Ethics, Medicine and Public Health (2015) 1, 220—229

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DOSSIER ''LONGEVITY''/PHILOSOPHICAL CONSIDERATIONS

Longevity reversed: Medicide, suicide and laicide after the Euthanasia Law of 2002

Longévité inversée : médicide, suicide et laïcide après la Loi sur l'euthanasie de 2002

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Received 3 February 2015; accepted 10 March 2015
Available online 18 May 2015

KEYWORDS
Longevity;
End of life;
Elderly;
Euthanasia

Summary In this contribution in the issue on ''longevity'' the focus shall be on developments in the area of end-of-life decisions in The Netherlands since the ''Euthanasia Law'' became effective on April 1, 2002. Dutch society has become a social laboratory on trends in death and dying after allowing a liberal policy (Youngner and Kimsma, 2012 [1]). Ever since 2002, there is a clear tendency to ''appropriate'' death. Individuals wish to choose the manner and time of their death, expressing a choice against personal longevity. In focusing on these different decisions at the end of life we propose a new descriptive model to distinguish the various current trends in dying. This empirical model to attain a good death, euthanasia, is captured in three distinctive terms: ''medicide, suicide and laicide''. In this contribution the effects of this liberal law shall be described on the relationship between the state, the courts, the medical profession, Euthanasia Review Committees, the public and pressure groups that aim to advance the ideal of a self determined death.

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http://dx.doi.org/10.1016/j.jemep.2015.04.008
2352-5525/

MOTS CLÉS
Longévité ;
Fin de vie ;
Vieillesse ;
Euthanasie

Résumé Cette contribution mettra l'accent sur les développements dans le domaine des décisions de fin de vie aux Pays-Bas depuis que la « loi euthanasie » est entrée en vigueur le 1er avril 2002. La société néerlandaise en adoptant une politique libérale est devenue un laboratoire social sur les tendances concernant la mort et les manières de mourir (Youngner et Kimsma, 2012). Depuis 2002, il y a une nette tendance à une mort « appropriée ». Les individus veulent choisir la manière et le moment de leur mort, exprimant un choix contre une longévité personnelle. En mettant l'accent sur ces différentes décisions en fin de vie, nous proposons un nouveau modèle descriptif permettant de distinguer les diverses tendances actuelles de la mort. Ce modèle empirique pour atteindre une bonne mort, l'euthanasie, est délimité en trois termes distincts : médicide, suicide et laïcide. Dans cette contribution, l'étude des effets de cette loi libérale portera sur la relation entre l'état, les tribunaux, la profession médicale, les comités d'examen de l'euthanasie, le public et les groupes de pression qui visent à faire progresser l'idéal d'une mort choisie.

Introduction

The term longevity is defined in several ways. From the more neutral ''life expectancy'' to actions to ''extent life'' and overcome its supposed brevity. Medicine for many years and still has been considered the instrument to attain the dream of a longer life and realize the ideal of a longer life expectancy. Medicine in the nineteenth century even was to realize the ideal of equality in a world abundant with social inequalities between people. For many years this institution seemed successful in realizing these goals. Antibiotics, resuscitation, maintaining artificial respiration and circulation and organ transplantation together with equal access realized the aim to postpone death and dying to a moment later in time. The question whether this development was in the end desirable medicalization or not, how important it may be, is here not discussed.

In the seventies of the previous century medicine's program to eliminate death came to be viewed, inspired by Illich, as hubris and alienation [2].

The institution of medicine had to come to terms with the dilemma to be able to continue biological life almost indefinitely, such as in patients in a persistent vegetative state (PVS), but at the same time realizing ''lives without quality''. Medicine struggled with a popular desire for interventions without limits, but only as long as they resulted in a meaningful life. Stopping medical care without further expectations for improvement or not starting interventions without realistic outcomes became the new medical morality and this approach was defined known as the category of non-treatment decisions: NTD's. These professional developments were enhanced by societal desires for patients' rights, to participate in this new morality [3]. One of its first expressions was a nationwide desire for open information when death could not be postponed and dying in dignity would be the only option left. This participation also resulted in public and professional debates on euthanasia and a right to have a choice to die. In the low countries, as opposed to Germany, the United Kingdom and the United States, this debate on euthanasia was unique: euthanasia in Dutch history has never been a significant issue for public debate until the early sixties and seventies [4].

From euthanasia to medicide

The ''old'' morality of euthanasia

In general, historical and systematic, the ideal of a good death, euthanasia, from the Greek word ''eu-thanatos'', was subdivided into three categories:

- active or passive;
- direct or indirect and;
- voluntary, involuntary and non-voluntary.

Common medical morality, officially shared by all medical societies in the Western world, agreed on a prohibition for all of these forms. Because they would lead to a shortening of life, in conflict with the ethical and religious principle of ''sanctity of life'', justifying medical protection at all cost [5]. A shortening of life, within the dominant Christian life-and-world view, was both a sin according to theology and a crime according to law [6]. With the exception of one form: only ''passive'' euthanasia was allowed, relating to two particular situations of medical interventions at the end of life. First of all the treatment of severe suffering, that as a ''potential but not intended side-effect'' would result in death, a group of interventions described by the terms: alleviating pain and suffering (APS). In the second place patients who could be kept alive, but whose quality of life however would be unacceptable and for whom the treatment was ''palliation'' until the moment of their death. The overriding conviction was that in these cases, life was not shortened but ran it's natural course. It generally came to be considered as ''normal medicine''. But, following the ''seminal'' arguments of Rachels, the line of reasoning accepted in this contribution is that there is no morally decisive difference between active and passive euthanasia [7].

He argues, for example, that allowing to die by withholding treatment, ethically acceptable, ''passive euthanasia'', usually means a longer period of agony and suffering as opposed to a lethal injection leading to a quick and painless death. In addition he argues against the common moral view that killing some one is morally worse than letting some one die. Especially because in withholding treatment the physician is not passive: he lets the patient die. That is an action. And even from a legal point of view on the ''cause of death'',