# Гуманітарні проблеми медицини та питання викладання у Вищій медичній школі

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## THE ASSISTED DEATH DISCOURSE: COMMUNICATIVE INTENTIONS AND THEIR IMPLEMENTATION

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*The article analyzes the communicative intentions of medical discourse devoted to the problem of assisted death, as well as the major difficulties in their implementation. In the context of the analyzed discourse, the tactics of reasoning and emotions intensification are particularly important. The intentional structure of discourse reveals the dominance of assertive and declarative techniques.*

Keywords: communicative intention, medical discourse, euthanasia.

The advances of medical treatment have enabled the modern people to delay death and live longer. Yet, the incurable diseases can turn one's life into an excruciating existence of diminished quality. The debate over assisted death is complex and ambiguous indeed, since it involves the issues of legal and moral ethics. As a matter of fact, it is quite a challenge to the physician's ethical responsibility. For instance, in the USA, assisted death and its subcategory – physician-assisted suicide – are illegal in most states, except for Oregon (by *Death with Dignity Act* from 1994), Washington (via *Death with Dignity Act* from 2008), Vermont (via *Patient Choice and Control at End of Life Act* from 2009), and Montana (since 2009). Likewise, throughout the world the attitude towards this phenomenon and its legalization varies (for instance, physician-assisted suicide is legal in Netherlands since 2002, but illegal in a number of other European countries). Thus, euthanasia definitely proves to be a divisive topic which generates the most diverse interpretations and attitudes.

Physician-assisted suicide implies the situation when a physician provides a terminally-ill patient with appropriate information or direct medical means for self-homicide. Since its publicized application by Michigan pathologist Dr. Kevorkian in 1990, the procedure of physician-assisted suicide has evoked a wide response and remains a hotly debated problem nowadays.

In the context of assisted death discourse, one can distinguish some prevailing communicative intentions. The aim of the article is to analyze these intentions and the peculiarities of their implementation. J.R. Searle provides the following taxonomy of intentions of speech: illocutionary acts are classified into five types, i.e., assertive, directive, expressive, commissive, and declaration. According to J.R. Searle, an assertive is to "commit the speaker to the truth of the expressed proposition"; directive is "to get the hearer to do something"; expressive is "to express the psychological state specified in the propositional content"; declaration is about how a "successful performance guarantees that the propositional content corresponds to the world"; and commissive is to "commit the speaker to some future course of action" [13]. Both opponents and adherents of the assisted death phenomenon extensively display assertive and directive intentions. These intentions are challenged with a range of ethical problems and controversies (for instance, the potential abuse of assisted death).

There are reasonable arguments on both sides of this polemics. Undoubtedly, the position of those who deny the relevance of assisted death and physician-assisted suicide is quite feasible. In fact, the adversaries of the physician-assisted suicide argue that this phenomenon is fundamentally repugnant to the medical practitioner's role. As Lois Snyder and Daniel P. Sulmasy observe, "pronouncements against assisted suicide date back to the Hippocratic Oath and have formed the ethical backbone for professional opposition to the practice of physician-assisted suicide" [14]. The authors of the article articulate the position of American College of Physicians-American Society of Internal Medicine as to the problems of assisted death and physician-assisted suicide. In their opinion, the legalization of this phenomenon will not only endanger the ethical integrity of medical service, but will jeopardize cer-

tain categories of population. Therefore, the scholars emphasize the necessity of improving the quality of palliative care instead of turning to physician-assisted suicide. Doctor-assisted suicide is therefore considered as inconsistent with the Hippocratic Oath. Indeed, this traditional oath taken by physicians explicitly inhibits a doctor from supplying patients with a deadly drug at their request. Moreover, the paramount value is placed upon human life by the Declaration of Independence and the U.S. Constitution.

However, it is necessary to remark that the unconditional denial and criticism of assisted death and doctor-assisted suicides can hardly help the patients whose quality of life is eroded by a terminal illness. The opponents of physician-assisted suicide propel a number of alternatives, such as hospice and palliative care; yet, these alternatives are not always able to adequately relieve the patient's intolerable pain. In other words, it is necessary to strike the right balance in every issue, and the problem of assisted death and physician-assisted suicides requires such an approach like no other. In fact, assisted death provides relief from suffering when "excruciating pain and prolonged agony" [4] infest the patient's existence at the end of life.

The adherents of doctor-assisted suicide argue that "the decision to end one's life is intensely personal and private, harms no one else, and ought not to be prohibited by the government or the medical profession" [14]. In this context, Tibor Machan lets in the possibility of "aiding and abetting" such kind of suicides in case if "one's life by all reasonable estimate can no longer contain any but the most negative meaning – such as relentless pain and agony" [9]. Thus, the scholar asserts that physician-assisted suicides are legally justified under certain circumstances, namely "when it is as clear as possible that … an individual's choice not to live could only be carried out through another person's solicited aid or support" [9]. It is argued that assisted death and doctor-assisted suicide must be legally justified under certain conditions, for instance, when the patient's existence has lost all meaning. It is concluded that in case if the patient is unable to independently put into operation his or her voluntary decision to terminate life, it is the physician's duty to relieve his or her suffering.

Thus, assisted death must be considered by policy-makers and medical professionals as a feasible method of release the terminally-ill patients from pain. In fact, the opponents of doctor-assisted suicides often emphasize that this phenomenon involves numerous cases of abuse and serious risks of involuntary deaths. For instance, Margaret K. Dore extensively discusses the contemporary tendencies of doctor-assisted suicide legalization in Vermont and Oregon. The author admonishes the advocates of physician-assisted suicide procedure of possible cases of abuse and identifies the potential groups of people who can be jeopardized by this abuse. Margaret K. Dore contends that legalization of doctor-assisted suicides will actually "create new paths of abuse" [6]. Moreover, Kurt Darr discusses the legal and ethical issues that are raised by the phenomenon of physician-assisted suicide, for instance, the danger of "slippery slope" which can ultimately lead to involuntary death [5]. As one can easily observe, the metaphorical image of "slope" occupies a central place within the framework of this communicative intention. Thus, the discourse generated by the opponents of this phenomenon extensively demonstrates the assertive intention, primarily implemented by means of vivid figures of speech.

Indeed, this practice can trigger the abuse against elders which is statistically widespread, yet difficult to detect in due time: "Assisted suicide acts empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has money" [6]. Likewise, in order to secure the patient's free choice and comprehension of the situation, the advocates of physician-assisted suicide extensively focus upon numerous safeguards against involuntary death. Thus, the condition of voluntary decision is indispensible for both sides. Vicki Lachman [8] extensively analyzes the safeguards and guidelines in the Oregon *Death with Dignity Act*. The emphasis is placed upon the challenge which will be faced by physicians and nurses in the context of gradual legalization of physician-assisted suicide. In fact, the Oregon Act "applies only to the last 6 months of the patient's life" [8].

The Act also implies a number of crucial guidelines and safeguards which are aimed at preventing the abuse and involuntary death. Moreover, in order to ascertain that the patient makes a fully voluntary and conscious decision, the Act requires "two oral requests by the patient, as well as a written request by the patient" [8]. Further, a 15-day waiting period must occur upon the first oral request, and 2-day waiting period must elapse upon the submission of the written request. The Act also requires that the patient informs the next of kin and pass examination of two physicians in order to determine the patient's mental adequacy and determination to end his or her life. J. Pereira provides "a moral defense" of Oregon's Act and argues that it is the physician's duty to reduce the patients' suffering. Moreover, the scholar emphasizes that doctor-assisted suicide is an essential instrument of maintaining the patient's autonomy and dignity. In fact, the scholars contend that "to respect autonomy is, first and foremost, to respect a person's ability to make decisions that shape his or her destiny" [12]. Therefore, the scholars assert that physician-assisted suicide "is not in conflict with the goals of good end-of-life care" [12].

As one can easily observe, the procedure of physician-assisted suicide involves a ramified system of preconditions and prevention mechanisms. However, it is not devoid of flaws and legislative gaps which need to be eliminated. These measures aspire to prevent the doctor-assisted suicide in

case of patient's psychological disturbance or depression; yet there is still space for combating the cases when patients experience external pressure. Hence, the advocates of assisted death adhere primarily to the assertive and directive intentions. In this context, the discourse is saturated with digital data and such lexical units as "request", "require", "must". In other words, the discourse generated by euthanasia advocates assumes a form of requests and advice, as opposed to metaphorical representations within the speech of euthanasia critics.

Thus, it has been shown that both sides of this polemics adhere to different communicative intentions and apply various means of their implementation. The assertive intention is "to commit the speaker to something's being the case, to the truth of the expressed proposition" [13], while the directive intention aspires to cause the hearer to take a particular action. It is the task of representatives of both sides of this debate to pool together their efforts and develop an immaculate procedure of assisted death and physician-assisted suicide. By joining their efforts, both advocates and adversaries of this procedure will be able to elaborate a system of life termination which will be able to relieve the patients' suffering if nothing else can be done about it. Only by way of uniting the forces from both sides of the polemics, this system will be improved as free of legal or moral breaches, containing no potential abuse and danger to vulnerable populations.

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**Реферат**

ЕВТАНАЗІЯ: КОМУНІКАТИВНІ ІНТЕНЦІЇ ТА ЇХ ІМПЛЕМЕНТАЦІЯ

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Ключові слова: комунікативна інтенція, медичний дискурс, евтаназія.

У статті проаналізовано комунікативні інтенції медичного дискурсу, присвяченого проблемі евтаназії, а також основні труднощі у процесі їхньої реалізації. У контексті аналізованого дискурсу особливого значення набувають тактики аргументації та активізації емоцій. Інтенціональна структура дискурсу виявляє домінування асертивних та декларативних технік.

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Ключевые слова: коммуникативная интенция, медицинский дискурс, эвтаназия.

В статье проанализированы коммуникативные интенции медицинского дискурса, посвященного проблеме эвтаназии, а также основные трудности в процессе их реализации. В контексте рассматриваемого дискурса особое значение приобретают тактики аргументации и активизации эмоций. Интенциональная структура дискурса обнаруживает доминирование ассертивных и декларативных техник.