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Difficulties experienced by the family in the challenges of euthanasia – hopes and illusions

Trudności doświadczane przez rodzinę w przypadku wyzwań związanych z eutanazją – nadzieje i złudzenia

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A – Koncepcja i projekt badania, B – Gromadzenie i/lub zestawianie danych, C – Analiza i interpretacja danych, D – Napisanie artykułu, E – Krytyczne zrecenzowanie artykułu, F – Zatwierdzenie ostatecznej wersji artykułu

Zajdal K.A. Difficulties experienced by the family in the challenges of euthanasia – hopes and illusions. Med. Og Nauk Zdr.

Streszczenie

Cel pracy. W obliczu zbliżającej się nieuchronnie śmierci, jak również w przypadku występowania charakterystycznych dla wieku podeszłego zmian wpływających na jakość codziennego życia człowiek w starszym wieku (niekiedy w pełni sił) zmuszony jest do uporania się z kryzysem rozwojowym. To być może skłania go do myślenia o eutanazji, o godnym odejściu, bez cierpienia, w otoczeniu rodziny. Czy rodzina sprosta tym oczekiwaniom, to już inna kwestia, ale także wyzwanie dla prawa. W tym kontekście istotne jest, w jaki sposób człowiek i jego rodzina uporają z tym wielkim wyzwaniem związanym z koniecznością pogodzenia się z kresem ziemskiej egzystencji i na ile potrafią poradzić sobie, by w dojrzały i etyczny sposób przekroczyć kryzys rozwojowy związany ze śmiercią. Celem mojej pracy było znalezienie odpowiedzi na pytanie, jak zachowamy się w sytuacji wyzwania związanego z własnym umieraniem, z odchodzeniem najbliższych. Nie jest łatwo myśleć o śmierci, kiedy jest się młodym i pełnym sił, a jeszcze trudniej, kiedy musimy o tym myśleć.

Materiał i metody. Materiał jest efektem badań przeprowadzonych na niewielkiej próbie 140 osób, posiadających rodzinę i dzieci. W badaniach użyto kwestionariusza ankiety, z deklaracji badanych wyciągano wnioski, bez korelacji.

Wyniki. Wyniki mogą budzić pewne zdziwienie. Inaczej myślimy o własnym odchodzeniu, a inaczej o odchodzeniu innych. Kwestią istotną są też ewentualne (hipotetyczne) decyzje w tym zakresie.

Wnioski. Wnioski są wielowątkowe: odnoszą się do nas jako osób, które być może będą odchodzić, jak i do naszych poglądów na odchodzenie najbliższych osób czy zwierząt domowych.

Słowa kluczowe

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Abstract

Objectives. In the face of inevitably approaching death as well as in the face of changes characteristic for old age which affect the quality of everyday life, older people (sometimes in their full strength) are forced to deal with the developmental crisis. This may lead to thinking about euthanasia, about a worthy departure, without suffering, in the family environment. Whether the family will meet these expectations is another issue, but also a challenge for the law. In this context, it is important how man and his family cope with this great challenge of reconciling themselves to the end of earthly existence and how much they can cope with in order to overcome the developmental crisis of death in a mature and ethical way. The aim of my work was to find an answer: how will we behave in the situation of the challenge of our own death, of the passing away of our loved ones.

Material and methods. The material was tested on a small sample of 140 individuals with family and children. They were examined with a questionnaire, conclusions were drawn from the declarations of the respondents, without correlation.

Results. The results may come as a surprise. We think differently about our own going away, and differently about the going away of others. The „possible" are also an important issue. (hypothetical) decisions in this respect.

Conclusions. The conclusions are multithreaded: they refer to us as people who may be leaving, as well as to our views on the leaving of the closest domestic animals.

Key words

old age, ways to help people in old age, euthanasia, the views of potential teachers

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INTRODUCTION

Social and care pedagogy in its research areas deals with people in need of care (among others, children, people with disabilities, seniors), as well as the carers themselves. An important challenge in this respect is also for andragogas, as those most frequently in need of support on many levels

are people in post-working age. On many occasions, the literature has undertaken a multifaceted analysis of human dignity issues, from the dignity of a child to the dignity of faith or death. In this light, the issue of care, to which is ascribed, *inter alia,* care pedagogy, should be supplemented by another dimension, i.e. the dignity of death. Every death should not lead to depression, but should be a stimulus to reflect on the sense of existence, perhaps to shape faith. Tales once wrote such words: „Death is no different from life. Can we consider such a statement to be true?

In this context I would like to refer to the notion of euthanasia, how is it defined? In Western publications we have two definitions of euthanasia:
1) also called merciful killing, the act of giving oneself up to a painless death that allows one to die without extreme medical means. Most often his is the decision to euthanize suffering people with incurable, particularly painful diseases or conditions. Euthanasia also affects animals.
2) Painless, mercy death [1].

There are two basic types of euthanasia:
– voluntary euthanasia is euthanasia carried out with the consent of those concerned. Since 2009, voluntary euthanasia has been legal in countries such as Belgium, Luxembourg, The Netherlands, Switzerland and the States of Oregon and Washington (USA).
– involuntary euthanasia – euthanasia is carried out without the patient's consent. The decision is made by another person because the patient is unable to do so alone.

There are two classifications of euthanasia:
– Passive euthanasia: functions when life-support procedures have been stopped. The definition of passive euthanasia is often ambiguous; for example, if a doctor prescribes an increase in doses of strong painkillers that may ultimately be toxic to the patient. It is arguable whether passive euthanasia occurs when doses of pain relieving medication are administered, whether the medication is passive or active because euthanasia has not yet occurred [2]

2ND CLASSIFICATION?

Jack Kevorkian was the person who contributed to the publicity for euthanasia and to the decision about his own. As you can read: 'He made the first machine to kill people for just 30 dollars. He drove it in his old Volkswagen all over the state of Michigan. The van, which also served as theathplace for his patients, was recently sold at auction. The authorities could not convict him for murder because he was not the one who pressed the button that triggered the mechanism to inject the poison into people's veins. He was sentenced in 1998 only for his own application of a deadly injection to a patient suffering from atrophic lateral sclerosis, which he showed to millions of Americans in one of the most popular TV programmes in the USA – '60 minutes'. The film was the basis for the fifth accusation of Kevorkian for murder. The doctor in the interview admitted that the authorities must now convict Korvakian or release him. It was supposed to be a way to legalize euthanasia in the USA, which is still perceived as an example of Kevorkian's heroism [3].

I was interested in another issue which is sometimes referred to in the media on the occasion of some high-profile issues, namely, euthanasia in Poland. Before I refer to this, I would like to raise the issue of the dignity of human life and the laws that defend it.

In the Constitution of the Republic of Poland, Chapter II, Article 30 states that: The natural and inalienable dignity of man is the source of freedom and rights of man and citizen. It is inviolable, and its respect and protection is a duty of public rights [4]. Thus, in Polish law, human dignity is inscribed in our lives and principles, and if there is such a provision, then ex legal regulations. Another document contains legal regulations that we adopted when we joined the EU. In the Charter of Fundamental Rights of the European Union, Chapter I, Article 1, 'human dignity is inviolable. It must be respected and protected' [5]. European law also thus defends human dignity, which it considers to be very important.

There is also a provision in another document, the Resolutions of 10 December 1948, the Universal Declaration of Human Rights chich contains postulates according to which one can fight for one's freedom and, above all, dignity. According to this Declaration: 'All people are born free and equal in dignity and rights. They are endowed with reason and conscience and must behave towards others in the spirit of fraternity' [5]. This declaration tells us to not only care for our dignity, but also to care for the dignity of others. These are only a part of the documents protecting the dignity of a person, patient or child, regardless of whether they have a family or live alone in an institution.

Social policy in its very broad scope, covering many spheres of the lives of citizens of individual societies, is based on several basic pillars. Its main components are social insurance and so-called family supplies. Diseases, reaching an older age and death are events which inevitability resulted in political decision-makers developing a stable system of social insurance benefits [6]. Activity should not be limited only to physical effort, because next to it 'the most important is mental and intellectual activity. If some elderly people, after retirement, become ill because they cannot fill their free time, it is connected not only with the feeling that a person has become unnecessary, but also with the lack of mental and physical activity' [7].

On the other hand, 'intellectual activity prevents the loss of self-respect, hopelessness and depression that so often accompanies old age. Physical ailments also decrease, probably because their symptoms, whose etiology is of a psychosomatic nature, disappear or are alleviated' [7].

From a religious point of view, as St. Thomas of Aquinas presents it, he does not call the soul immortal, but indestructible – after Aristotle he claims that man is a psychophysical unity, and the soul is a substance form of the body, i.e. it gives the shape of carnality [8].

One can therefore conclude that human activity consists mainly in satisfying biological, social and cultural needs and performing tasks resulting from participation in a specific social system, from relations and dependence on the surrounding world [9].

In T. Biernata's book we read that 'the answers obtained from young people allow us to state that the concept of euthanasia was known to most people (lack of answers and other answers – 10.8%). Euthanasia was supported by 52% of respondents, i.e. every second respondent (the place of residence did not differentiate between the acceptance of euthanasia). Opposition to euthanasia was expressed by 27.6% of respondents, and 9.4% of youth had not yet formed

an opinion on this issue. The support for this practice among youth is higher than in the adult population' [10]. This means that we have a significant percentage of statements of young people supporting euthanasia for the elderly and the sick. Why is this happening? Perhaps it is only a matter of declarations, because it is easy to declare something anonymously, but in a situation when we would have to make a decision about euthanasia in relation to ourselves or a family member, would such a decision be equally easy?

You think differently about your 'end of life' when you are 17 years old, you think differently about your „end of life" when you are 17 years old, you think differently about your health problems and say 67 years when you have no hope (?).

What do you offer the terminally ill? This could be palliative care. Palliative care is a field of medicine that deals with the treatment of symptoms and the satisfaction of medical needs of patients in the final stage of a disease, i.e. when it is not possible to extend the patient's life by directly influencing the cause of the disease, and the patient's condition requires medical care. [11]. In a word, palliative medicine is aimed at people who can no longer count on other medical assistance. It is the final form of assistance for patients. The subject of this care is the fight against pain and other symptoms, as well as psychological, social and spiritual problems. The aim of palliative care is to achieve the best possible quality of life for the patient and the family.

Another form of state care is the hospice. A hospice is defined as a 'programme or specialized care home for terminal patients, a care facility for terminally incurable patients in the final stages of terminal disease, which satisfies the mental, social and physical needs of dying patients and their families, or a place and at the same time a philosophy of care for suffering and/or dying people' [12]. Of course, the self-esteem of hospice patients is very bad, because the knowledge of approaching death or long-term dependence on others is conducive to depression and well-being. The majority of authors believe that a hospice is a so-called alternative for sick, handicapped and dying people, because each of these patients needs the help of specialists 24 hours a day (at least in theory). They are addicted to others, their lives depend on the help of people who devote themselves to this work.

There also exists another form of 24-hour care for chronically ill patients:

They are created in hospitals (apart from typical hospital wards, which provide acute care in acute cases), which provide inpatient services and 24-hour health care services. Its scope covers patients whose health condition does not allow them to be discharged home, and who require continuing treatment at the department for the chronically ill, care and rehabilitation. There are also people who have undergone an acute phase of hospital treatment in short-term care units and have completed the diagnosis process.

There are also persons after surgical treatment or intensive conservative treatment, persons requiring further hospitalization due to their health condition and the need for constant medical supervision and professional rehabilitation [13]. Persons staying in this centre receive appropriate assistance in their illnesses. As the name suggests, these are wards for people with chronic diseases.

Other forms of care for chronically ill people are also Care and Treatment Centres (ZOL) and Care and Care Centres (ZPO).

Euthanasia in selected EU countries. In The Netherlands, a parliamentary law adopted in October 2001 allows euthanasia at the repeated request of a suffering and terminally ill patient. In May 2002 in Belgium, a parliamentary law was adopted that allowed (since November 2002) the use of euthanasia at the three-time request of a patient at the terminal stage – this law is more restrictive than iTthe Netherlands. The United Kingdom is one of the countries where euthanasia is not recognised, but where the so-called'"no cumbersome treatment' is recognised: '*the United Kingdom is a country that recognises the right to withdraw from treatment, or at least not to continue with useless procedures'* [14]. In Denmark, Law No. 351 of 14 May 1992, amending the medical practice, and Law No. 482 of 1 July 1998, relating to the legal status of a patien, entitles a person of legal age and capable of legal acts to write a Will of Life. Danish law allows a preventive person to ask not to be kept alive in the event of a serious accident. In Sweden, the determination of this question depends to a large extent on judicial practice. Thus, Article 2, Chapter 23, Section 2 of the Penal Code provides for a reduction in the penalty if death is inflicted out of compassion. In any case, euthanasia is always punishable [14]. Spain is one of the countries where euthanasia is a criminal offence: A person who, upon explicit, certain and unequivocal request, causes or participates '*actively in acts leading to the death of a person suffering from a serious illness, which must necessarily end in death or cause great and permanent pain, shall be liable to imprisonment for a term of between six months and one year* [14]. This should not be surprising as Spain is a Catholic country where religion influences the law.

Of course, there is also the Hippocratic Oath, which formulates certain rules of conduct for doctors, and there is also such a phrase: '*I will use medical treatments according to my ability and ability to benefit the sick, defending them from harm. I will not give lethal poison to anyone, not even on demand, nor will I advise anyone, nor will I ever give a means to a woman for a miscarriage'* [15]. You can also rely on patient rights and the Criminal Code if the right to life is violated.

Attempted research. It was not my intention to carry out tests on a representative sample. I just wanted to know the opinions of a certain group of people, quite a small group, and this is more of a contribution to a broader study. The survey itself was conducted using the survey technique and a questionnaire as a tool. The questions had an open and closed. Before I conducted this survey, I discussed it with the students, and I heard a lot of emotional stories about the passing away of my loved ones, often in pain and suffering. Of course, this study is not representative, but can give an insight into this age group. I did not analyse or divide the respondents according to gender and age; however, all the respondents were parents with their own children. I compared the respondents only in terms of year of study (Bachelor and Master degree). The group consisted of 140 students from the oldest year of undergraduate pedagogical studies (3rd year of Bachelor's degree and 2nd year of Master's degree – potential teachers). There were groups of respondents from two universities, one from a provincial city (Zielona Góra), the other from a small city with 45,000 inhabitants (Brzeg Opolski). What is important, all the surveyed students were parents of children of different ages.

My initial question concerned the euthanasia of animals. As a child we usually have an animal at home, then as a parent

we sometimes give in and buy an animal. Dogs, cats and cats hale shorter than humans; we therefore have to face the fact that they sooner or later they will die. What, then, is our relationship to the dying of animals?

Table 1. Students' attitude to euthanasia of domestic animals, percentages

	Bachelor degree N=80		Master›s degree N=60	
I once had an animal (e.g. a cat, a dog, a parrot) in a house that is no longer there (?)	Yes	No	Yes	No
	90	10	92	8
When an animal is seriously ill, I am in favour of putting it out of its misery, putting it to sleep.	Statements only of the group of respondents who had an animal in their home.			
	I definitely agree – 90 I agree – 5 I don›t have a 5th sentence I don›t agree – 0 I definitely do not agree – 0		I definitely agree – 80 I agree – 10 I don›t have a tenth sentence. I don›t agree – 0 I definitely do not agree – 0	

Are the statements of the respondents surprising? Probably not, because an animal, often treated as a family member, does not always have a 'worthy' departure. When an animal becomes sick and suffers, we often have to clean up after it. Then, although it is often a difficult decision, we agree to have the animal put to sleep. What is more, we agree that the vet will 'recycle' the animal, we rarely take care of its body, its burial. His also what happens with domestic animals, as well as with household pets. One does not cry over a dead cow, pig or chicken, unless it is a material loss.

Is it the same with people? My initial questions concerned grandparents, parents – that is, adults.

Table 2. Hypothetical decision-making about the fate of relatives (adults) in the face of incurable disease, percentage data

	Bachelor degree N=80	Master›s degree N=60
In a crisis situation when a binding decision has to be made: would I continue with further treatment and sustain the life of the family member, or I would give such a decision to the competence of the doctors?	77	81
I would like to make such a decision on my own	15	8
I have no opinion on that	8	11

This is a hypothetical situation in which we do not have to make a specific decision, we have an alternative. A sick person, a chronically ill person, who is on the verge of life and death, depends on the doctors and the actions taken. Both groups of respondents, to a large Entent, thereforeleave the responsibility to make such a decision in the hands of doctors. Does this mean that to a small degree, in the opinions of respondents (15 and 8 percent), they consent to euthanasia? This answer is not unambiguous, because it refers only to the decision about further treatment. In the spontaneous exchange of opinions after the study there were expressions such as: after all, a miracle can always happen, the doctors may be wrong, my loved one may not want, e.g. painful treatment, so I would like to be able to make such a decision on his behalf. For the most part, the few voices allowing for the disconnection of, e.g. life support equipment or interruption of treatment, are somehow the decision of the patients themselves who communicate this to their relatives, counting on their intervention.

If I have a sick person in my family, e.g. parents, grandparents, then I 'trust to God' their fate, I will not make any 'unethical' decision, I will wait for the development of events and for the 'will of God'.

The fifth part of the surveyed potential teachers (Bachelor›s degree) concerned the wish to decide about the fate of their loved ones. Therefore, what is the situation when an adult family member asks for the treatment not to be stopped, but for death, shortening the suffering? The answers to this question are presented in the table below.

Table 3. Decision-making in the case of a request for death from a family member (older person), percentage data

	Bachelor degree N=80	Master›s degree N=60
I would definitely agree to such a request	0	0
I would agree to it after consideration or consultation with the family	8	5
I have no opinion on that	10	5
I would not agree to such a request	5	5
I would definitely disagree with such a request.	77	85

These figures tell us a great deal about ourselves, about our decisions, if we would have to make them ourselves. The students did not want to give such an answer, they asked about the hypothetical condition of the patient, whether it was a distant or close family member. Only 8% of those surveyed recognised the right to euthanasia, but only after consultation with their familie, and only in special cases. In the case of the Master›s degree students, this ratio was also low at 5%. Generally, there was a very high resistance against making such a decision, especially in the personal situation of, e.g. a mother or father, and I am not sure whether such an indication at this point in the declaration process would be transferred to an actual decision.

The next question I asked concerned small patients, i.e. children who stay in a hospice. The first question concerned children in general, the second – their own children. I presented a hypothetical situation when, in the opinion of doctors, the child›s condition is incurable, strong analgesics are administered, the issue of leaving (death) is a few days or more.

Table 4. Decision to accept euthanasia of an incurably ill child, if such a decision depended on the respondent and was legally admissible, percentage data

	Bachelor degree N=80		Master›s degree N=60	
	Someone else›s child	My child	Someone else›s child	My child
Consent to euthanasia	3	0	5	0
I have no opinion on that	20	0	5	0
No consent for euthanasia	77	100	90	100

The respondents› declarations differed slightly in terms of choice in relation to their own or someone else›s child. Own children are more ‘protected’ and we do not allow the thought of euthanasia. In general, with regard to children, the respondents were more cautious about making any decisions than they concerned older people. No on in any of the examined groups agreed to the euthanasia of their own child, which probably should not surprise us. Few voices in favour of euthanasia of another child may be a statistical error, although in the conversation after the examination it was sometimes voiced that it is ‘better’ to shorten the ordeal, just like the beloved pet, so that it does not get tired, because the child ‘hurts more’ than the elderly.

My last question before last was: ‘What are the reasons for not agreeing to euthanasia, where to look for them?’ Only those who were strongly opposed to euthanasia responded.

Table 5. Reasons for disagreement with euthanasia, percentage data.

	Bachelor degree N=80	Master›s degree N=60
Religious motives	95	90
Ethical motives	90	95
Fear of remorse	95	90
Lack of consent for such behaviour on the part of relatives who reserved for themselves such a ‘departure’ during their lifetime	90	85
Other recitals	5	0

The data do not add up to 100, because respondents could choose more than one answer.

The results of the answer to this question should not be surprising if we look at the statistics of people in Poland who admit to their faith. According to the latest census in Poland, only 929 000 people do not admit to having professed a literal faith, and more than 34 million Poles are believers. It can also be seen that many relatives have directly reserved for themselves, while they are still alive, the lack of help in dying. Most likely, they were motivated by religious considerations, although this would require separate research. Ethical issues and remorse also strongly determine the lack of consent for help in leaving.

The last question I asked concerned a specific issue, namely, whether the respondents themselves would like to be comfortable enough to be able to decide their fate at a time of incurable illness or painful symptoms of illness, to say the obvious: would they be in favour of euthanasia?

Table 6. Decisions of the respondents regarding self-euthanasia in case of suffering or incurable disease, percentage data

I would like to be able to make a decision about euthanasia if I were very sick, dying and suffering.	Bachelor degree students N=80	Master›s degree students N=60
Yes	80	85
No	10	10
I don›t have an opinion.	10	5

There is a certain contradiction between the previous declarations and the reference to oneself. When we hypothetically refer to close adults, such as parents, grandparents or children, we are very restrained when it comes to decisions abort euthanasia. In his, we are held back mainly by religious or ethical motives. With regard to ourselves, we are no longer so determined. We can also clearly see the difference between the generations. In both groups, almost 90% of family members (parents, grandparents) reserved the right to refuse euthanasia during their lifetime. If we look at the declarations of the students, their attitude to euthanasia is very different from that of the older generation. What is the reason for this different opinion? Perhaps the possibility of deciding about oneself, awareness, talking about it in the media, fear of pain and suffering? In the decisions of these young people there is no fear of sin or violation of God›s will, which had reference in the decisions in relation to other people, but not to oneself.

SUMMARY

Of course, in such a short article I did not raise all the issues related to euthanasia, but only indicated that it is a big problem that will recurr in discussions and attempts to legalise euthanasia – as well as the defence of life. Polish society is divided on this issue, as can be seen from research and his survey among students of pedagogical studiem who are perhaps potential teachers. In general, they were ‘open’ to help in reducing suffering, but not to helping their loved ones should they have to make such a decision. Some students stated: ‘If you asked about euthanasia for animals, it would be simpler.’ Probably so, because we ‘shorten’ the suffering of pets and eat the meat of slaughtered animals, although we do not participate in this act ourselves; nevertheless, we allow it.

It would be best if ‘such a procedure’ was performed by the patient himself, without asking our opinion – somewhere in silence or loneliness. Then ‘we’ would no longer have anything to say, it would hapten and perhaps we would feel relieved. A friend who had been working for over a year with his sister, a seriously ill mother with Alzheimer‘s who needed constant help, chich meant they were on duty every other day, told me that if there was an opportunity and the mother asked for euthanasia, he would have agreed to it. But he said this at a time of great fatigue, when his private life was not working as it should have. His is a different declaration with a different physical consent.

And if it concerned us specifically, would we take our own lives? How can we answer this question? When you are 23-years- old how can you answer it when diseases are terminal and there is no hope? We look at old age and a certain end of life differently when it concerns our child suffering from unimaginable pain.

CONCLUSION

In the face of inevitably approaching Heath, as well as the changes characteristic of old age affecting the quality of everyday life, the elderly are forced to deal with a developing crisis. As A. Brzezińska and S. S. Hejanowski wrote:

While integrity can be defined as the tendency of the mind to experience order, harmony and meaning in relation to the whole surrounding world, people and its own life, both past and present, despair is connected with the inability to come to terms with the fact that on this one already experienced

life, the whole existence ends. (Brzezińska, Hejmanowski 2005, p. 630).

Perhaps this makes one think about euthanasia, about a 'worthy' departure, without suffering, surrounded by the family. Whether the family will meet these expectations is another matter, but it is also a challenge for the law. In this context, it is important how a person and the family deal with this great challenge related to the necessity to come to terms with the end of earthly existence, and how much they can cope with in order to overcome the developmental crisis related to death in a mature and ethical way. Certainly faith will be a great support, maybe even a rock.