

The “Right to Die” through the Prism of Medical Philosophy

Sawadogo Joseph

Faculty of Medicine, Faculty of Human and Social Sciences, Department of Philosophy, Université Saint Thomas d’Aquin (USTA), Ouagadougou, Burkina Faso
Email: sibirijoseph@gmail.com

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Abstract

The prohibition on administering lethal medication to a patient can be found in the first code of medical deontology (450 BC), which calls on doctors to practice their art with purity and piety. Today, in some countries, doctors are faced with an ethical and deontological dilemma: patients or their relatives request deep and continuous sedation in the name of the “right to die”, believing their life to be inhuman and unworthy! The very concept of the “right to die” is a complex and delicate subject, undefined and un-framed by law. However, it is often discussed in the context of individual rights and medical ethics, often leaving the physician torn on one side by compassion and a sense of medical duty to alleviate a patient’s unnecessary suffering. The “right to die” is an ethical and legal concept that supports the freedom of a human being who is incurably ill or “tired of living” to end his or her life, or to obtain the necessary assistance to do so, by refusing treatment. Yet the universal Hippocratic law that underpins medical practice formally prohibits doctors from assisting suicide. This prohibition is based on the physician’s commitment to defending and preserving life until its natural end. The aim of this study was to see in what sense we can speak of a “right to die” in the philosophy of medicine, so that death can be experienced with humanity and dignity, even by means of deep and continuous sedation. The subject is all the more topical as this right is claimed in the name of human dignity and individual rights and freedoms.

Keywords

Right to Death, Hippocratic Law, Dysthanasia, Euthanasia, Palliative Care

1. A Move towards Claiming the “Right to Die”

After the genocidal atrocities of Nazism, which led to the very term euthanasia

being rejected, the word came back into use, thanks to medical advances in the use of analgesics and painkillers. The term has become less “repulsive” and has become established in stages (Derville, 2013). The first stage was that of “mercy killing”, out of compassion. This stage was marked by a series of judgments in which individuals who had generally killed disabled children, for example, were tried and then finally acquitted: around ten cases in Belgium, Italy and France; these were ordinary people who committed euthanasia for subjective reasons of “compassion”. Then comes the second stage, the introduction of new words and concepts, such as “dying with dignity”. The emphasis was no longer on altruism, but on “dignity”—a complex and subjective notion that can vary from one person to another and from one culture to another. In 1974, three Nobel Prize winners (Jacques Monod, Georges Thompson and Linus Pauling) signed a manifesto in favor of euthanasia. The manifesto states: “We believe in the dignity of the individual; the individual must be free to decide his or her own fate”.

And after dignity comes the third stage, that of the present day, with the notion of “individual rights and freedoms”: the citizen has the right to take his own life; to choose his death; this would be part of the exercise of his personal freedom. Any obstacle to individual will be-come insurmountable. Euthanasia is much more accepted today in the West because the way people view death has changed. In his highly acclaimed book of the time, “L’Histoire de la Mort en Occident, du Moyen-Age à nos jours” (The History of Death in the West, from the Middle Ages to the Present Day). (Ariès, 1977), the author explains this slow evolution. We started with integrated death, i.e. death taken care of socially, by integrating the work of mourning in society as it is still done today in Africa, for example (Ariès, 1977). The parent is not alone in coping with the death of a loved one: his or her family, both close and distant, surround him or her; neighbours come to sit around a good meal and together they defy this cruel death; they do the collective work of mourning. In Africa, joking kinship, a form of solidarity, goes a long way towards soothing and calming hearts stricken by the pain of separation.

Ariès speaks of “tamed death” for the period of the High Middle Ages (9th/mid-14th centuries); of “self-death” (14th-17th centuries) after the terrible pandemic of the Black Death; of “death of you” (18th-19th centuries); and finally, he identifies “inverted death” or occult death (20th century) (Rameix, 2004). These conceptions of death follow the religious and sociological criteria of each period in Western history. In the 21st century, we need to identify another concept of death, from a sociological and religious point of view (Doucet, 2004). It is emerging mainly through societal demands and the growing influence of countries that have taken the step of legalizing euthanasia. The Netherlands was the first country in the world to legalize euthanasia with the Act of 12 April 2001 on the Interruption of Life on Request and Assisted Suicide, a law laying down six conditions for the act performed by a doctor to be legal. Belgium has followed suit and has already practiced euthanasia legally for

two decades, even though the practice is strictly regulated by law. Only the patient can request euthanasia, and this must be done consciously, without pressure and repeatedly. In addition, the patient must be suffering from one or more incurable diseases, with unbearable suffering, whether psychological, mental or physical. Since 2014, this right to euthanasia has been extended to minors as well (Fonteyne, 2023).

In addition to the old terms and concepts relating to the end of life, new expressions have appeared that give a clearer picture of people's desires through opinion polls or televised debates (Derville, 2023). Terms such as "Right to die", "Death with dignity", "Right to assisted suicide", "Death with dignity", and "Dignified death" have appeared, although there is not always agreement on their true meaning (Castra, 2010). This evolution in the terms of the debate also shows the direction in which the protagonists of the 'right to die', i.e. general practitioners or palliative care specialists, terminally ill patients, patients' relatives, psychologists and political decision-makers must now take the debate. For years, the challenge of suffering has been vigorously tackled by palliative care, which alleviates many of patients' anxieties and sometimes their desire to end their lives. With the advent of palliative care and specialized training centers, euthanasia would never have a reason to exist. Palliative care provided by a well-trained team assists patients, their families and loved ones. Good palliative care can prevent and control physical, psychological, social, spiritual and existential suffering (Sicard, 2013). With advances in biomedicine, we now have the means to "die without excessive suffering", to die "with dignity", and to "freely" choose one's death, as proposed by certain "death clinics" (Sicard, 2013). These are philanthropic organizations offering their services to individuals who wish to end their lives in a legal and controlled manner. They operate within a strict legal framework and require individuals to be able to make an in-formed and voluntary decision about their own death.

2. The Formal Prohibition of Hippocratic Law

"No entreaty of any man will induce me to administer poison to any person; nor will I advise any man to do so."

The formal origin of this law, inherited from the physician-philosopher Hippocrates, is a contract of trust between the carer and the patient: "*Primum non nocere*". The doctor has an imperative duty, according to his art, to save, preserve and promote life! For opponents of any form of legalization, the right to die would imply a duty to kill for someone else, in this case the doctor or those under his orders. The traditional role of the doctor is to treat, relieve suffering and preserve life. Giving a lethal drug would contradict this role. Life is considered sacred and inviolable. Thus, giving a lethal drug would be a violation of this respect (Danet & Gautron, 2009). Doctors must avoid any confusion of roles by putting themselves in conflictual situations where patients themselves or their relatives may ask them to perform deontologically reprehensible acts (Fantino et

al., 2007). It is important to note that opinions on this subject may vary from one country to another, depending on the cultural, ethical and legal contexts. For example, some might argue in favor of euthanasia or physician-assisted suicide in certain circumstances, although these practices are controversial and illegal in many places. If a patient is in severe pain and explicitly requests a lethal drug (in jurisdictions where this is legal), the doctor's refusal could be seen as harmful, considering aspects of patient autonomy, quality of life and dignity at the end of life. The argument most commonly put forward in favor of infringing this Hippocratic law is precisely the desire to put an end to the suffering of an incurable patient. Even if pain is often well treated, particularly in appropriate palliative care services, there is still significant psychological or spiritual suffering that is not physiological pain. Illness can be perceived as an unacceptable deterioration by the patient, especially if it leads to alterations in the mental faculties on which Western moral values are based. The advance directives adopted by several legislations guarantee respect for individual freedom, with each person having the right to decide what they want to do with their body and their life; this would make it possible to control unofficial practices and avoid possible abuses in medical practice (Pelluchon, 2016).

3. The Right to Die as a Right to Reclaim One's Own Death

3.1. Africa's Contribution to this Sense of Life and Death

Marcel Anganga sums up a remarkable study on Africa's contribution to thanatological ideologies and currents of thought:

In Africa, the continent that is the mother of mankind and the source of our civilization, life and death have been linked for over 200,000 years BC. In-separable. Together, they constitute the two facets of human existence and, as a result, death is the consequence of life. Consequently, in Black African cosmogony, traces of which can be seen in Judaism and Christianity, the ideology of life takes precedence over that of thanatology, because life does not end with death. On the contrary, it exceeds it, transcends it and continues into the Beyond. So death is not the last word in life for the African. It is, remains and will remain a dotted sentence that will end in the village of the ancestors on the final return (Anganga, 2011).

What Africa can contribute in the anthropological approach to the mystery of life runs counter to the thanatological ideologies of the West, and could perhaps help us to discover a little more of the human in modern man (Bodo, 2018). An ideology of life restores the human to its rightful place in this kind of osmosis between life and death, as Anganga points out, echoing a statement by two of his elders:

Increasingly, for individuals and societies alike, death appears to be the key to history. Existentialist philosophy proclaims the triumph of death; glut-tonous material-ism precipitates individual societies towards death; literature, cinema and television have no lessons to teach humanity other than

the art of giving death. Yet the African cultural heritage, with its vision of the world and its conception of man, advocates just the opposite. In other words, the victory of life over death. Civilization in the Pharaonic world, as in traditional Africa, consisted of organizing and managing man in the cosmos, with a view to ensuring the victory of life over death. For us, the question is simple. We say that in the face of the ideologies of death, there is room for the ideologies of life, and that Africa has something to contribute to the research, organization and management of man and the cosmos today. Africa's contribution must be that of a civilization of the triumph of life over death (Anganga, 2011).

The link between life and death is an integral part of African cosmogony. In the African vision of the world, life and death are close to each other and carry every existence. They characterize it. As such, they are like two sides of the same hand. In Africa, life and death are inextricably linked, whereas in other cultures death is a source of confusion. It is hidden, including illness. We don't talk about it (Anganga, 2011). On the contrary, in Africa, when someone is ill, they 'sell' their illness, they talk about it to whoever will listen, to find an appropriate remedy for their ailment; when someone dies, we say that God has only taken back what he had entrusted to him (the breath of life); when an old person dies, we say 'he has gone home'; we don't say that I have 'lost' a loved one, because death has not altered their being or their life. The festive celebration of funerals is the sign that life triumphs over death; life is celebrated by making thanksgiving libations for the full life of the one who is passing to the other side of the shore; funeral songs praise the beauty of life and give advice to those who are still on pilgrimage to the land of the Ancestors for their conduct (Degorce, 2014; Durantel, 2014).

[...] For Africans, life is a gift. It is a gift and comes from somewhere. Man is not its initiator. He does not know all its secrets and it remains an enigma. The same is true of death, which is shrouded in the same mystery for the African. While many civilizations see death as an absurdity, a nonsense of human existence, and many people, at the thought of it, lose their footing, become depressed and sometimes accelerate it by committing suicide, the man of the Tropics, faced with the culture of death, thinks about life and seeks, in his own way, how to increase it if it ever diminished. So Africa [...] has more to contribute and more to say in this debate about the two existential termini of the human earthly journey: "life" as *terminus a quo* and "death" as *terminus ad quem* opening onto life. A new life. Another life (Anganga, 2011).

For the Mossi of Burkina Faso, the concept of death is influenced by their belief in God, who is omnipresent in their daily lives. For the Mossi, death represents only physical disappearance, the body disappearing from the sight of one's loved ones. While invisible, the spirit or soul continues to exist in a different world and in a different form. The Mossi believe that all objects possess a

soul, and so anything given to a deceased person on earth goes to join them in the land of souls. Funeral rites among the Mossi are very long and complex, and consist of numerous ceremonies and funeral vigils that facilitate the deceased's access to the status of ancestor. The Mossi make a distinction between the black dead, who have had a good death, and the red dead, who have had a bad death, i.e. by accident, following an injury, by being bitten, or far from the village. The rites performed in honor of the black dead are very long and complex, and include funeral ceremonies and vigils that facilitate the deceased's access to the status of ancestor. The Red Dead, on the other hand, are condemned to wander, trapped in an intermediate state between the worlds of the living and the dead (Pradelles De Latour, 1996).

In Africa, the duty is to live well in order to die well and be reborn to life with the Ancestors thanks to their protective spirits. The earthly life is then spent preparing for the journey to the other side of the river; hence the absolute need to live in accordance with traditions, habits and customs, with what is "born-found" (rog n mik), according to established norms, in order to deserve a funeral worthy of a wise man (Kouakou, 2005).

3.2. A New Perception of Death

In the West, we have gone from "tamed death" to "inverted, occult death" in the space of ten centuries; in the 21st century we absolutely must define a "reappropriated death" to use Suzanne's expression (Rameix, 2004). In this sense, we could conceive of the "right to die" as the "right to reappropriate one's death"; the right to die thus conceived would perhaps enable us to experience—the formula is not so paradoxical, since "dying and death" are an essential dimension of human existence—a new form of death. As we approach death, we can and must learn to live, not survive (Fourques, 2018)! The apparent conflict between the right to die and the prohibition in the Hippocratic law against aiding suicide has been resolved, as the protagonists at the end of life are in the same dynamic of bringing death to life as an inescapable passage, but one that opens up another perspective, another form of presence. The "right to life" must not be allowed to become a "right to quality of life" and, because of this imperative, we must not want to shorten a life that is not worth living. Nor should this "right to life" lead to an incurable patient's agony being prolonged unnecessarily.

I agree with Rameix that:

"The right to die—like any claim to a right—is part of the fight against exclusion, discrimination and abandonment. We could sum it up by saying that it is perhaps the right of every person at the end of life to be a dying person in the midst of the living. Every word in this definition carries meaning. "To 'be' a dying person is first and foremost to really be, to be able to feel that you exist, not to be crushed, annihilated, annihilated by pain, suffering and fear, by loneliness and rejection. Being "a dying person" means that the dying process is not prevented, that there is no therapeutic

obstinacy, that the person can even refuse treatment, that there is no lying, no pretense, that no one is allowed to make the dying person believe that he or she is not going to die. Being a dying person “in the midst of the living” means that the dying person is surrounded and accompanied by everyone: the carers, the family and civil society, which is represented by volunteers, to whom the law on access to palliative care recognizes a great and rightful place”.

Exclusion, discrimination and neglect.

These are the three plagues to avoid when managing the end of life. We don't have the time here to go into all the aspects of palliative care, whose positive impact on alleviating moral and psychological suffering is emphasized by caregivers and relatives of the terminally ill. This is why Rameix insists on the need to feel one's existence, to feel loved again, not to be annihilated by pain, suffering and fear, by loneliness and social rejection; what atrocious memories of the psychosis provoked by the Covid-19 pandemic and the hundreds of patients abandoned to their fate...

She insists on avoiding dysthanasia, the therapeutic relentlessness that needlessly prolongs the patient's agony; while telling him the truth about the inevitable outcome of the disease, helping him to give meaning to this departure, without depriving him when the organism can receive nourishment and rehydration (Carol, 2015).

Of course, there are exceptional and emblematic cases, such as that of the quadriplegic Vincent Lambert, which divided his family and necessitated the intervention of the State and the European Court of Human Rights. These are cases that should help us to think things through.

This is the best way to make death more “human”, according to what we have seen of African anthropology. Above all, it enables the legislator to avoid legally legitimizing “murder”, since “death” would be “premeditated murder”; whereas palliative care, defined as “active and continuous care practiced by an interdisciplinary team in an institution or at home, aims to relieve pain, alleviate psychological suffering, safeguard the dignity of the sick person and support those around them”. In France, for example, the law of June 9, 1999 established a right of access to palliative care for anyone whose condition so requires; it even made it compulsory to include a palliative care component in the multi-year contracts signed between healthcare establishments and the public authorities responsible for their supervision; and since 2016, it has made it compulsory to include palliative care in the initial and ongoing training of healthcare professionals. Doesn't this guarantee a “right to die” with dignity and in the best possible conditions? Clearly, this does not resolve all the questions that doctors will have to answer when faced with patients and their loved ones, and with the existential anguish that comes with the end of life. But if contemporary society itself had a different way of looking at death, as a “passage” to be lived through, it would be rare for patients to ask for euthanasia.

3.3. Conclusion

The aim of this study was to examine, from the point of view of the philosophy of medicine, whether we can speak of a “right to die”, understood as the legalization of euthanasia in the form of “assisted suicide”, or in the form of a “death clinic”, a self-service safe suicide. If the terms of the debate are clearly defined, this conception of the “right to die” is contrary to medical ethics and deontology. However, on the part of a terminally ill patient, the “right to die” can be seen as an SOS issued by a person distraught at the inevitable end of his or her life. Medical ethics allow patients’ existential anguish to be soothed by occasional sedation of varying depths. Well-conducted palliative care makes it possible to manage the other symptoms of suffering and preserve the patient’s dignity, in other words, to humanize the end of life; in this, the medical profession observes the principles of medical ethics: respecting the patient’s autonomy; caring for him or her with benevolence and never infringing on his or her life; and, in all justice, fraternally helping him or her to “let go” and live out their departure from this life. It’s a new perception of death that needs to be established, in a world that is becoming increasingly mechanicalized, medicalized and standardized, and in which fragility and vulnerability are less and less tolerated. It’s a call for a more compassionate medicine, respectful of the mystery of life, that anthropology and medicine can help us to understand (Mauro, 2008).

It is necessary to recognize the limitations of this study: the historical part marking the ideological evolution of euthanasia combined with changes in the social perception of death, could have been developed further. For many years now, we have been seeing sedations instituted in response to a representation of gentle, “idealized” or anesthetized death, or of controlled death: the dosage is deliberately increased beyond symptomatic needs. We also observe prescriptions whose purpose is the “comfort” of the team or the family (Pasche, 2019). These data call into question the moral and legal validity, and therefore the appropriateness, of unjustified sedations. Secondly, the study sought to remain at the philosophical level, taking into account the pluralism of conceptions of the meaning of life and death; One who does not believe in an afterlife, and who has no hope in another way of life, does not have the same existential anxieties as a believer.

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Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

References

- Anganga, M. (2011). Vie et mort en Afrique noire. *Théologiques*, 19, 87-106. <https://doi.org/10.7202/1014182ar>
- Ariès, P. (1977). *L'homme devant la mort (1977) en deux tomes: Le temps des guerres et La mort ensauvagée*. Points Seuil.
- Bodo, M. (2018). Learning to Be Human: The Part of African Culture. *Diogenes*, 263-264, 45-55. <https://doi.org/10.3917/dio.263.0045>
- Carol, A. (2015). A Medical History of Death Criteria. *Communications*, 97, 45-55. <https://doi.org/10.3406/comm.2015.2771>
- Castra, M. (2010). L'émergence d'une nouvelle conception du "bien mourir": Les soins palliatifs comme médicalisation et professionnalisation de la fin de vie. *International Journal of Palliative Care*, 25, 14-17. <https://doi.org/10.3917/inka.101.0014>
- Danet, J., & Gautron, V. (2009). Réflexions sur les fondements de l'incrimination d'usage de stupéfiants. *Archives de Politique Criminelle*, 31, 43-78. <https://doi.org/10.3917/apc.031.0043>
- Degorce, A. (2014). *Chants funéraires des Mossi (Burkina Faso)*. Khartala.
- Derville, G. (2013). *Le pouvoir des médias*. Presses Universitaires de Grenoble. <https://doi.org/10.3917/pug.dervi.2017.01>
- Derville, T. (2023). Derville T., Docteur, ai-je le droit de vivre encore un peu? L'euthanasie et le suicide assisté démasqués, Paris, Salvator, ISBN 978-2-7067-2342-1. *Nouvelle Revue Théologique*, 145, 670-672. <https://doi.org/10.3917/nrt.454.0670>
- Doucet, H. (2004). Le bien mourir et les traditions religieuses. *Gérontologie et société*, 27, 35-54. <https://doi.org/10.3917/gs.108.0035>
- Durantel, J. M. (2014). La danse du masque noir. Rites funéraires des Mossé du Kadiogo (Burkina Faso). *Systèmes de Pensée en Afrique Noire*, 13, 219-229. <http://journals.openedition.org/span/1430>
- Fantino, B., Wainsten, J., Bungener, M., Joublin, H., & Brun-Strang, C. (2007). Representations of the Role of Family and Friends Accompanying the Patient. *Santé Publique*, 19, 241-252. <https://doi.org/10.3917/spub.073.0241>
- Fonteyne, C. (2023). Étude de cas: Éthique narrative et accompagnement d'une demande parentale d'euthanasie dans le contexte belge. *Médecine Palliative*, 22, 206-212. <https://doi.org/10.1016/j.medpal.2023.04.004>
- Fourques, C. (2018). Rester vivant à l'aube de la mort. Clinique du quotidien en ehpad. *Clinique*, 15, 118-133. <https://doi.org/10.3917/clini.015.0118>
- Kouakou, K. (2005). Death in Africa: Between Tradition and Modernity. *Études sur la Mort*, No. 128, 145-149. <https://doi.org/10.3917/eslm.128.0145>
- Mauro, C. (2008). Les mots de la mort en soins palliatifs. *Partage d'expériences cliniques Études sur la mort*, 134, 51-58. <https://doi.org/10.3917/eslm.134.0051>
- Pasche, F. (2019). Fear of Death, Death Anxiety, Ego Defence. *Cliniques*, 17, 18-24. <https://doi.org/10.3917/clini.017.0018>
- Pelluchon, C. (2016). Comment délibérer sur la fin de vie et l'aide active à mourir? *Cités*, No. 66, 15-30. <https://www.cairn.info/revue-cites-2016-2-page-15.htm> <https://doi.org/10.3917/cite.066.0015>
- Pradelles De Latour, C.-H. (1996). Les morts et leurs rites en Afrique. *L'Homme*, 36, 137-142. <https://doi.org/10.3406/hom.1996.370080>

Rameix, S. (2004). Le droit de mourir. *Gérontologie et Société*, 27, 97-111.

<https://doi.org/10.3917/g.s.108.0097>

Sicard, D. (2013). *Medical ethics and bioethics*. Presses Universitaires de France.