CLINICAL ETHICS

Boundaries, borders, and limits. A phenomenological reflection on ethics and euthanasia

C Leget

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The subject of euthanasia divides both people and nations. It will always continue to do so because the arguments for and against this issue are intrinsically related to each other. This paper offers an analysis of the interrelation of the arguments, departing from a phenomenology of boundaries. From the participant perspective the boundary of euthanasia appears as a limit. From a helicopter perspective it appears as a border. Reflecting on both perspectives they turn out to complement each other: the positive effects of the former correspond to the negative effects of the latter. In order to see how this interrelation of viewpoints works out in the case of euthanasia a paradigmatic case is analysed from the perspective of the patient, the doctor, and the family. This phenomenological analysis does not directly lead to normative conclusions. It helps by both paying attention to, and dealing with, the complexity of the issue with intellectual honesty.

The subject of euthanasia divides both people and nations. Its controversial nature gives rise to emotional discussions and sometimes even accusations. This contribution is not aimed at taking an ethical stance on the subject of euthanasia. Its main objective is to bring to light how the different arguments for and against euthanasia are interrelated. The ethical intention behind this enterprise is a desire to promote a good discussion by an invitation to introspection and reflection on the fact that both one's own arguments and those of one's opponent are intrinsically connected.

The method used here is a phenomenological analysis. The reflection is based on the way boundaries play a role in the perception of euthanasia, and boundaries always do play a role with respect to this issue. In most countries euthanasia is forbidden by law; in those rare countries in which under certain conditions physicians are allowed to perform euthanasia, the many regulations as regards to the procedure indicate that there is an awareness of the fact that moral boundaries are crossed.¹ Euthanasia will be defined here as direct and intentional killing at the patient's explicit and long term request (the Dutch definition). This definition implies that the focus in this article is not on passive, involuntary, or indirect forms of euthanasia.²

This paper begins with an introduction to the phenomenology of boundaries. Then a case will

be introduced that is analysed from the perspectives of three parties involved: the patient, the doctor, and the family. Some conclusions will be formulated at the end.

THE PHENOMENOLOGY OF BOUNDARIES

Two perspectives

The concepts of boundaries, borders, and limits are spatial concepts that can be applied to non-spatial issues by way of analogy. The spatial nature of these concepts is an indication that boundaries are a matter of perspective. Dependent on the perspective that is adopted boundaries may have different appearances. Two irreducible perspectives divide the way one becomes aware of boundaries into two categories.

The first perspective can be called the participant perspective. From this first perspective the boundary appears as a limit. Anyone who has experience of travelling abroad will experience the borderline between two countries as the limit of the country one is trying to leave. For those who have no passport or visa the boundary limits their plans and aspirations. Another example: when I touch a patient who suffers in order to express my empathy and offer some consolation I will experience my skin as the limit between the patient's pain and my own being.³ The skin is the boundary between myself and the world around me. With my hands I can try to touch the patient's suffering body from the outside, but I cannot take over her physical pain. In my analysis I will reserve the term "limit" for boundaries as they appear from the participant perspective.

There is, however, a second perspective. From a helicopter perspective, boundaries appear as a point of contact, connection, and touch. The same borderline that divides one country from another is a point of contact which makes them neighbours. The same skin that limits my ability to experience the pain of the patient can be a point of contact enabling me to touch the patient in order to offer consolation or relief. As points of contact, boundaries embody the chance for communication with what is beyond. They ask for exchange between what is inside and what is outside. In my analysis I will reserve the term "border" for boundaries as they appear from the helicopter perspective.

Positive and negative aspects

Both in their appearance as limit and as border, boundaries have positive and negative aspects with regard to human agency. These aspects,

Correspondence to:
Carlo Leget, PhD, Radboud
University Nijmegen
Medical Centre,
Department of Ethics,
Philosophy and History of
Medicine, 232 EFG, PO
Box 9101, NL - 6500 HB
Nijmegen, the
Netherlands; c.leget@efg.
umcn.nl

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Figure 1

however, have a different appearance, depending on the question as to whether one focuses on what is contained within the limits, or what is beyond them. If one focuses on what is within the limits, the positive effect of boundaries is that they promote and endorse concentration. In order to become a good oncologist I have to limit myself to studying and practising oncology. This concentration enables me to progress in a way that would not be possible if I devoted my time to many specialties at the same time. The price I pay for this, of course, is that the limitation may become a source of frustration. I may have the desire and ambition to express my contribution to medicine in many ways—for example, by not only being an oncologist, but also by being a part-time nurse and psychological counsellor—which I cannot do as long I stick to one specialty.

If one focuses on what is beyond the limits, boundaries may have the positive effect of offering protection from undesired entities that come from outside. Focusing on oncology helps me to deal with the distraction provided by the enormous stream of medical literature that is produced daily, or the temptation to run away from difficult situations by taking refuge in one of my other part time professions. The negative counterpoint of this, however, is that boundaries may increase limitation and isolation. I may become so absorbed in my work as an oncologist that I pay too little attention to important developments in other areas of medicine that are relevant to my specialty.

For this reason the helicopter perspective is an interesting and important perspective to adopt as well. From the helicopter perspective boundaries appear as a point of contact. Again, as points of contact, boundaries have positive and negative aspects for human agency that have a different appearance, depending on the question as to whether one focuses on what is within the boundaries or what is beyond.

Adopting the helicopter perspective, and considering the positive effect of boundaries as points of contact, one might say that they enable “expression”. The very same boundaries that frustrate the traveller without a valid passport are the point of contact with the world in which he wants to express his desire to widen his horizon. The very same boundaries that define my specialty as an oncologist can be a starting point for broadening my focus and horizon.

However, there is also a price to be paid for this expression. From the perspective of boundaries as points of contact a possible threat is that of losing both the effect of concentration and that of expression and ending up in “dilution”. The reason why countries maintain their borders is because they want to protect themselves against loss of identity and

coherency. Oncologists who aspire to master all adjacent specialties run the risk of superficiality and dilettantism.

Focusing on what is beyond the limits, one discovers the same logical coherence. If one considers borders as points of contact the effect of limitation is replaced by what can be called “inspiration”: what is beyond the boundaries may come in and have a positive enriching effect. Countries may receive many positive and stimulating influences when they let in people from other cultures. Oncology as a specialty may develop by integrating insights from other disciplines.

Again the price that is to be paid may be the loss of the protective function that was identified with the function of boundaries above. Countries that neglect their borders become vulnerable to all kinds of invasive influences. Specialties that do not define and mark off their identity become vulnerable to an “invasion” of misunderstanding and misuse.

A conclusion that can be drawn from this phenomenological analysis is that the positive qualities that are related to boundaries as limits correspond to the negative qualities of boundaries as borders and vice versa. Both the possible positive and negative effects of boundaries appear as two sides of the same coin. This can be illustrated with the following diagram, which will be used as a framework for the discussion of euthanasia (fig 1).

THE PROHIBITION OF EUTHANASIA

In by far most countries in the world euthanasia is considered to be a boundary for medicine. The way in which this boundary appears, however, differs according to the person who is involved in the situation in which a patient asks for euthanasia. I shall now introduce the case of a paradigmatic patient who has made a euthanasia request and investigate the perspective of the patient, the doctor, and the family.

The case of Mrs A

Mrs A, a 66 year old woman who has made a modest career as a broker, suffers from lung cancer in a terminal phase. She is cared for at home by her husband who is assisted by her two daughters and a district nurse. Mrs A is the kind of person who has always been in control of everything during her active life and even now she is sick, she manages to organise all arrangements that are necessary in her terminal situation. She has a good relationship with her husband and her two daughters and she is determined not to wait until she suffers from dyspnoea too much. Right after her disease was diagnosed she began to talk to her general practitioner (GP) about “helping her” when she became short of breath. The

physician did not think it was necessary to discuss the topic at that time, but now she increasingly brings up the subject in conversations. Her husband thinks it is important to carry out her wishes, but for him it would be too early to say at this stage of the process. One of her daughters has no problem with euthanasia being performed on her mother, the other does not know what to think of it. The family physician thinks euthanasia is never a good option because in his experience even the final hours of life may be full of unexpected meaningful experiences for all parties involved.

The patient's perspective

From the patient's perspective and focusing on what is within the limits, a positive aspect of the prohibition of euthanasia is what I called "concentration" above. Mrs A cannot escape from the situation of suffering by putting an end to life and is stimulated to focus on the physical, psychosocial, and spiritual aspects of pain relief that palliative care has to offer. The very same quality of the boundary that promotes this concentration on palliative care, however, can be a source of frustration for those who like Mrs A, for one reason or another, do not want to live any longer and see no way of escaping the situation they are in.

Remaining with the patient's perspective, but now focusing on what is beyond the limits of the prohibition of euthanasia, a positive aspect is that patients are protected from pressure by relatives and society. Patients are sure that whatever their financial, social, or medical situation is, they need not fear for any pressure being applied to bring their lives to an end. The other side of this coin, however, is that patients who do want to put an end to their misery may experience it as a serious limitation of their doctor's engagement when he cannot help them to relieve their suffering in the way they wish him to.

Looking at the case from the helicopter perspective, and focusing on what is seemingly frustrated by the prohibition of euthanasia, the appearance of the border as a point of contact in this case means that there is no longer frustration but expression. Mrs A can express and realise her wish to escape from the situation she is in and die in the manner that she thinks is the most suitable for her. The counter part of this, however, is that the effect of concentration is also lost. The stimulation to look for alternatives is missing and there is a risk of "dilution": euthanasia may become one of the many alternatives that are at hand at the end of life. In the long run one may fear the effect of a (logical) slippery slope.

Focusing on what is kept outside the boundaries, the positive thing about the boundary as point of contact would entail that there is no longer any limitation and the doctor can offer any help that is requested. The negative counter effect of this would be that the vulnerability of Mrs A increases as she is less protected against the "good intentions" of the physician.

The doctor's perspective

From the doctor's perspective, and focusing on the room that is left within the limitation of the prohibition of euthanasia, one meets the same double face of the boundary as limit. The positive outcome of the prohibition is again what I called "concentration": the GP is stimulated to explore alternative ways of relieving the suffering of Mrs A, making sure that any alternative option is tried. This stimulation, however, is obtained thanks to a limitation of possible options and can be experienced as a source of frustration when the patient asks for precisely the option that is ruled out by the prohibition, as in this case.

Focusing on what is beyond the limits, one can see that the doctor is protected from any pressure that may be brought to bear by patients, relatives or which cultural trends, may raise matters of conscience. At the same time, the doctor may

experience the prohibition as placing a limitation on the possible ways in which he can help the patient toward the solution he and the patient agree upon.

From the helicopter perspective, and focusing on what is inside the boundaries, when the doctor crosses the border of euthanasia he discovers that he now has an increase in the number of possible ways he can help the patient and no longer faces the frustration of not being able to express his good intentions. The negative effect is that the stimulation to look for alternatives is lost and the risk of a slippery slope is increased.

Focusing on what is outside the boundaries, as a positive effect the limitation of helping possibilities is no longer there, but the protection from the pressure from family, society, and patients may increase, which means that physicians become more vulnerable to "invasions" than before.

The family's perspective

From the family's perspective, and focusing on the room that is left within the limitation, the prohibition of euthanasia may have the effect of stimulating the reflection on their possible contribution to the wellbeing of the patient. The counter side of this is that family members may become frustrated when they see that Mrs A is suffering and that nothing can be done.

Focusing on what is beyond the limits, the prohibition of euthanasia protects the family from pressure from society or physicians to end the life of their beloved. It even protects the family from the initiatives of those patients that flee forwards in the sense that they do not want to wait until the phase of severe suffering is reached, and decide to have their life terminated, sometimes faster than family members—like Mrs A's husband and one of her daughters—can keep up with. Again these protective effects of the limit have a counter side. In those cases where patients, doctors, and families agree that it is better for the patients to have their lives ended by euthanasia, the family may feel the limitation of not being able to help and contribute to the self chosen death of a beloved one.

Adopting the helicopter perspective and focusing on what is inside the boundaries, again we find an increase in the ways the family can help and thus express their love in contributing to euthanasia within the context of a compassionate family. The frustration of seeing a loved one suffer knowing that something can be done is no longer there. Again, however, the loss of stimulation to look for alternatives increases the risk of a slippery slope effect in the long run.

Considered from the helicopter perspective and focusing on what is outside, we see a combination of no longer being limited to contribute to what is perceived as a good death on the one hand, and less protection against the wishes of doctors and patients on the other. Again, freedom, and vulnerability to invasions, go hand in hand.

FROM PHENOMENOLOGY TO ETHICS

How does this phenomenological analysis contribute to an ethical evaluation of euthanasia in general and in the case of Mrs A in particular? Before we can answer this question it might be good to examine what we have achieved by this phenomenological approach.

In the first place, it is interesting to see that by adopting this phenomenological approach the well known and much debated arguments for and against euthanasia appear as two sides of the same coin. It is easy to see that both series of arguments for and against euthanasia are important to take into consideration because they are logically interrelated. Whenever an argument for or against is put forward, one enters a network of logical connections that brings up other

arguments. The phenomenological analysis of boundaries helps to organise the complexity of the debate and may be a first step toward avoiding one sided and ideological conclusions.

In the second place, this analysis shows that boundaries operate in many different ways, depending on the perspective one adopts and the perspective of those involved. There is not one single perspective from which to reflect on euthanasia. Even the helicopter perspective is not a neutral point of view, but a perspective that has certain limitations that can only be overcome when one of the many participant perspectives is adopted.

In the third place, it is clear that from this overview one cannot directly infer moral conclusions. In order to do so one needs reflective guidelines that have a moral content. The phenomenological analysis offers no more than a map of arguments in their interrelatedness: it offers no normative criterion by which to weigh these arguments against each other. The use and importance of the phenomenological analysis lies in the fact that it is a helpful instrument that can help us neither to forget nor overlook the complexity of the issues involved. Once this complexity is taken into consideration there is a better chance that the normative evaluation of the issue at stake will meet the standards of intellectual honesty.

Some readers might argue that allowing the helicopter perspective to play a role might imply that the prohibition of euthanasia is no longer categorical: euthanasia would thus be considered as a boundary that is to be respected, but which can also be crossed in some cases. I do not think this is the case. The helicopter perspective is aimed at making sure that all possible options are taken into consideration. The

normative judgment as to whether euthanasia should be prohibited or not is dependent on one's normative guidelines and the situation of the persons involved. In order to make a moral judgment about the case of Mrs A one would need to know much more about the country she lives in, the prominent cultural values that guide her and her family, her medical condition, and the physical, psychosocial, and spiritual dimensions of her terminal condition.

The phenomenological approach to euthanasia as a boundary helps to pave the way toward a wise decision by mapping out the different interests and problems that are connected with each of the perspectives discussed. In different cultural contexts the phenomenological approach will bring into relief different interests and problems. Which interest is considered to be of overriding importance is a matter of choice based on culture and argumentation. This argumentation is likely to be balanced since it will take into consideration both the interests and the ambiguities that are inextricably bound up with one's own position and the interests of the other parties involved.

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REFERENCES

- 1 Schotsmans P, Meulenbergs T. *Euthanasia and palliative care in the Low Countries*. Leuven, Paris, Dudley, MA: Peeters, 2005.
- 2 Garrard E, Wilkinson S. Passive euthanasia. *J Med Ethics* 2005;31:64–8.
- 3 Lebrun J-P, Frogneux N, Gaziaux E, et al. *Habiter et vivre son corps*. Bruxelles: Lumen vitae, 2002.

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