America and death: reflections on euthanasia

The contribution of Smith and associates in this issue, "A good death: is euthanasia the answer?," calls for more attention to research in palliative care, and argues against the assumption that active, direct, and voluntary (ADV) euthanasia is necessary. I agree with the authors' basic lines of argument against ADV euthanasia, and the following comments are intended to explain in part why the cultural pressure for ADV euthanasia is so powerful in America.

SUPPRESSION OF DEATH

The newly-awakened support for ADV euthanasia stems from significant changes in American health-care practices. The current calls for its legalization result from the alienation of dying people in America.

■ *See Smith et al, p.99*

Charles O. Jackson describes a prevalent attitude that represents a "major withdrawal on the part of the living from communion with and commitment to the dying."[1] He contrasts this to 17th- and 18th-century America, when dying persons were not hidden from society, but died at home surrounded by family and friends. By the 19th century, death and dying had become less acceptable, and society attempted to mute and beautify the harsh reality of death: "a dimension of the secular vision in America and elsewhere has been that death became a taboo topic."[1]

It is still taboo: today, although Herman Feifel, Elisabeth Kübler-Ross, and others have articulated the importance of providing the dying with a "tamed" death in the midst of supportive love at home or in hospice, most Americans are reluctant to approach the issues surrounding death. Workers in hospital intensive care units (ICUs) know well that people who die in the ICU feel depersonalized, surrounded by antiseptic white gowns and linens. Contact with family and friends is restricted to brief, timed visits. According to historian Philippe Aries, "although it is not always admitted, the hospital has offered families a place where they can hide the unseemly invalid whom neither the world nor they can endure."[2] He further observes that hospitals, in offering medical technology to the dying, obtained a monopoly on death: "By a swift and imperceptible transition, someone who was dying came to be treated like someone recovering from major surgery."

In hospitals, as well as in extended care facilities and nursing homes, the dying person's social contacts are diminished. When the family members visit, loss of emotional control frequently ensues. Under these conditions, solemnity and peace are difficult to sustain, the more so because the mystical interpretations of death that undergirded the *ars moriendi* of former times are not a part of today's hospital culture.

The demystification of death and the unfamiliar and depersonalizing nature of the hospital environment are not the only roots of our modern "homelessness" in dying: lack of direct experience with death also contributes to modern attitudes. Urban living inhibits us from witnessing the cycle of life and death in nature. Nuclear family structures have replaced extended family structures, so that the individual's sense of loss over the death of a loved one is intensified.[3] The average life span has been extended from three decades to seven, so that children generally do not witness deaths of siblings, parents, or friends; and when death does occur, the use of funeral specialists makes it unlikely that the family will ever deal with the corpse.

All of these factors combine to suppress our interaction with death; now some seek to suppress their own death process with the help of techniques such as lethal injection. In our culture, there is no social space for dying: the mechanization of dying creates a world in which technology reigns and personal rites of passage are lost. Under these conditions, ADV euthanasia becomes an attractive option.

CONTROL

Modern technological culture encourages the exercising of ever greater control over human events. American families often prefer that their loved ones die in the controlled environment of the medical intensive care unit, where the mechanical beeping signals and flashing lights imply a mastery over nature. To them, these machines seem to represent the best standard of care, and to shift away from them is seen as downgrading the quality of care. Frequently, families resent the offer to move a dying patient from the MICU to a special care unit that provides comfort only. They think that if they can not avail themselves of the latest technology, they are "missing out." It is difficult for them to accept that medical treatment can be futile.

To leave death in the hands of nature or God is anathema to those who are possessed by the desire to control nature. We see this in our pursuit of genetic engineering technology: with the advent of research to map the human genome, selective abortion of all but the cosmetically "ideal" child is an approaching possibility. Research is also under way to control the aging process with growth hormone or scavenger cells. Our culture seeks technological control from the womb to the tomb.

Before the advent of technological control over terminal states, the dying person's inner control over the ceremony of departure brought order to the dying process. Today, this inward control has largely given way to external mechanical control. Spiritual and moral agency has been displaced by a technological agency. In our modern culture, to die at home is to die out of control.

ADV euthanasia is a logical consequence of the desire to exercise technological control: it seeks to remove human events from the domain of nature. The only force contending against this form of control is the sense that the time of death is rightly decided only by nature, deity and destiny. Thus, many who oppose ADV euthanasia do not appeal to ethical arguments, but to theological ones which view us as merely stewards over our bodies, and therefore not holding ultimate control over them.

CARING

Acceptance of euthanasia also results from the devaluing of caring. Our medical system concentrates on stealing people back from immanent death at the expense of humane palliative care. Daniel Callahan has identified our health-care system's "bias toward acute-care, high-technology medicine, with its comfortable presumption that it *does* something for people in contrast to merely holding their hands."[4] Under this presumption, "merely" caring for patients appears as acting only "by default." Callahan passionately calls for the recovery of caring in society's attitude toward the dying: "At the center of caring should be a commitment never to avert its eyes from, or wash its hands of, someone who is in pain or suffering, who is disabled or incompetent, who is retarded or demented; that is the most fundamental demand made upon us."

One might contest Callahan's idea that life-saving health care should be rationed based on age alone,[5] but his efforts to bring care "as a positive emotional and supportive response" into symmetry with technological interventions deserve support. He is appropriately critical of our failure to train medical students to "care" in the seminal sense of the word, and he charges that, in however glowing terms "caring" may be discussed, "it always loses out to an emphasis on scientific knowledge and technical skills...." Technology has muscled aside the most basic expressions of care.

Apart from palliative care, the dying need compassion and enduring supportive emotional intimacy. Both to give and to receive care is a basic human need, but our culture values passion more highly than compassion, and the tasks of caring are readily viewed as demeaning to the caregiver. In addition, the patient's state of being partially or constantly dependent on others is viewed as an unreasonable imposition on those who support them. The lack of financial support for caregiving is a measure of the devaluation of caring in our culture. Against this backdrop, ADV euthanasia appears inviting; but, as Smith and associates suggest, euthanasia is a "technofix" for the inability to both cure and care.

SUFFERING

Another element leading to the call for euthanasia is that American culture seeks to avoid the reality of

suffering. Utilitarian philosophy speaks of the "greatest happiness of the greatest number": our commercial advertisements inculcate the notion that to be acceptable one should be zestfully happy. By contrast, Buddhism teaches that suffering is an inevitable part of existence. Dying is antithetical to our "tyranny of the normal," for it requires us to face the limits of happiness in the midst of eventual suffering. Euthanasia provides a way to dodge the reality that life is a sometimes onerous spiritual journey.

Will Initiative 119 of the State of Washington win the support of Americans? Will values of caring, support, and communication with the dying be lost in our culture, and acts of assisted or unassisted preemptive suicide and euthanasia become commonplace? Or will we look for better ways to control pain and give supportive care? Smith et al have articulated the value of giving care and support, and this is pure gain.

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