SENIORS' PERSPECTIVES ON SUICIDE AND EUTHANASIA

From inability to let well enough alone; from too much zeal for the new and contempt for what is old; from putting knowledge before wisdom, science before art, and cleverness before common sense; from treating patients as cases; and from making the cureof the disease more grievous than the endurance of the same; GoodLord deliver us. Sir Robert Hutchison

Do not go gentle into that good night.
Old age should burn and rave at close of day;
Rage, rage against the dying of the light. Dylan Thomas

Life is an incurable disease. Abraham Cowley

The topic of suicide and euthanasia is put forward as a topic that senior citizens should address for the following reasons.

We all pass through various transitions during our lifespan. Some are eagerly awaited and represent no difficulty. Others can be quite traumatic. For most seniors, the next transition is usually the final one, in other words, death. How seniors, (or for that matter, anyone) deal with their mortality, is related to their stateof mind, and sense of well being, factors that assuredly affect theirhealth.

Our Judeo-Christian society has long been obsessed with death-avoidance. We have trouble facing death and justifiably fear the manner of our departure. This is manifest by how medicine is practiced, with its principal aim prolonging life and avoiding death, no matter the circumstances; by the nature of our religiousinstitutions that promise much about an afterlife; by our laws, which have long criminalized the taking of human life irrespectiveof the context, with the exception of "war"; and by our obvious phobias vis a vis death, based on ignorance, trepidation of the unknown and an inability to acknowledge death as a natural part ofthe human life cycle, to be accepted, not feared.

The proponents of biomedical high technology have taken advantage of our death phobia. They have discovered gold in those'hills of death.' A market place approach has been utilized to promote and sell life prolonging technologies, in many instances tothe detriment of patients and their families. These technologies encompass exotic means of diagnosis, as well as therapies such as wondrous surgery, drastic chemotherapy, and doubtful pharmaceuticals. Usually, one thing they have in common is that they are very costly. Another, is that often, they promise much anddeliver little. The effects of the therapy are often worse than theoriginal disease it was supposed to conquer. According to some palliative care professionals, cancer patients often endure very disagreeable deaths due to the side effects of the chemotherapy, such as liver, kidney, pulmonary and cardiac failure. Further, and somewhat ironically, it is well known that the use of drugs to control pain (e.g. morphine) frequently shortens life.

An inordinate number of mindless bodies using costly and much needed beds crowd chronic care facilities. (These resources could be used for a host of higher priority public health situations. The author has a friend in her late sixties, who had a brain

tumour removed a number of years ago. She is currently nearly totally paralyzed, partially blind and has no awareness of self, family, friends, or where she is. She lives in a vegetative state. She is being cared for at a chronic care hospital in Ottawa.)

We are an aging population. A significant proportion of us will have to face up to our demise and unfortunately for many, in horrific life-terminal circumstances. To cope with this, first and perhaps foremost we must learn to deal and live with 'natural death' as a normal, non-threatening phenomenon. We need to moveaway from the myth of 'perpetual youth.' Only then can will we beable to overcome our antipathy towards those who wish to end their lives as they choose. More and more of us are starting to appreciate that it is better to 'die with dignity' than to suffer theneedless pain, anguish, daily indignities and loss of decorum that frequently accompanies the oft well meaning desire to prolong life at all costs.

The options, real and potential, for those who wish to end their lives are, suicide, (rational and supposedly non-rational) medically-assisted suicide and, euthanasia, (active and passive). There has been much discussion and debate over the correctness of these both as a moral issue and as means of ending one's life. There are thosewho argue that the choice of suicide is a fundamental right - no matter whether it is rational or not. This is somewhat contentious. It is crucial that discussions about these issues be initiated, that they involve seniors and include questions such as: Are death anddying areas that require further study and research? Is there anormative stance that any group, seniors or others, should take toeither support or reject the positions of those who favor thevoluntary ending of one's life when conditions are of great duress? What can seniors contribute to the debate?

As it is our lot to die, the manner in which we proceed to that fate must be considered a critical component of the current debatearound the reform of medicare. It is time we collectively revisitedour assumptions, fears and hopes. Those closest to the ultimate outcome, seniors, must participate in the discussions and influencethe ultimate policy decisions.

Appendix

Some notions have to be clearly defined. The following comments and definitions are proposed.

a) While euthanasia originally meant a "quiet and easy death," it

has come to mean, "the action by an external party of inducing a gentle and easy death." Active euthanasia refers to a direct actionthat causes immediate death, e.g. the administration of a lethal dose of a drug. Passive euthanasia refers to the removal of life support systems or to the non-taking of medical action that leads to the natural eventual demise of the patient involved.

b) Voluntary euthanasia occurs when a conscious and mentally competent patient requests it. In other words, the informed consent of the patient is required.

c) Rational suicide occurs when a mentally competent person takeshis or her own life by his or her hand for what appears to be sound reasons.

d) Involuntary euthanasia occurs when prior consent has not been given and the patient is unconscious or mentally incompetent. In some cases, this type of euthanasia may occur against the patient's will and in others, without it. The latter case is usually referred to as non-voluntary. This type is usually passive and effected with the family's consent.

e) Assisted suicide occurs when the person committing suicide is provided with means to end his/her life by someone. When an M.D.provides these means, it is labelled 'Medically-Assisted Suicide.'

f) A living will is one in which an individual makes it known thathe or she does not wish to be resuscitated or kept alive by artificial means, should he or she become unconscious or comatose after a horrible accident, become the victim of a painful and incurable disease or lose most normal faculties due to old age. The apparent virtue of the living will is that the patient has made thedecision in a competent fashion when well and under no pressure from family and friends. Dying people are often not able to make rational decisions. On the other hand, since euthanasia once accomplished is not reversible, there can be no second thoughts. Further, under the guise of a living will, the potential for criminal homicide becomes greater. Finally, if more and more people opt foreuthanasia, research into the relief of chronic pain could lose its current support.

Jack Basuk
June, 1994
http://www.jackbasuk.com