Euthanasia

Framing euthanasia

J P Bishop

Death cannot be mastered through a metaphysics of efficiency that interprets all actions in terms only of cause and effect, but it can be transcended if we leave the frame open to death's ambiguity

In the second of this two part series, I describe how in shifting our frames from one of human purpose and meaning to one of efficiency, we shift the possible answers we get to our questions about voluntary active euthanasia (VAE) and physician assisted suicide (PAS). Thus, by placing VAE/PAS within the frame of efficiency, we narrow our focus to the final effect in the world of cause and effect—namely death. Thus, in ensconcing euthanasia within a legal framework meant to instrumentally and efficiently control euthanasia, we are in fact narrowing our focus on death. Thus, in legalising VAE/PAS we are not just adding one choice to a panoply of other choices, we are in fact changing the nature of all choices, for each choice conditions all others. We should therefore live with the lie that VAE/PAS do not happen as opposed to living with the lie that through efficient legal control we protect patients from medical dominance.

AN ANECDOTE

Several years ago an acquaintance told me about a terrible situation in which he found himself during the Vietnam war. He was Green Beret—one of the elite special forces corps of the US army. He was in an area that was officially off limits to the US. His unit came under heavy fire and a buddy was shot in several places but was still alive. His comrade was in serious pain, but what scared him the most was that he might die in the jungle, be eaten by a wild animal, or be captured by the enemy. There was no way to get him out. The wounded soldier begged my acquaintance to take his life by shooting him. My acquaintance took out his pistol and complied with the wishes of his friend out of a sense of compassion as well as a sense of obligation.

I offer this anecdote to make the point that I do not think that all instances of euthanasia are wrong. It is entirely possible that the circumstances are such that an action to take the life of someone might be justified. In this essay,

however, I will argue that in ensconcing VAE/PAS within law, efficiency mindedness is perpetuated, closing off other important features of caring for the dying.

In the first part of this two part series, I showed that the traditional distinction between killing a patient and allowing the patient to die of natural causes hinges on an older formulation of causality than the one to which we have grown accustomed. I explained that because we think primarily in terms of efficient causality we primarily focus on the effects of actions more than upon the purpose and meaning of an action. The mechanism that gets us from point A to point B takes precedence over the meaning of the action and over the experience of moving from point A to point B. The final effect in the immanent series of causes and effects is death—when the mechanism plays itself out.

I also argued that this kind of mechanistic and efficiency minded attitude fundamentally changes the nature of the care of the dying. Death is the final effect of all other causes and effects, and the efficiency minded aspect will drive the process forward, leaving little hope for the possibility of transcending the efficient machinery of death through relationship.

In this essay, I will examine the way the question was framed in the US Supreme Court cases dealing with PAS/VAE and show that finally we are left with a choice between two lies. I will then show that the efficiency paradigm as it applies to euthanasia in all its forms fundamentally reframes our understanding, not only of euthanasia, but also the entire enterprise of medicine. For once euthanasia is ensconced in law it will change the shape of all medical decisions.

WHICH QUESTION?

Martha Minow, in her eloquent and astute analysis of the 1997 US Supreme Court decision on euthanasia, asked an all important question—a question that

often gets missed in political discussions generally and the discussion on euthanasia specifically: which question do we entertain?¹ As with all questions, it is indeed the question itself that defines the quest, thus delimiting the answers.

The question before the US Supreme Court in part dealt with VAE/PAS; it also dealt with the legal question of due process under the law, as guaranteed by the 14th amendment of the US constitution. This amendment in part states that no state shall “deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws”.² The plaintiffs had argued in lower courts that they were not getting due process or equal protection under the law.^{3,4} The plaintiffs’ argument went something like this. There are two people with cancer. Patient A gets pneumonia. At first Patient A chooses antibiotics, but her condition deteriorates. She is placed on a breathing machine. While on the machine, Patient A decides that she really does not want to live with the indignity and pain of cancer, so she asks the physician to remove the breathing tube and to make her comfortable. The physician complies. The patient dies comfortably from her pneumonia. Patient B also has cancer. Patient B does not get pneumonia. Patient B also decides she really does not want to live with the indignity and pain of cancer, so she asks her physician to write her a prescription for a cocktail of medications that will result in her death. The doctor is prohibited from doing so by law in most states. Patient B cannot have the assistance of her physician in helping her to die in the way that Patient A can. Patient B claims that she is being treated differently by the laws of the state. The Supreme Court ruled that Patient B does not have a constitutionally guaranteed right to have assistance in her suicide/death; but on the other hand, the Supreme Court also indicated that should a state legislature grant the right to assistance with suicide, it may not rule it as unconstitutional. Thus, there is no right to VAE/PAS under the constitution, but a state might be able to grant that right and not violate the constitution.

Minow’s essay commenting on the decision plumbs the depths of the questions that the court decides to entertain. Some justices saw the question put before them in terms of human liberty. Others saw it as a question of which governmental organisation gets to decide whether there is a liberty to take one’s life: the US congress, the justices of the various courts, the state legislatures? Still another question

entertained by the court was, is there a rational basis for a distinction between withdrawal of life sustaining treatment and participation in suicide? Also, there is the ever familiar framing device used in medical ethics: the “who decides” question—the autonomous patient or the state. Minow catches the justices vying with one another, clashing over how to frame the issue through questions, not just for this case, but for future cases.

Yet, Minow’s question was an altogether different question from the questions put before the courts, or, perhaps better, an altogether different question from the questions used to frame the court’s opinion. Rather, the all important question as seen by Minow with regard to VAE/PAS is: which lie do we countenance? On the one hand, should we countenance the lie that VAE/PAS does not occur? This lie effectively means that government—politicians, bureaucrats, policemen, prosecutors, and magistrates—already look the other way in most instances of VAE/PAS. On the other hand, should the political forces—forces that decide so many of the questions that frame our lives—countenance the lie that government can prevent VAE/PAS from becoming involuntary euthanasia, through efficient control of the processes of terminating a patient’s life? The implied answer offered by Minow is that one cannot expect that a law prohibiting VAE/PAS (in the form of murder laws) would be effective at curbing VAE/PAS; but neither can one expect that legislation to protect physicians who prescribe death inducing medications from prosecution would also protect vulnerable patients from physicians or family too eager to help patients die. The implied answers to these questions yield a more accurate question: which of these two lies better protects patients from the medical tendency toward mastery of patients’ lives—a tendency toward which modern medicine has historically been prone?

WHICH LIE DO WE COUNTENANCE?

Again, I do not want to suggest that all instances of physician assisted death (whether PAS or VAE) are wrong. In the struggle to continue caring for someone who is actively dying, I can imagine circumstances in which a physician might reach for the potassium chloride in the heat of the moment. I have heard my professors tell of patients drowning in their own blood from Kaposi’s sarcoma of the lung in which they felt something had to be done to stop their suffering; that something was VAE. I have not been in a situation where I

thought there was no other option, so I cannot say that any particular action where a physician feels nothing else can be done is wrong. Only the actors in that situation can discern what is acceptable. However, I do want to acknowledge that, generally speaking, one ought not to terminate a patient’s life under any circumstances. While this might be a seeming contradiction, I am of the belief, like Robert Burt, that death does not fit into our rational schemes and that when dealing with death we must treat it with ambiguity.⁵ On the one hand, I cannot judge someone, who, out of a deeply held compassion for her patient, feels there is no other alternative; on the other hand, physicians ought not to participate actively through VAE/PAS in their patient’s death. Irrational? Yes! Contradictory? Perhaps!

Burt makes the claim that when we attempt to deal with death in a rational manner, we wind up exceeding the limits of reason because finally death cannot be mastered, even by reason. In the process of attempting to master death through rational discourse, we end up violating something different, or betraying other things held sacred. Death, despite all of medicine’s inclinations to the contrary, is not masterable technologically, discursively, psychologically, sociologically, or spiritually. Burt argues that when we do attempt to master it, it returns to haunt us. Take the inclination to master death technologically as an example. With the rise of technology, we were able to prolong life mechanically. The use of technology makes rational sense. But then in the 1970s we found ourselves with patients sustained on balloon pumps and breathing machines, without hope of getting them off the machines, and we concluded that they were living lives worse than death. Death returned with a vengeance. Rather than a rational attempt to categorise and master death, we should treat death as the mystery that it is. Death is an aporia; it defies all of our capacity to know and to intellectually or mechanically master. Death is an insoluble perplexity.

The lie that VAE/PAS does not happen is a lie with which we have been living for a while now. This lie leaves open the possibility for judicious police investigators or prosecutors to turn a blind eye in those cases in which they judge that the circumstances, intentions, purposes, and means justify the action, discerning those instances where prosecution is warranted. Investigators and prosecutors can exercise compassion as well. Should the prosecutors not feel they are in a position to make such judgments based on the evidence, then the courts deal with the question as to whether a

particular action is justified. That is in fact how it happens now, and it seems to me that the current system leaves enough ambiguity in place for judicious people in authority to be able to navigate the tumultuous and ever changing waters of death and dying. Even to draw attention to this lie will make many of us—modern, enlightened people that we are—very uncomfortable because there is no system to master the situation. We live within the paradigm of efficiency, as I argued in the first essay. We live under the myth of efficient control, and to acknowledge that in life (and death) there are certain things best left uncontrolled makes us very uncomfortable. I will return to this point a bit later. For now, let me turn to the other lie.

The other lie—the lie that VAE/PAS can be controlled and in controlling it nothing really changes in the practice of medicine—is a worse lie. First, at a very naïve level this lie suggests that somehow involuntary euthanasia—the “nasty” version of euthanasia because it does not have proper authorisation under the watchful eye of the doctor—can be prevented. Or, put more specifically in the UK context, we want to stop the Harold Shipmans of the world from committing acts of involuntary euthanasia. After all, Dame Janet Smith’s report found that Shipman’s first victim, Mrs Eva Lyons, had terminal cancer. Dame Janet holds that this act was an act of involuntary euthanasia.⁶ But would a euthanasia law prevent involuntary euthanasia?

We should acknowledge that the actions of Shipman were the actions of a man who already stood outside the boundaries of the law and outside the boundaries of acceptable professional behaviour. Shipman’s actions were criminal not professional actions. If any of his actions to kill were ever motivated out of compassion or care, then we have to ask ourselves a question that proponents of VAE/PAS simply dismiss. Does the act of taking a life change the one who does it? Conclusions are that at first Shipman did indeed practice involuntary euthanasia; but having a law supposedly set up to protect the vulnerable from involuntary euthanasia would not have stopped the likes of Shipman. It would be exceedingly difficult to make the claim that a law designed to control euthanasia would have led any sooner to Shipman’s capture, or the prevention of his actions. Thus, we can dispense with Shipman and the idea that a law would protect the vulnerable.

Rather, the law would actually exist, not to protect vulnerable patients, but rather to protect physicians from

prosecution for murder, which is why the cases in the US were presented to the courts in the first place. In the 1997 US Supreme Court case, the plaintiffs had already died in both instances, but the cases were carried forward by the physicians involved so as to get definitive guidance from the courts as to whether there is a constitutional right to have a physician assist the patient in death.

Thus, by ensconcing VAE/PAS in law in order to protect physicians, medicine will operationalise death, putting in systems of efficient control. First, as indicated in part one, the physician will manage procedural efficiency of the social apparatus because the physician—or a physician—will be the one to define the capacity and competency of a patient to make a decision about death. Second, the physician is the one with the expertise to act as the final instrumental/efficient cause of death. Thus, the physician ensures that the prime directive of efficiency is met. The efficiency paradigm will take over, placing patients on a conveyor belt toward their deaths, resulting in no hope for transcending death through meaningful interactions with family, friends, and even with the physician. Once the physician herself becomes the efficient instrument of death—a cog in the efficient system toward death—too much is lost for all patients.

Lest one object that this is hyperbolic rhetoric, I offer an actual process for comparison. Anyone who has cared for the dying knows of the practice of the Do Not Resuscitate (DNR) orders. Originally, these were instigated by patients' rights groups, who would keep physicians away from dying patients. Allowing someone to die was not part of the activity of physicians at the time. While the DNR is laudable, I want to describe what I have seen on the wards of American hospitals in the practice of getting DNR orders. Physicians are much more likely today to have a statistical idea of who might survive aggressive life support interventions and who might not. Thus, they are more likely to decide if they would or would not like to "code" a patient. In instances where the physician judges that a "code" would be futile and fruitless, they are likely to frame the "code" situation in a very negative light, so as to influence the patient's choice. A detailed description of a "code" situation, replete with phrases like "slam a tube down your throat", "break your ribs with the compressions", "stick a large catheter into your chest", is offered in the name of informed consent. The point of this overtly descriptive, even while accurate, charade to

inform the patient is to get the patient to come round to the doctor's opinion that she should have a DNR order in place.

I take this example as the exact issue with which we are dealing in VAE/PAS. Once VAE/PAS is ensconced in law, the pressures will begin even before the doctor enters the room. For, once the question of a person's life is framed by the option of legally ending it, it changes everything for all of us. Frames change the meaning of what is seen, and what question is asked; in short, the efficiency frame itself will become coercive, drawing one's eye to the focal point of death. Minow eloquently describes the subtle aspects of the lie that would suggest that VAE/PAS is controllable. This lie:

...depends on the very idea that some line would remain between abuse and non-abuse in a regime permitting assisted suicide. The lie is the denial that such a regime reaches beyond vulnerable patients to all patients, dying or not; to all family members, self serving or not; and to all physicians, those who endorse suicide assistance and those who do not. The option of medical assistance in dying would alter the menu for all involved. It would turn the continuation of living into a question, open for debate, doubt, and persuasion (Minow,¹ p 22).

In other words, a right to have a physician assist you in suicide makes staying alive a daily choice (Minow,¹ pp 22–3). The lie is that, if we change the law, we are not really changing anything but the timing of the death of one person. The lie is that if the law is changed nothing really changes in medical practice except the sanctioning of one well controlled, efficiently monitored, and effectively executed death. The option to assist in suicide will result in subtle changes that will exist subliminally, literally beneath a threshold of recognition of all concerned—patient, family, doctor—and not just those who might be engaged in dying, caring for a dying loved one, or carrying out the death inducing activity. Living itself becomes an open question because all has been radically reframed; and the issue of control will give the illusion that all is well.

This lie is far more sinister for it is a double lie. It tells us that the medical practitioners have control of the situation through their procedures, all the while duping us into thinking we have control. The lie that death is controllable

through legalising VAE/PAS tells us that it will be controlled through good practices. Yet, as with the DNR order, physicians will frame the situation for patients in such a way that it will appear to be the most rational option, even if not intending to do so; or families will, well intentioned or not. The worst part of this double lie is that the patient him/herself may frame it in such a way that his or her death is the most rational option, even if it may not be when looked at in terms of purpose or meaning. I fear that in the efficiency frame, there can be no hope of the healing that occurs in relationship. There can be no hope of attaining something that transcends the efficiency of the machine. Physicians armed with a new treatment category tend to utilise it, to legitimise it over and above the way the law legitimises it. In short, to have one more option is not just one more choice in the panoply of choices. Each choice conditions all the others, shifting the frame of what is clearly seen. Death will become the most rational of choices because, in the efficiency frame, death—the final effect of all causes and effects—becomes the focal point of the picture.

ANOTHER ANECDOTE

One morning on rounds a few years ago, the students and house staff physicians on my team entered a room with me. In the room was a woman in her mid-forties. She had widely metastatic breast cancer. We had failed in adequately controlling her pain and something needed to change. She was delirious, unable to communicate with us. She had the look of death, that distant staring off that I have seen often. She was thin, wasting away. Death was immanent. The look of the patient had a distinct effect on one of the students; when we walked out of the room he stated in no uncertain, though still compassionate, terms: "I could easily give her an injection of potassium chloride". I dealt with the comment privately with the student after I had given the house staff some direction on better management of her pain by starting a morphine drip, among a myriad of other suggestions. Everyone assumed that the morphine drip meant that the patient was dying immanently and that I intended her death. After her pain was controlled, she woke up; she was able to converse with us. She was also able to converse with her family.

I learned two things from this incident. First, I wondered if someone who would not agonise over a decision to end a patient's life was the right kind of person to perform the action of VAE. While this young person was a student still in training, I have to wonder

whether repeatedly acting to take the lives of patients will not anaesthetise practitioners to the gravity of their actions. Of course, the proponents of VAE/PAS will say that this is an empirical question. Do physicians become inured to the effects of taking patients' lives? The answer to this question would seek to make it more efficiently controllable, through counselling for the physician, furthering the efficiency paradigm by finding the most efficient way to maintain physician compassion after carrying out so many deaths. Of course, my question is a framing question and one which is not open to empirical investigation. Our frames prevent us from seeing so much, for the physician for whom VAE/PAS would be made easy through counselling may not be the kind of physician that we would want to carry out acts of VAE/PAS.

The second thing I learned from this incident had to do with intention. If I intended to take her life, I would have seen my action of treating her pain with a morphine drip as a failure, because she did not die. But I understood the action as one to help make her final days comfortable. If, with her consent or her family's consent, we had acted to give potassium chloride, then too much that is important would have been lost. A different kind of healing would have been precluded.

Now we can return to the question of the ambiguity of death. Death threatens all meaning, and yet it places the most important aspects of the meaning of our lives clearly in perspective. Our patient had not just one more week, but a whole lifetime of memories to revisit with friends and family, transcending her failing body. And when there are no friends and family the physician can become a companion along the way, the occasion for the patient to tell the story of her life. Dealing with death in a non-mechanistic, non-efficient way, that is to say, in offering oneself to the other who is dying, allows both patient and physician to experience death for what it is: an aporia—a gap in our knowing; a gap that defies our rational categories; a gap that opens us to the mystery of life

itself and that comes to shape the meaningfulness of life itself. Of course, one cannot efficiently make that happen for all patients: but that possibility is lost when the physician becomes the next cog in the wheel toward efficient death.

CONCLUSIONS

I began this essay with the story of an acquaintance caught in a terrible situation. He had no choice but to take his friend's life; or so it would seem. I cannot question him for I was not there. But were there other options? What if he had said to his comrade: "I am staying right here with you to keep the animals away, or until you die, or until we are both captured together"? I wonder if the technology, the efficiency of a weapon, hemmed him in to the choice of killing his friend. I wonder if a single new choice is not just an addition $n + 1$, but one that radically changes all other options and thus changes everything.

I have claimed in these two essays that the metaphysics of efficiency—a metaphysics that only looks at efficient causes and effects—frames our world in such a way that all actions are only assessed in terms of their effects. That means that when it comes to the human animal, death is just the final effect in a series of material causes and effects, and in so far as the physician acts to cause the death, she becomes part of the instrumental and mechanistic world of medicine. The physician in this way cannot become part of a different kind of healing, one in which meaning, purpose, and relationship transcend the immanent series of causes and effects.

The older distinction between killing and allowing to die no longer makes sense within a framework of efficiency. I am arguing that if the law changes and we allow VAE/PAS, we will essentially be playing into the mechanism of efficiency toward the final effect of death. Once death is placed more centrally within the efficiency frame, all choices will come to look different.

Thus, these two things taken together—the lack of human purpose in the medical mindset, and the reframing of every aspect of choice in death,

affecting all choices in life—result in making the choice of death easier, both for patient and physician. Moreover, given medicine's propensity to control and master living and dying, I am arguing that once death is ensconced within law, we will find ourselves actually limited in our choices. Those who would see death as a meaningful part of the human experience will be made morose by a society of sanitary efficiency. Those who might find life affirmation in their dying days through conversation, and yes even in their pain—as morose as it might sound to the efficiency minded—will not have the opportunity to transcend the mechanism. All that is left for the dying patient to do is to die in the metaphysics of efficiency, and this efficiency is the worst form of nihilism, for it claims not to be nihilistic. Death cannot be mastered through efficiency, but it can be transcended if we leave the frame open to death's ambiguity.

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Correspondence to: J P Bishop. Peninsula Medical School, Knowledge Spa, Royal Cornwall Hospital, Truro TR1 3HD, UK; jeffrey.bishop@pms.ac.uk

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REFERENCES

- 1 Minow M. Which question? Which Lie? Reflections on the physician assisted suicide cases. *Supreme Court Review* 1997:1–30.
- 2 Fourteenth Amendment to the US Constitution: section 1. <http://www.gpoaccess.gov/constitution/html/amdt14.html> (accessed 30 Jul 2005).
- 3 *Washington v Gluckberg*, 117 S Ct 2258 (1997).
- 4 *Vacco v Quill*, 117 S Ct 2293 (1997).
- 5 Burt R. Death is that man taking names: intersections of American medicine, law, and culture. San Francisco: University of California Press, 2002.
- 6 Smith Dame J. The Shipman inquiry: report 1: section 10. http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/27_01_05_shipman_firstreport.pdf (accessed 30 Jul 2005).