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Essay

Reflections on euthanasia in Colombia[☆]



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ABSTRACT

This reflection article provides an overview of the historical development of the term “euthanasia”. It is postulated that the distortion of the term “euthanasia” has hindered the debate around it, so it is imperative to establish the distinction between and other aspects of end of life. Issues associated with palliative care and euthanasia in Colombia are analysed, and some opinions and proposals are presented.

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Reflexiones acerca de la eutanasia en Colombia

RESUMEN

Este artículo de reflexión revisa el desarrollo histórico del término eutanasia. Se postula que desnaturalizarlo ha dificultado el debate y que debe diferenciarse de otros aspectos del final de la vida. Se hace un análisis de la problemática de los cuidados paliativos y la eutanasia en Colombia. Al respecto, se presentan algunas opiniones y propuestas.

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Introduction

There are issues that society needs to deal with if it is to be fair and inclusive. Just like we do not walk or run as we leave the uterus, collectivities did not jump spontaneously from *behaving savagely* to proclaiming Human Rights. Something similar is happening with the implementation of euthanasia: it rises slowly and strenuously, carrying in its bosom an inertial weight that pulls it down.

Despite varying ethical perspectives on euthanasia, there is a majority social consensus in favour of not criminalising it.¹ This is reflected not only in the media hubbub around the cases but also in the jurisprudence.²⁻⁴

Bearing in mind that it is already performed and will continue to be performed in medical practice⁵⁻⁸ – although not as rigorously as it should because of its legal status – reluctance to decriminalise it has been considered an act of hypocrisy.⁹ At the same time, the action being clandestine to avoid prosecution, creates unnecessary unfairness and suffering for patients and families alike.

One of the difficulties that plagues the debate is the semantic ambiguity that colours the history of the concept itself. This situation calls for clarity regarding the terms, including the distinction between euthanasia and assisted suicide.

On the other hand, Ministerial Resolution 1216/2015 recognises patient rights to palliative care (PC) before euthanasia, and determines that the procedure should be discontinued in the event of irregularities.¹⁰ However, given the current situation of PC in this country, this implies verifying the effectiveness of some inexistent reality.

From the secular, hermeneutic and critical perspective, this paper analyses the current situation of euthanasia in Colombia. There are significant gaps in terms of the care of terminally ill patients, which need to be approached simultaneously by society, the academia and the State in order to arrive at some proposals.

Historical development of the concept

The etymological meaning of euthanasia is “good death,” that is to say that it refers to an *ideal way of dying*. It is a socio-cultural concept that, just like cultures, is subject to transformation.

In Classical times, the notion of a good death meant several things and was not associated with a single practice.^{11,12} Contrary to various views at the time, Hippocrates – the father of the ethical paradigm that underpinned the deontologic codes of Western medicine up until the 20th Century – stated “...and I will abstention from giving a lethal drug to anyone, even if they ask for it.”¹³

The Middle Ages, imbued in Judeo-Christian religious beliefs, gave rise to important changes regarding the act of dying. As described by Philippe Ariès: “...in death, man experienced one of the uppermost laws of the species and did not seek to extol it or escape from it.”¹⁴ Euthanasia became sinful because the end of life could only come from God.

During the Enlightenment, David Hume countered this view: “If determining the time of death is entirely up to God and if man’s decision regarding the time of death were a

breach against the divine right, a man taking action to preserve life would be as criminal as he who decided to destroy it.”¹⁵

Francis Bacon before that time had reintroduced the term “euthanasia” in the philosophical debate and gave direction to the concept’s evolution. He proposed euthanasia as a means to free dying patients from suffering, the prerequisite being the patient’s wish. He also elevated it to the category of the physician’s moral duty: “I believe the role of the physician to be not only that of restoring health but also of mitigating pain and suffering, and not just when this mitigation may lead to recovery, but also when it can achieve a smooth, easy passage; because that “euthanasia” is no small blessing (. . .) But physicians, on the contrary, hold it almost as a law or religious duty to retain the patient even after declared terminally ill while, in my opinion, they should study the way and find the means to facilitate and alleviate the pain and agony of death.”¹⁶

Later, Jeremy Bentham proposed that it is for the good and happiness of the patient and the family to help the patient die with dignity.¹⁵

In 1848, John Warren published “Etherisation; With Surgical Remarks,” where he suggested that ether could be used to “mitigate the agony of death.” Twenty years later, Samuel D. Williams published his work “Euthanasia” in the *Popular Science Monthly* journal proposing the use of anaesthetics for that purpose, bringing up, for the first time, the question about the anaesthetists participation in the process.¹⁷

During the 20th and 21st centuries, secularism became stronger in several cultures. Together, the growing use of technology in medicine, an ageing population and the greater number of patients with degenerative and/or terminal diseases, create end-of-life situations previously unsuspected. As a result, discourses regarding concepts of dying with dignity are again coming under the limelight,¹⁸⁻²¹ some of them in favour of euthanasia.

It is not within the scope of this article to expound on all the interpretations and rationales for the multiple definitions and classifications of the term euthanasia, but for the sake of accuracy regarding the conceptual framework, the definition of the Borja Institute of Bioethics is proposed as the one that better represents its foundational origin: “Euthanasia is every action by a physician or any other healthcare professional under his supervision, who directly causes the death of a person suffering from a disease or injury which current medical knowledge cannot cure and which, due to its nature, causes unbearable agony and will result in death shortly. This action comes as a result of the patient’s freely reiterated request, and is performed with the intention of doing good, freeing the patient from that suffering, and respecting his or her will.”²²

Consequently, this action by a physician requires three essential elements: the patient’s expressed request, unbearable physical or psychological suffering, and terminal clinical condition. From this conceptual perspective, the term euthanasia should not be used in the context of patients in a persistent vegetative state, existential suffering or other situations outside the argument of finality. In those cases, the discussion required has to do with aided or assisted suicide.

Although certain similarities overlap both practices (the suffering that promotes them, the respect for autonomy on which they are based, and the empathy and/or compassion

that they elicit), differences between the two have important ethical, legal and social implications.

Contrary to legislations in other countries,^{23,24} the distinction should not be made relative to the executive assistance protocol, but rather in relation to the condition of the individual making the request. Specifically, euthanasia means helping a dying person to die at the person's request, by means of an easy, painless and peaceful passing. The dilemma is not between life and death, but rather *how the person wishes to die*. In the case of individuals who are not suffering from a terminal disease, the question is *whether their own lives are worth living*. They are not faced with impending death, but they wish to die.

A distinction between euthanasia and assisted suicide made on the basis of the individual performing the act is flawed because it disregards the principles of doing good and justice towards the person who suffers. Even if the final decision on the *how* is up to the petitioner, direct assistance should always be offered openly and feasibly, avoiding the potential mistakes resulting from the lack of assistance.

In contrast, a distinction between euthanasia and assisted suicide made on the basis of finality would not only facilitate agreement but has practical consequences. *Verbi gratia*: reserving the term euthanasia only for terminally ill patients would prevent insurers from evading their contractual obligations with regard to individuals who chose that form of death.

According to the view of the Borja Institute, adjectives that qualify euthanasia should be avoided because they create confusion and redundancy, as in *euthanasia is active, direct and voluntary*. Passive euthanasia is *not* euthanasia but rather limitation of therapeutic efforts; indirect euthanasia is *not* euthanasia, but rather a medical complication; non-willed euthanasia is *not* euthanasia, but rather intentional homicide; eugenics or the aim to control population are *not* euthanasia; and so on.

Can we refer to death with dignity in Colombia?

There are five relevant scenarios related to *death with dignity* and clinical end-of-life decision-making: palliative care, vital testaments, limitation of the therapeutic effort or redirecting therapy, palliative sedation, and euthanasia, the latter being the one that continues to create the greatest controversy in the world.²⁵

According to the Royal Academy of the Spanish Language, the word "dignity" means having the quality of "*deserving something*." UNESCO uses the idea of unalienable dignity as the foundation for human rights and duties. Given that it is considered the result of a value judgement, the meaning proposed by Pyrrho et al. becomes clear: "*a relational construct derived from the recognition of the other*."²⁶

Paradoxically, the notion of "human dignity" is wielded both to defend euthanasia as well as to condemn it^{21,27} but, in spite of that, this argument has a place in the discussion because it upends that of autonomy in two ways: moral responsibility towards the other, and the protection of the most vulnerable.²⁸

It cannot be denied that palliative care in Colombia is in a dire condition. According to the Quality of Life Score

prepared by the Intelligence Unit of The Economist, the score for Colombia is 26.7% on the world PC ranking, and the country is 68 among 80 participants.²⁹ Along those same lines, of the 120,000 cancer deaths that occurred in 2014, only in 20,000 cases was care provided by the 23 certified PC services.³⁰ The majority of these patients die in precarious circumstances, subject to unnecessary suffering, and without adequate support.

The pitiful condition of PC in the country is multifactorial but, above all, it is due to weak government healthcare policies.²⁹ Another side of the problem is the shortage of specialised human resources, not to mention the huge gap in humanistic training of the practitioners.³¹ There is also the need to tackle the economic, social and cultural challenges that families are faced with when it comes to taking part in the care of their loved ones. Barriers to dialogue (namely, the lack of education for decision-making and poor ownership of those decisions) are an important limitation.³²

Understanding the situation in Colombia is essential when considering the possibility of importing examples from other countries that took the leap of decriminalising and implementing euthanasia, because they may not apply to the Colombian context. Moreover, the available legalisation models vary significantly in terms of their conceptual and procedural perspectives.^{23,24} In other words, it is *important to frame the debate within the framework of our own reality*.

It is worrisome that precarious living conditions, social exclusion and the absence of an appropriate affective environment may bring terminally ill patients to the point where they wish to die.³³ Without adequate regulation and implementation, euthanasia could become the only means to which a suffering patient could resort in order to find relief, in view of the huge failings of the healthcare system and the negligence of the State. However, the opposite could happen, that is, that only those who are privileged because of their social, economic and educational condition end up receiving assistance.³⁴

Even in the face of these issues, proposing that the availability of good palliative care would eliminate the need for euthanasia is not right.^{35,36} Palliative sedation cannot provide relief to all patients,³⁷ as stated also by the Borja Bioethics Institute: "*There will always be situations and specific cases where demands for euthanasia will occur and they will require an answer within the framework of lawfulness*". Moreover, the scenarios are not antagonistic. On the contrary, the Belgian experience attests to the fact that palliative care and euthanasia may evolve reciprocally and synergistically.³⁸

The Colombian State has recognised that, society being secular, respect for the autonomy of the individual must be maintained during illness and death. Although life needs to be protected, people cannot be made to live in painful conditions, against their will and deepest convictions. As set forth in Ruling C-239/97: "*Nothing is more cruel than to force a person to survive in the midst of shameful suffering, in the name of other people's beliefs*."

From a strictly legal point of view, the right to live cannot be placed above the freedom of the individual in all cases.³⁹ On the other hand, guarantees must be established in favour of whoever has the right, and not against him or her.

Recently, the Ministry of Health published the protocol for implementing the procedure of euthanasia in Colombia.⁴⁰ It

begins with an adult patient suffering from a terminal disease who requests euthanasia. Then, the treating physician has to assess the requirements to consider the procedure by defining the conditions of finality, assessing suffering, ruling-out the existence of therapeutic alternatives, and confirming the persistence of the explicit request.

The next step is to assess the patient's ability to express that will and, if found to be competent, the case is submitted to an Interdisciplinary Scientific Committee (ISC) to confirm all the requirements. The members of the Committee must be independent from the treating physician and must not be related in any way, personal or professional, to the patient making the request. In the event of disagreement between the two assessments, the ISC must consult with another practitioner and re-examine the case.

Although the protocol is a first step, the following are some of its weaknesses and flaws: (a) it does not describe the participation of the administrative agencies or the responsibilities of the healthcare institutions; (b) it does not define how access to, and continuity of, the process will be ensured for the entire population; (c) it may be subject to "red tape"; (d) except for the pharmacological proposal of *exitus letalis*, it is very ambiguous when it comes to the characterisation of the other procedures and the human resources required (for example, the participation of the clinical psychologist or the psychiatrist appearing as interchangeable, allowing the possibility of replacing the ISC, etc.); (e) it mistakenly assumes that every treating physician is capable of assessing suffering; (f) it does not ensure continuity of the medical practitioners throughout the entire process.

Draft legislation 030/2015 was considered recently for regulating the practice of euthanasia and assisted suicide in Colombia.⁴¹ It proposed some valuable and other debatable matters such as the following: (a) *restricting euthanasia to the treating physicians* (implying that all physicians would be required to accredit training in this area, which is unrealistic and out of proportion); (b) *establishing an oversight system after the procedure* (which is useless because nothing may be corrected after the fact and, moreover, it delegitimises the ISC's assessment and elicits an atmosphere of legal mistrust against the participants); (c) *combining euthanasia and assisted suicide* (which is inadmissible due to the considerations described above).

Colombia has still a long way to go before the ideal of a death with dignity for all can be achieved. Hence the importance of continuing to foster the discussion in academic, legal and healthcare spheres.

On the role of the anaesthetists

Only seven days after the publication of Resolution 1216/2015, the Colombian Society of Anaesthesiology and Resuscitation addressed a letter to the Minister of Health stating its views.⁴² This reflects its great interest and is supported by a historical fact: Juan Marín Osorio, considered the father of the practice of anaesthesia in Colombia, conceded to having practiced euthanasia several times, even in the case of two of his relatives, for reasons of love and a feeling of solidarity with human

suffering.^{7,43} Unfortunately, not much has been written in this regard.

Some authors believe that anaesthetists are an important complement of the PC multidisciplinary team given their experience with critically ill patients and their knowledge of pain management and use of psychotropic and sedative agents.⁴⁴⁻⁴⁶ Although we recognise these strengths, there are two situations that oppose this consideration: first, the anaesthesia syllabus does not include an in-depth study of end-of-life considerations; second, the daily practice of anaesthesia focuses on the management of specific clinical cases in which there is little interaction and follow-up with patients and their families.

So far, everything that has been said regarding euthanasia starts with the assumption that the patient and his/her physician are able to have a true dialogue throughout. However, that is no easy task. To achieve this, guide decision-making and act impartially, practitioners require the right skills to establish a dialogue, the ability to reflect on, and construe the principles that determine moral judgement, and a feeling of profound respect for the patient's own free will.⁴⁷ Hence the importance of delving in greater depth into the areas of bioethics and other humanities courses during the training process. Considering how critical empathy and assertive communication are for the terminally ill patient, support should not be limited to one isolated phase of the process. Consequently, we propose that anaesthetists could take part in processes designed to ensure death with dignity, but only if these aspects previously described are reinforced as part of their training.

It would be of value to develop a survey that could shed light on the views of the Colombian anaesthetists regarding this issue.

Conclusion

Understanding euthanasia as a valid option in processes designed to ensure death with dignity recognises the moral plurality and autonomy of our patients. Although it should not be considered a substitute for palliative care, it is one more among the different end-of-life options.

However, Colombia is still far from being an appropriate setting and it is up to all to build it. The state, society and the academia must come together to solve the gaps in the care of terminally ill patients, bringing justice and quality to the health system.

Ethical disclosures

Protection of human and animal subjects. The authors declare that no experiments were performed on humans or animals for this study.

Confidentiality of data. The authors declare that no patient data appear in this article.

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