EUTHANASIA CONSIDERED AS DEVICE PARADIGM

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In this paper I take as my point of departure the way euthanasia has been legally settled in the Netherlands. My concern is not with the question whether euthanasia is morally or religiously acceptable. In my view, philosophy is not well equipped to answer this question. Of course, it can sort out arguments for and against euthanasia; it can analyze and assess them. But it cannot speak with any authority about the pros and cons of the subject itself. Most arguments, even if valid, fail to seem cogent to opponents. Therefore, I shall try to avoid the moral issue and focus my attention on the regulation of euthanasia, with a glance at the practice of Dutch physicians.

After introducing the Dutch case, I shall interpret this situation from the perspective of the so-called *device paradigm* of technology. According to this interpretation technology is the characteristic of contemporary life. Looking at euthanasia through the spectacles of the device paradigm accentuates two specific features: namely, the role of the expert and the place of pain in a technological context.

THE DUTCH CASE

Philippe Ariès, the historian of death, has many times emphasized that in *traditional societies* a deathbed is not the physician's department. At the deathbed, his part has been played out. It was his office to help people to avoid the evils of sickness, physical deficiencies, ailments of old age and a premature death. But there were moments when nothing could be done. In the end nobody could be saved from death. In *modern society* the physician's task has been enormously extended in the sense that our whole life has been brought under a medical regime. Medical examinations are the order of the day. It is impossible to avoid the physician when going to school, doing sports, having a job, taking out a life insurance policy, etc. Our health is controlled as a matter of routine. In our modern societies it is not only a question of medicalization of life, but also of death. That means that decisions at the end of the patient's life are increasingly

becoming one of the medical responsibilities. The result is that our death has become artificial. Today a natural death is likely an exception to the norm. Thus in normal cases the physician swings the scepter at our last bed by prompting the possibilities and impossibilities left to us. I have to be cautious; I speak about a trend. A hundred years ago in some municipalities in the Netherlands more than half of all deceased had no physician's assistance. That is now inconceivable. Whoever is unwell hurries up to make at least a short visit to the hospital in order to make use of the paraphernalia of modern medicine.

Many bitter deaths might be a product of modern medical science because postponement of death due to medical monitoring in a sense requires its toll. But, fortunately, the modern physician is not left with empty hands when confronted with the bitter pains of the last sickness. He has means to alleviate them at his disposal. This has become part of terminal care with which a physician is entrusted. In this sense one can say that dying has also been brought under the medical regime. Euthanasia is a separate chapter in the sense that in the view of the Dutch, terminal care is considered as medical practice, but euthanasia is not considered as medical practice. Let me explain this Dutch subtlety.

Euthanasia is defined as purposefully acting to terminate life, by a person other than the person concerned, upon request of the latter. To avoid any misunderstanding, the acting person intended here is the physician. This acting is to be distinguished from *physician-assisted suicide* which refers to prescription, supply, or administration of drugs with the explicit intention of shortening life at the patient's request. Euthanasia is also clearly to be distinguished from the following phenomena:

a) the non-treatment decision: the stopping or omitting of treatment when treatment is senseless according to medical judgment although treatment would probably have prolonged life;

b) an alleviation of pain and symptoms with opioids in such dosages that the patient's life might have been shortened; in this case shortening of life is an unintentional side effect;

c) the refusal of treatment of the person concerned, even when the non-

treatment has the consequence of his or her death;

d) the refusal of food by the patient (starving oneself).

The term euthanasia is appropriate only when the patient requests an intervention by means of a written advance directive.

It should be emphasized that euthanasia and help at suicide are prohibited in the Netherlands, although both are done upon request of the patient. They are an issue of the criminal code, and as such they are punishable acts. That is also the reason why euthanasia cannot be considered as a medical act. If it were a medical act it could not be a punishable act. A physician acting according to the standards of the medical profession does not offend the law. But to save euthanasia as a crime it cannot be considered as medical practice. But there is a way out: a physician who assists people in their dying (euthanasia and suicidal help) may appeal to circumstances beyond his control. The criminal offense has taken place, but it is not punished, because it has been a question of*emergency*. There was a conflict of obligations: on the one hand the obligation to protect life, and on the other the obligation to relieve a person from unbearable suffering.

The physician is obligated to report his case of euthanasia. Then the public prosecutor judges the state of emergency. The physician may go free, if he has carefully followed nine guidelines: (1) the patient's request is voluntary, and (2) well considered. (3) It is a matter of a longstanding desire to die. (4) Suffering is not acceptable for the patient. (5) The physician should have a consultation with a colleague. (6) Diagnosis, course of illness, and alternative therapies are to be explained to the patient. (7) Relatives should be informed unless the patient did not wish this. (8) A written report describing decision making, and (9) mentioning this to a coroner are also obligatory.

Preparing my paper I found a lot of discussion on end-of-life decisions in the newspapers. Three topics were favorite. In the first place much attention was paid to the evaluation of the behavior of physicians with regard to the guidelines. Most doctors do not report that they are involved with euthanasia. Only 40% of the cases of euthanasia have been reported. That means that the rest of the cases—60%—are not announced and the procedure remains untested. The reason is quite clear: doctors do not like to subject their medical conduct to the public

prosecutor. Not reporting means fewer formalities. It irritates a lot of them that what in their eyes is normal medical behavior is in fact a crime. One of the proposals, as a result of these investigations, is that doctors should report their cases to a committee of experts of the medical, judicial, and ethical professions. If the case does not comply with the guidelines, then it will be referred to the public prosecutor. In this way, this commission can hold the public prosecutor at a distance. A separate question is when the announcement should take place: before or after carrying out euthanasia. The crux of the whole affair is that this procedure around euthanasia is a political compromise between Dutch liberals and Social Democrats on the one hand and Christian Democrats on the other. In so far as this proposal amounts to decriminalizing euthanasia, it will not receive all-out support from the Christian Democrats, because it might have the tendency to undermine the original compromise.

In the second place, many emotions were evoked in the newspapers on the practice of end-of-life decisions in nursing homes when old people suffering from senile dementia refuse to eat and drink.

And last but not least, the third topic of attention was the book of the American psychiatrist, Hendin, on the practice of euthanasia in the Netherlands. He attributed much hypocrisy to the Dutch practice of euthanasia. It goes without saying that the Dutch like admiration but not critique. He reproaches the Dutch that they do not understand the difference between euthanasia and sedative treatment that might lead to death. To him sedative treatment is an alternative to euthanasia.

These three topics were discussed in many articles in all the newspapers. At least one might say that there is a Dutch willingness to discuss these matters, and it will probably contribute to a greater openness to and tolerance of euthanasia as a possibility. After this brief look at the Dutch case I shall introduce the perspective of the device paradigm.

THE SPECTACLES OF THE DEVICE PARADIGM

In his book, *Technology and the Character of Contemporary Life*, Albert Borgmann develops his theory of the device paradigm as a characteristic feature of modern technology. It stands for a specific pattern. In short, technology is a

matter of *devices* that procure *commodities*. The car, the coffee machine, the water tap, air-conditioning, electric lines, the refrigerator, etc.—all are examples of devices that procure commodities. The car yields speed, the coffee machine coffee, the water tap water, the air conditioner fresh air, the electric lines electricity, etc. These commodities are technologically *available* to us and are supposed to enrich our lives. They do so without imposing burdens on us. We ask for the ninth symphony of Beethoven and we put the compact disc on the CD player. We put the ignition key in our car and we have the speed we want. We turn the tap and we have clean water without delay. We dive into the refrigerator . . . and so on. It looks as if technology paves the way to the land of Cockaigne. This availability of goods is interpreted by Borgmann as the fulfillment of the promise of technology. Something is available if it has been rendered instantaneous, ubiquitous, safe and easy (p. 41). We have to take notice that this availability of commodities procured by devices belongs to the foreground of technology. This foreground has its condition in the concealment of the machinery of the devices. We use the computer as typewriter without any knowledge of the machinery of that device. It does not matter whether our watch is digital or mechanical with regard to the indication of time. We enjoy the disposal of all sorts of goods, but know nothing about the background of technology. This has far-reaching and breathtaking consequences for the labor process, the division of labor, the relation of labor and leisure, our relationship towards reality, etc. It is even more exciting to discover that this pattern of the device paradigm is to be recognized in all our societal and political processes. In this regard Borgmann's book is a stimulating eye-opener. The device paradigm stands for and teaches us a specific pattern how to deal with our problems. We want to get what we like in an easy, safe, and instantaneous way. Thus we embrace the medicalization of our life on the supposition and trust that it yields health.

What does it mean if one looks at euthanasia from a technological point of view? Looking at it with the spectacles of the device paradigm I shall only accentuate two aspects: the role of the expert, and the technological unburdening of dying—each a so-called "commodity" of the device paradigm. The formulation is rather paradoxical. Fulfilment of the wish to die is not a triumph as is most technological acting, but rather a failure, a defeat of life. But it has nevertheless all the characteristics of technological acting.

THE ROLE OF THE EXPERT

The doctor plays the role of the expert in this procedure. He considers the question. To put it quite straight: the patient should pass an exam and the expert is examiner. He scrutinizes whether the wish to die is voluntary, whether it is well considered, whether the wish has been longstanding, and not liable to emotions, etc. The physician examines whether the suffering is unacceptable to the patient. What at first sight seems to be a matter of self-determination turns out to be a matter of complete dependency. With regard to questions of death a strong re-evaluation of the physician's position has taken place. In former times absent at the deathbed, now prominently present. Research has demonstrated that well educated people have more chances to get their request granted than those who are less educated. Those who show much emotion will be confronted with a negative answer. And so on. The physician finds himself in the position of the expert because he has access to lethal drugs. This technologically privileged position maneuvers him at the same time into the role of moral examiner. It is society that attributes this role to the doctor in an ambivalent way. He is a technological expert but at the same time he has been prohibited to act medically. The inaccessibility of lethal drugs makes the whole procedure into a technological adventure in which the patient is incompetent. Being alienated from nature, the patient has no knowledge about the herbs and fruits in his own garden. Confronted with these final questions he has to throw himself into the arms of the experts. Tried and tested methods out of ancient times have been blotted out.

UNBURDENING OF DYING

The question on the deathbed is often relief of the burden of pain. It is technologically transformed into a mild death. The modern doctor declares war on the pain and he kills it in a technological and radical way. Neither the patient nor the doctor has any understanding of the meaning of pain as in former days. Both talk about pain completely along technological lines. We do not hold the opinion any longer that pain should be tolerated, alleviated, and interpreted. The medicalization of pain robs a culture of an integrative program of treatment of pain. Opium, acupuncture, or hypnosis were means of alleviating pain, but they were always put into practice in combination with language, rites, and myth (Illich, 1975).

Of course, there are people who want to raise the moral or religious

question with regard to euthanasia, and they declare themselves against it. Most people who are morally against euthanasia support sedative treatment. Their position shows how difficult it is to leave the technological society behind, because from a technological point of view (not moral), euthanasia is not very different from sedative treatment. A question of hours or days. It belongs to our technological society that we cannot deal with pain. One is not responsible for it. Here again one discovers that technology is not a means for a specific end, but a transformation of a problem.

Living in a technological society may be compared with climbing mountains. Whoever thinks that he has gone up too high should try to go down very carefully if at all possible. One can imagine that under some circumstances going down might be more difficult than going up. If he cannot tolerate it any longer, who dares to ask his neighbor to interpret the meaning of his pain? Has not our modern society left these questions behind itself?

Two years ago a friend of mine got a brain tumor. When his situation and prospect were clear to him, he made two appointments with his family and his doctor. In the first place he wanted euthanasia to be executed if he got into an irreversible coma with no prospect. In the second place he wanted no drugs to alleviate the pain, because he did not want to die as a rich man in the West. He interpreted his dying as a pilgrimage in which millions of people before him took part. I do not tell this story about this curious form of solidarity as an example or an appeal to us who like to climb mountains of technology but only as a testimony concerning a possibility partly outside the thin air of technology.

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