mentions that according to one study, published in the Netherlands Journal of Medicine, typical patients requesting euthanasia are persons "who fear becoming dependent and losing dignity through pain and humiliation" [4]. The 1990 version of the Dutch Euthanasia Guidelines contained the question: "Was it predictable that the patient would no longer be able to die in a dignified way?" [my translation], as if dignity was a measurable thing [21]. In fact, although this was certainly not meant, such questions
indicate that our dignity is essentially determined by the perception of
others. Loss of dignity refers to a feeling of degradation resulting from
a loss of control. Having control is perceived as an essential human
capacity. This feeling of loss of dignity might particularly be present in
the context of AIDS.

Dealing with death and a long process of dying has become highly
problematic. While we are definitely confronted with the notion of
death, information campaigns to prevent the spread of the infection
and the distribution of condoms and needles do not offer us a response
to questions related to our individual death. Death is there in prevention
campaigns, but in an abstract way. It threatens our ordinary life but is
kept as far away as possible, as a complete stranger. The process of
removal of death, linked with the development of our control over dis-
ease and dying, has deprived us of meaningful answers about our dying.
Death as symbol of the ultimate triumph of nature, of the final loss of
control, has become difficult to accept, especially when it affects people
in the prime of life.

Euthanasia as the Restoration of Power

The claim for euthanasia might be a response to these tendencies.
Euthanasia offers the promise of control over death and permits indi-
guals to avoid a painful confrontation with the process of dying. At
the same time it gives us a language to deal with dying. Our difficulty
in finding a language about dying, partly the result of the loss of sacral
rituals within society, partly the result of our hiding of death, is resolved
by discussing about the mode of dying. Death is transformed into “a
matter of management” [22], and is in that way rationalized and defi-
nitely “under control.”

With our valuing of self-determination and freedom, it is understand-
able that language of control offers an interesting alternative in the
context of the silence of death. Euthanasia is therefore very often simply
defended “to optimize patient control” [4, 23]. The idea of choosing a
way of dying might function here as a repatriation of the human do-
main, in sight of definite loss. This desire for control over dying is what
Sue Rodriguez motivated when she challenged the Canadian criminal
law provisions on assisted suicide [8]. Rodriguez was a British Columbia
woman who suffered from Lou Gehrig’s disease. She claimed that the
criminal law provisions on assisted suicide violated the Canadian Char-
ter of Rights and Freedoms. In her action, she asserted that she had a
right to control what happened to her body. For her, this right entailed
control over the time and manner of death. She was not requesting an
immediate relief of pain and suffering, but wanted to have the opportu-
nity to decide in the future how she would die. Although she was losing
physical control over her deteriorating body, she wanted to be able to make choices as to what would happen to her. For Rodriguez, dignity meant mental control over the reaction to her bid for assisted suicide. At the same time, her attempt to gain control at least over the manner of dying might have appeased or helped her to deal with the reality of her approaching death.

The phenomenon of living wills also be understood in this context. Living wills create at least the illusion (if not the reality) of individual self-determination after one has become incompetent. They promise to give power over what will happen to us when we are no longer capable of deciding and when we lose control. In our fear of losing rational control over our living and our fear of dying, we give ourselves the illusion of control, by pointing out the way we want to die. However, the language of choice conceals that this does not give power over death itself.

As stated before, it is often suggested that euthanasia empowers individuals confronted with an inhumane, aggressive medical technology. At the same time, most defenders of euthanasia would only allow euthanasia in a medical context. Ten Have and Welle correctly remark: “Instead of counterbalancing that power and enhancing the individual’s autonomy and control over his or her own life, it seem that social acceptance of euthanasia is resulting in physicians’ acquiring even more power over the life and death of their patients” [24]. Could euthanasia become an institutional medical response to a defeat in the sight of death? A restoration of lost power? Is euthanasia a way of making medical sense of an event that baffles our dream of the preservation of a productive, controlled life?

The Consequences of Legalizing Euthanasia on Our Perception of the Good Life

In a way, there is nothing particularly troublesome about our attempt to control nature and our environment, including ourselves. Indeed, being human fundamentally involves the ability to use and change our environment in an intelligent way. It is also understandable, in the context of our culture, that we perceive physical and mental decline to a certain extent as degrading. Regulating euthanasia, then, seems to be the natural consequence of a tendency to control. The demand for legalizing euthanasia is very often a compassionate and human response to immense pain and suffering. However, one should raise the question whether in a given society, a perception of loss of dignity and human value in dying should be promoted or, on the contrary, tempered. Legalizing euthanasia definitely suggests that indeed, life is “inhuman” and undignified when death and dependency approach. Euthanasia
may send the message that when the quality of life declines, so does the value of that life.

Arguments of the “slippery slope” should be placed in this context. Indeed, if we establish a system that promotes a particular self-perception and allows for “controlled death” on demand, are we not helping to seriously limit the perception of what constitutes a life worth living? Does this not necessarily lead to the promotion of euthanasia in non-voluntary cases, on the basis of compassion for “undignified life”? Legalizing euthanasia confirms that, indeed, when people are no longer independent and capable of full participation, life is no longer worth living and ending life is a humane solution.

It is often suggested that legalizing euthanasia allows people to choose according to their individual perception of the value of life. However, self-perception is formed in the context of a given culture and society. Thus, the cultural and societal context in which euthanasia legislation is claimed has to be taken into consideration. The tendency to require control and self-mastery makes the claim for euthanasia a particularly dangerous one. We ought to be concerned that our self-perception will change under the influence of the message sent by legalized euthanasia.

More “practical” tendencies in our society might also be mentioned in this context. Indeed, the major crisis in the health care system urges not only health care professionals, but certainly also individual patients and their families, to limit health care expenses. Although it might be wrong to suggest that euthanasia is consciously promoted to solve the health care crisis, we should be aware of this crisis as it forms an important part of our societal context. Euthanasia could in first instance become an acceptable social practice when people perceive themselves as undignified because of suffering and physical dependence. Is not there a danger that we will gradually perceive the ordinary suffering of old age linked with financial dependence as undignified and inhume?

How can we ever find an objective basis to limit the practice of euthanasia? Euthanasia takes place in a specific cultural and societal context, and the safeguards against abuse are subject to temporal interpretation. The experience of the Netherlands should warn us against accepting euthanasia on the basis of notions such as unbearable suffering and loss of dignity. These notions are easily extended, and limitations are difficult to formulate. In the Netherlands, people suffering from long-term depression now also seem to have a right to be killed on the basis of unbearable suffering. Until recently, this would have been considered as contrary to our primary obligation to care for the sick.

It is worth considering whether the notion of the sanctity of life would not form a bulwark against a tendency to overaccentuate the importance of some human qualities that we do not always possess in the course of our life. The idea of sanctity of life protects us against the perricious
consequences of a system that sees life as undignified when one loses control and when one becomes dependent. It obliges society to promote the idea that every life is worth living and that we should do everything to make life bearable for those who suffer. In short, it forces society to promote human life for all, rather than to confirm the worthlessness of life for some. Endorsing the sanctity of life on a societal level does not mean that we cannot understand a demand for euthanasia on an individual level. However, legalizing euthanasia does more than that: it questions the principle itself and undermines the balance between the societal protection of life and the pressure for increasing control upon individuals. As such, it promotes a limited view of the good life.

Conclusion

We should be aware of the fact that the demand for euthanasia is the result of a complex set of interactions, linked with a particular view of the good life. Medicine has developed as a result of our rational approach towards the world. It has allowed us to perpetuate an extreme form of control over our body and mind. With the powerful position it has taken in our culture, science and medicine in particular have influenced our view of the world. We have reshaped our image of the good life in light of medicine’s promise of the control of life and death. Legalizing euthanasia (and thus institutionalizing it) will reinforce and indeed extend this image. It will become part of our perception of the good life and reinforce the need for absolute physical and rational control. Our fear must be that in doing so, we will create our own notion of the “Lebensunwerten Leben” (life not worth living). Will we not feel the need to end our lives as soon as we perceive that we are no longer capable of having an “ordinary,” productive life?

In the flood of letters to the editor to newspapers across Canada regarding the Sue Rodriguez case, there was one in particular that caught my attention. It was written by a man, also suffering from Lou Gehrig’s disease. One might wonder whether preserving his way of thinking is not an essential societal obligation. He deserves the final word: “I have had to rely on other human beings at all times in order to maintain basic activities of daily living for quite some time now, but at no time deep down I felt a loss of dignity and of respect... Dying is a part of the cycle of life. One can learn a lot from that process and live it to the end and still die with dignity” [25].

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