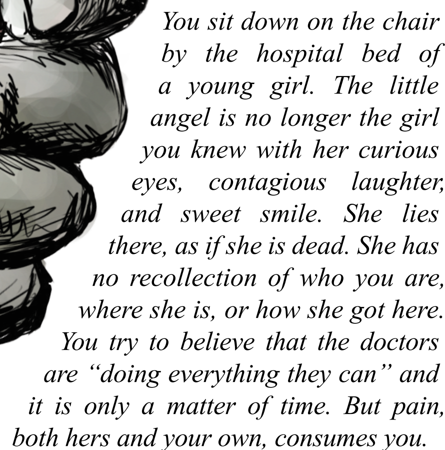

Child Non-Voluntary Euthanasia

WHEN QUALITY TRUMPS QUANTITY

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You sit down on the chair by the hospital bed of a young girl. The little angel is no longer the girl you knew with her curious eyes, contagious laughter, and sweet smile. She lies there, as if she is dead. She has no recollection of who you are, where she is, or how she got here. You try to believe that the doctors are "doing everything they can" and it is only a matter of time. But pain, both hers and your own, consumes you.

For decades, the medical community has debated how best to alleviate the pain and suffering of patients while respecting moral values and judgement. Throughout these years, the field of medicine has birthed new methods and technology to enhance palliative care. However, at times, the patients' conditions only worsen and the use of treatments and medications are to no avail. In these circumstances, euthanasia provides an alternative solution to the suffering of patients and their families. Euthanasia is defined as "knowingly and intentionally performing an act that is explicitly intended to end another person's life."[1] It is currently legal in only eight jurisdictions around the globe. However, in late 2013, Bill 52 by the Québec legislature proposed to decriminalize euthanasia as a medical aid for death. Not only has this initiated further debate on the topic in Canada, but it may encourage other governments to consider implementing euthanasia. This opinion piece discusses how legalizing euthanasia would serve the interests of the patient and healthcare system, with a particular focus on child euthanasia.

RELIEF FROM SUFFERING

Within the clinical setting, there are numerous cases where patients experience extreme discomfort caused by virtually untreatable illnesses. A 2000 study led by Joanne Wolfe investigated parental accounts of symptoms suffered by children in the terminal stages of cancer. The results revealed that 89% of children endured substantial suffering from at least one symptom, with mostly ineffective treatments, as shown in Figure 1.[2] The ineffectiveness of symptom treatments leads to a patient's poor quality of life until death. Euthanasia, however, is a promising alternative as it provides an opportunity for physicians to relieve their patients from intractable suffering rather than prolong a painful dying process.

Euthanasia should be given special consideration in paediatrics, where infants and children who are terminally ill are unable to or are inept at giving legal consent to medical procedures. Legal protocols can provide a safe procedure for non-voluntary euthanasia. For example, the Groningen Protocol establishes criteria under which physicians in the Netherlands can euthanize infants without fear of prosecution.[3] The protocol outlines four requirements: "The presence of hopeless and unbearable suffering and a very poor quality of life, parental consent, consultation with an independent physician and his or her agreement with the treating physicians, and the carrying out of the procedure in accordance with the accepted medical standards."[3] With regards to the first criterion, it is important to recognize that verbally incapacitated children are unable to explicitly indicate their symptoms and communicate their suffering to physicians. Instead, physicians must try to determine the child's level of suffering by observing vital signs and behaviour.[3] The protocol enforces standards for non-voluntary euthanasia that prioritize morality and the comfort of the patient while providing legal protection for physicians. Its success in the Netherlands indicates that child euthanasia can be authorized and well-accommodated without significant legal and moral tension in a developed country that embodies Western cultural values.

MORALITY AND DIGNITY

Establishing a legal protocol for non-voluntary child euthanasia not only prioritizes morality and the comfort of the patient, but also protects a patient's dignity. Terminally ill patients may experience an unimaginable degree of suffering.[3] Without the option of euthanasia, they are forced to spend their final moments in a state of severe deterioration. Their worsening state will

also occupy their friends' and relatives' last memories of them. This argument hence raises the question of whether a newborn or child has personal dignity. Personal dignity should be defined such that it indiscriminately emphasizes the value of human life, thus entitling children or infants to the same level of dignity as adults. For many, relying on life support for sustenance is neither a dignified nor desirable way to live the last days of one's life. The loss of independence can cause adult patients to suffer depression and other mental illnesses; a child should not have to be forced to endure this experience at such a young age. Circumvention of the suffering through euthanasia may be a proper way of preserving morality and dignity.

HEALTH ECONOMICS

Health economics is the study of optimal resource allocation to maximize efficiency and effectiveness in the healthcare system, on both an individual and aggregate level. With this understanding, another argument that supports child euthanasia is the allowance for a better distribution of limited resources amongst patients. Children suffering from terminal illnesses or medical conditions are placed in paediatric intensive care units, which provide the highest level of medical care in a hospital.[4] The average daily cost for an intensive care unit bed in Canada is $3,184, amounting to over $1 million a year. There are around 3,500 of these beds across the country.[5] Based on a cost-benefit analysis, it would be more economical to allocate the hospital bed, nurse, medication, and financial resources to a child with a reasonable chance of recovery.[6]

An efficiency standpoint may appear insensitive and uncompassionate, as one can argue that an infinitesimal chance of recovery is still hope. However, the child in his or her physical state is not only an economic burden to the health care system, but is also a source of emotional and physical strain on overlooking physicians and nursing staff. Studies show that primary caregivers of terminally ill patients experience increased health problems, depression symptoms, and psychosocial stress.[7] This is particularly true for the close family and friends of the child.

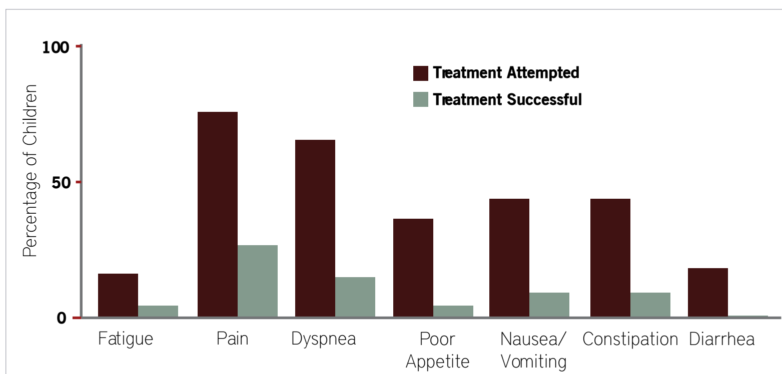

FIGURE 1: In children who showed sufferable symptoms, according to parental accounts., the percentages of successful symptom treatments: Treatments to relieve symptoms were seldom successful, as the most effective treatments for pain and dyspnea were respectively only 27% and 16% effective. Consequently, a majority of patients were reported to have little fun and immense fear, while 63% of the patients appeared distressed to their parents.[2]

A hospitalized child requires a high degree of care, but statistical analysis has shown that there are also great financial and social burdens placed on the child's family.[8] Loved ones struggle emotionally when they witness the child suffering; this distress is heightened by their inability to meet the patient's needs. Child euthanasia can play a role in optimizing the utility and performance of the Canadian medical system in the paediatric field as well as in relieving loved ones from the socioeconomic, psychological, and emotional burdens associated with sustaining the child.

CONCLUSION

In considering the suffering of the patient of the patient, preservation of dignity, and economic pressures, the benefits of implementing child euthanasia should not be overlooked. Death is a private matter, and it can be argued that the government should not interfere with such a personal decision. The Groningen Protocol from the Netherlands presents an effective routine and structure, setting an example that can be adopted by other countries around the world to practice euthanasia on reasonable grounds in paediatrics. Authorizing euthanasia under regulations will also allow for more optimal resource allocation in the Canadian healthcare system. Though illegal now, euthanasia should one day be adopted by consensus and no longer regarded as a moral equivalent to killing. It is important to understand that there is a difference between keeping an individual alive and allowing him or her to truly live; medical technology and palliative care are not enough to bridge the gap between the two. After all, quality trumps quantity, and life is no exception. ■

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1. Canadian Medical Association. Euthanasia and assisted suicide [Internet]. Ottawa: Canadian Medical Association; 2007. [cited 2014 Jan 16]. Available from: http://policybase.cma.ca/dbtw-wpd/Policypdf/PD07-01.pdf.
2. Wolfe J, Grier HE, Klar N, Levin SB, Ellenbogen JM, Salem-Schatz S, et al. Symptoms and suffering at the end of life in children with cancer. N Engl J Med. 2000; 342(5): 326-33.
3. Verhagen E, Sauer PJ. The Groningen protocol: euthanasia in severely ill newborns. N Engl J Med. 2005; 352 (10): 959-62. Available from: http://www.nejm.org/doi/full/10.1056/NEJMp058026#t=article.
4. The Nemours Foundation [Internet]. When your child's in the pediatric intensive care unit. 2012 [cited 2014 Jan 15]. Available from: http://kidshealth.org/parent/system/ill/picu.html#.
5. Dasta JF, McLaughlin TP, Mody SH, Piech CT. Daily cost of an intensive care unit day: the contribution of mechanical ventilation. Crit Care Med. 2005; 33(6):1266-71.
6. Beck AT, Steer RA, Beck JS, Newman CF. Hopelessness, depression, suicidal ideation, and clinical diagnosis of depression., Suicide Life Threat Behav.; 23(2); 139-45.
7. Pruchno RA, Potashnik SL. Caregiving spouses: physical and mental health in perspective. J Am Geriatr Soc.1989; 37(8):697-705.
8. Emanuel EJ, Fairclough, DL, Slutsman J, Emanuel LL. Understanding economic and other burdens of terminal illness: the experience of patients and their caregivers. Ann Intern Med. 2000; 6(132): 451-459.

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