Dying for yourself

Introduction

Most people today want a quick, self-imperceptible death. Euthanasia and assisted suicide, characterized by the cultural dominance of self-determination in modern societies, seems to be proven tool - with the corresponding consequences for the medical profession, which is sometimes asked and even obliged to provide support that goes beyond dying care. But is self-determined death even a possibility? Or is it more of a catchphrase, through which the urge for control should also find its way into this highly sensitive area of life?

Cultures of death through the ages

Cultures of dying are shaped by different images of people and ideas about existence. In the Middle Ages, for example, the "Ars Moriendi" was considered the art of dying well: Based on the assumption that the final and irreversible struggle for one's own soul is carried out in the process of dying and that it is decided whether one will end up in hell, i.e. damnation, or expecting salvation in the form of redemption and heaven, the historical "Ars Moriendi" describes the central guide for the transition from life to death. This death culture was shaped by the great fear of sudden death. It was desirable to have time for the proces of dying. In this the dying person is actively accompanied in order to be able to find salvation for his soul. People of all classes were convinced of the need to go through the dying process in this form. This conviction lasted until modern times.

Since then, the image of ideal death has changed significantly. What was absolutely feared in the Middle Ages is now very desirable for many people: the sudden, ideally imperceptible occurrence of death. Because many people are living under the idea that the end of earthly life also means the end of their only life. As a result, in contrast to earlier epochs, are life threats and death one of the acutal taboo’s. However, the dream of a quick death, has just little to do with the reality of dying. Many of people are dying in hospitals or nursing homes after a long illness.

The creed of self-determined death

If dying comes into people's perception today, it is provided that modern medicine is able to significantly extend life. But this also increases the fear of long infirmity and agonizing death. Not least because of the therapeutic advances in medicine, many people fear foreign control, social isolation and loss of their dignity when they go through the dying process in hospitals or nursing homes. Ultimately, the suppression of dying and death from public perception runs parallel to an increase in individualization in society, which is also accompanied by social isolation. The high proportion of people dying in hospitals and nursing homes shows that the wish of most people to go through the inevitable dying process in a dignified and secure manner with their families does not correspond to reality. According to Terezie Styglerova from the Czech Statistical Office (CSU) are cardiovascular diseases of death and cancer the most frequent causes of death. (2) She told a press konference that the three most frequent causes of death are the same for men and women, but also that women die more often than men of Azheimer’s disease and other dementia and diabetes. (2)

The social changes and also changes in the life/death-situation of the individual are shaping the current discussions. Under the creed of self-determined death, individualized decision-making spaces are required. Euthanasia and assisted suicide seem to be tried as proven tools. The self-determined time of death, accompanied by the suppression of feared physical symptoms such as pain, shortness of breath or nausea, supposedly promises a "fear-free death". At least that is how it suggests the demand for assisted suicide by the medical profession. However, this requirement overlooks the fact that there is neither scientific competence nor medical experience on assisted suicide. It also ignores the fact that suicide is an act contrary to the biological nature of humans.

For decades the topic „euthanasia“ is being discussed with varying intensity and from new perspectives. This also flares up a recurring demand for legal regulations that should allow doctors to enable terminally ill patients to die.

In Czech Republic is euthanasia (like all other forms of killing) prohibited and classed as a murder. The first parliamentary attempt to legalise euthanasia in Czech Republic came in 2016. „The bill was proposed by a group of deputies from ANO and the Pirate Party including Věra Prochazkova (ANO) and Lukáš Bartoň (Piráti). The proposal was submitted by the Ministry of Justice and Chairwoman of the Legislative Council.“ (1) One of the big questions are if the assisted suicide should be covered by health insurance or privatly. „The Ministry of Social Affairs said that the proposed bill did not contain enough safeguards against human error or infringement of the law.“ (1)

One of the general ideas of the Basic law is that one person cannot be master or mistress of the life of another. Everyone should have the right to life and to not be deprived of their life, therefore it is legally forbidden in many countries. And killing on demand is also widely regarded as ethically and morally unacceptable.

Letting die – passive euthanasia

Another area of euthanasia is letting die. Life-extending measures such as artificial nutrition or ventilation are not used here. Letting die is exempt from punishment and even legally required if the patient has previously stated this in a living will, for example, or if the current situation has caused it to do so.

End-of-life care includes all therapies that help alleviate pain and suffering at the end of life. A doctor who provides pain relief for a patient accepts that treatment with strong painkillers will shorten the patient's life.

It can be seen that the boundaries of euthanasia can be blurred in certain situations. This means that doctors are very cautious in this regard and try not to take any measures that are ethically / morally, but above all legally unacceptable. Thereforethere is a long tradition of completely inadequate pain therapy for seriously ill patients and accordingly there has been a shortage of adequate palliative medical treatment for a very long time. It was only at the beginning or in the mid-1990s that a rethink began, from which, among other things, the hospice and palliative care law that has now been passed has grown.

Assisted suicide

In assisted suicide, a doctor prescribes deadly drugs for a patient. Alternatively, a relative or friend can obtain it and provide it to someone willing to die. Compared to letting die and caring for the dying, in assisted suicide there is a crucial difference: Suicide is suicide. The level of action therefore lies with the dying person ans is not discredited by law. Everyone can legally take their own life within the framework of the self-determination assigned to them. The earlier idea of the culpable "taking-yourself-out-of-life" hardly exists today. The evangelical tradition also respects the freedom that God has given to make individual decisions up to the point at which a person takes his own life.

But that does not change the fact that doctors and ultimately even all people have a duty of care at the moment when someone else wants to take their own life. Everyone should try and even be obliged to try to prevent this suicide.

For example in Germany is assisted suicide is legally permissible. Every person is given the opportunity to take their own life or to organize help for suicide. This freedom, but also the desire to regulate support in suicide, were expressed in the Bundestag debate on July 2, 2015, the first reading of four draft laws on euthanasia. (3)

Role of doctors

The role of the medical profession is in the focus of the current discussions about assisted suicide. In order to understand their self-image and their resulting situation, the medical treatment mandate and the relationship between the medical profession and death must be examined. This mission is based on a centuries-old tradition of turning to and healing people.

However, since the 19th century, medicine had achieved relatively little effectiveness due to a lack of possibilities. Only with technical and medical progress has it been possible to consistently fulfill the medical treatment mandate. This relates to maintaining a person's life, developing new technologies, extending life and dealing with new situations that were previously not treatable. The undoubtedly great and great successes of modern medicine with regard to the end of life means that there are certainly medical professionals who have difficulties with dying. It is not infrequently viewed as a personal defeat if a surgical procedure does not bring the desired success, if the drug therapy does not result in a cure but rather complications, or if despite all the technical efforts, no explanation for a serious illness can be found. The specialization harbors the risk that the patient will be out of his or her own To relocate a department because the curative expertise did not bring the desired success. On the other hand, patients ask themselves whether treatments are really necessary or whether they are motivated by the fact that doctors cannot accept that a life is coming to an end, or whether they act for economic reasons. Here grows also the desire for self-determination and control over one's own death. Control then replaces the lack of trust in the doctor and in his willingness to give the patient the support and accompaniment that are really important to him at the moment of death.

Medicine and dying

The Hippocratic tradition, which focused for a long time exclusively on healing and alleviating suffering, once defined that staying with the patient when treatment has no prospect of success is not part of the contractual relationship between doctor and patient . In a comparable way, Socrates has already defined from other contexts: "It is not part of medical practice to accompany the dying." Doctors used to turn away from the dying. This has only changed fundamentally in the current medical understanding. Until the 1990s was terminal care largely not a medical task. That was an issue for other professional groups such as pastors. Medicine has been trying to get closer to dying for around 20 years. The complexity of the matter lies in the fact that this is a long and difficult journey. Because when doctors, when in doubt, argue for life and the protection of life, every patient must also be able to rely on the fact that the person he confides in in a hospital would never think of himself as his Desire to kill or to assist him in suicide. Accordingly, this is clearly regulated in under professional and also criminal law.

In this respect, the medical profession is currently facing a fundamental change that is just slowly towards moving end-of-life care. It can certainly play a leading role in this: both terminally ill people, whose suffering can only be alleviated through death and those who want to end their lives for fear of old age and loneliness. The prerequisites for this are sufficient time, attention, space and a clear, understandable legal situation.

Act self-determined

Acting in a self-determined manner is an essential basic motivation today. Self-determination is in The American Heritage Dictionary (1992, p. 2059) defined as the determination of one's acts or states by oneself without external compulsion. „The noun "determination" has a number of meanings that influence how one understands this definition. To make a determination means to come to a decision or render a judgment. To act with determination means to be firm in one's resolve and resolute. One, thus, might conclude that self-determination means to make one's own decisions or to act resolutely." (5) The National Ethics Council already stated in 2006 that the right to self-determination of the person, but also as a downside the imposition of self-determination, shape the ethos of modern lifestyle. People can and must decide for themselves how they want to live. However, the individual remains dependent on the solidarity of the community. Nobody can live alone. The fact that self-determination requires support through solidarity, which in certain cases makes it possible in the first place, should also be undisputed in modern civil society. (6)

So that people receive the desired individual advice and support in the event of a serious illness and also in the face of approaching death, the early and clear expression of will is an elementary component of self-determined action. For doctors, the patient's will is the basis of every treatment and therefore also its limits. In practice, the determination of the presumed will of the patients often leads to uncertainties for example if their ability to make judgments is lacking due to illness. If there is insufficient clarification, doctors are well advised to argue for life. Then a decision is made in dubio pro vita. The National Ethics Council put it this way at the time.

In some countries exists a legal framework for living wills which, among other things, requires the person to be of legal age, sipulates the written form and specifies specific measures, but does not exclude any basic measures or actively seek euthanasia. Since, on the other hand, the living will can generally be revoked informally at any time, its mere existence does not always provide in the specific situation the desired clarity. It is therefore advisable to obtain prior medical information and legal advice. In addition, advance directives should be continuously updated.

Social responsibility

The cultural dominance of self-determination in modern societies should not hide the fact that dying is not a rational matter that can be controlled and directed at will. Societies that are strongly oriented towards economic goals therefore repeatedly reach their limits in practice with their attempts at explanations and approaches to solving this issue. The basic rational assumption that control should always be better than trust, is incorrect. This is not „just incorrect“ thesis, but it is especially not true related to the topic of dying.

A person dies in peace with him/herself (and with God) only if within the last few hours, he/she has been able to realize that there is a good reason to trust. Accordingly to this regard it is not surprising that many patients can once again have in the pre-terminal phase very positive experiences with appropriate care.

Social responsibility also includes a broad acceptance that spaces must be created for the worries, fears and needs of the dying people. These are on the one hand the physical rooms in hospitals and nursing homes, in which it is possible to say goodbye in a dignified environment. But on the other hand these are also the temporal freedom areas that must offer sufficient leeway for turning to people. The Hospice and Palliative Care Act is the first and very important step in creating these spaces. The goal must be to find a more natural way of dealing with dying (individually) and also with one's own death for society as a whole.

Conclusion

A new culture of the last stage of life does not need new laws, it needs time, care and a framework that will encourage this. The Hospice and Palliative Care Act provides this framework for accompanying the dying. It can be legitimate for relatives or even trusted strangers to help a seriously ill person in order to be able to leave life on their own. Medical action must never go beyond terminal care. A change in this situation would lead to a massive loss of trust between the patient and the medical profession and would further encourage existing fears. Self-determination in connection with one's own death is a fiction. People would like to die independently - but unfortunately that is often not the case. Therefore should the attempt to resolve this contradiction between the wish and the reality by imposing duties on the medical profession with regard to assisting suicide, be vigorously opposed.

The current legal framework in Czech Republic is absolutely sufficient. Changes are only necessary and helpful to a very limited extent. Other legislative changes would complicate the whole situation.

It is not the supposedly legally organized control which is needed, but a new culture of trust in the doctor-patient relationship should be the order of the day. To get there it is good that this topic is being discussed and that a path will be found for the future.

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