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## Euthanasia, Dignity, Autonomy - A Reflection on Medicine

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### 1. Introduction

The purpose of this chapter is to present a reflexion on euthanasia using personal experience and philosophical references. Our goal is to present some aspects of this topic but not to say what to think or what to do. We hope it will give the debate a good introduction<sup>1</sup>.

In what follows, the term euthanasia must be understood as being the act of ending, at his request, the life of an adult (or emancipated minor), who is able to decide for himself, suffering from a serious incurable condition (illness or accident) and experiencing constant and unbearable physical or psychological suffering. This request will be repeated with calm, and without any external pressure. The act will be carried out by a third party, in the case considered here, a doctor. It is important to specify that the doctor can refuse to carry out euthanasia and that in addition no one is forced to participate if it is against his morals or conscience.

The Belgian law of 28 May 2002, published at the same time as the law on palliative care and the law relating to patients' rights, imposes more obligations (1). The most pertinent ones concluded in giving the patient all information, particularly in relation to palliative care, obtaining the opinion of a second or even third doctor (in the case of unforeseeable short-term death), and making sure that all persons designated by the patient have been met beforehand. The legal text does not specify the practical medical methods (this is not its role), but these are accessible and have been published many times. It is useful to specify that the legal text avoids the notion of medically assisted suicide, and that the stage of the condition ("terminal phase," "palliative phase," "end of life") has been removed. By adapting the second proposal, it echoes opinion issued by the Belgian Bioethics Consultative Committee on 12 May 1997 (2). As a reminder, the essential question posed by the BBCC was: "Is it appropriate to legislate on the subject of euthanasia?" which resulted in 4 proposals: A complete decriminalisation of euthanasia (The practice of euthanasia is freely accepted), a "*a posteriori*" regulation (The act is declared after its completion), a "*a priori*" regulation (A commission decides before if the act is legally acceptable) and a complete *Status quo* (no change of legal framework).

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<sup>1</sup> Some references are taken from book written in French or translated from other languages in French.

Since its implementation, the Federal Commission for Evaluation and Control has published the conclusions detailing the declarations of the doctors who have carried out euthanasia. All the data are available (3).

We shall not go into details about the history of the Belgian legislation on this theme, but it should be remembered that we had to wait many years before the subject could be debated in Parliament, that it was needed a conversion of the majority so the historic veto be lifted. The debate was rich, contradictory, pluralist, with both sides being heard and many different opinions expressed, resulting in the present-day text. This text was based, should it be noted, on legal proposals such as those of Roger Lallemand or Edouard Klein (invariably rejected...) or on the texts of Professor Yvon Kenis, co-founder of ADMD (Association for the Right to Die with Dignity), who wrote about the legal proposal: “It is not ideologically oriented, as it takes no position about the direction of life or about the hereafter. It deals only with real cases of unbearable suffering and denounces the prejudice whereby death must be preceded by a long and cruel agony. (...) Should one not sacrifice the duration of life for its quality that a patient wishes to retain until the end?” Such foresight and such sense of the issue could only demand respect.

Although some oppose euthanasia and palliative care (similarly to the therapeutic obstinacy), this Manichean position is absurd both semantically and in practice. How can we say that medicine is capable of alleviating all physical, mental or moral suffering? In Belgium, where, should it be noted, all euthanasia must be the subject of a declaration to a Control Commission, it can be observed that most of the patients having requested and obtained euthanasia had previously benefited from palliative care. A recent study by a VUB (Vrije Universiteit Brussel) team confirms that decisions, taken within a multidisciplinary framework regarding euthanasia and assisted suicide, did not restrict the practice of palliative care (4). Evidently, this will not doubt its qualities, but its limitations. We have many times received patients, referred by doctors working in palliative-care units, who maintained their request for euthanasia despite the efforts and undeniable competence of our colleagues. These patients recognised the quality of the care, the support, the listening, the appropriate monitoring of pain in these units, but could not tolerate to be made to feel guilty, either because their request was refused in the name of precepts to which they did not subscribe, or because a so-called “controlled” sedation was proposed to them as an alternative. This solution eludes both the patient’s request and the real meaning of the action that is carried out. In effect, far from being “controlled,” this sedation only prolongs the agony and if death occurs prematurely, some health professionals mention the double-effect phenomenon (result of an act that was not part of their intention). Of course, there are circumstances in which it would be better to sedate a patient in order to spare him a painful death, such as in the case of terminal dyspnoea or the threat of a haemorrhage. This ties in with both compassion and ethics. This is well described in the book “Principles of biomedical ethics of Beauchamp and Childress<sup>2</sup>, (5). By contrary, if this sedation is proposed as an “alternative” to euthanasia, it is an intellectually inappropriate process that is aimed merely at appeasing the practitioner’s conscience. To deliberately sedate a patient in the name of his comfort is not a harmless act. We know the risks involved in the administration of sedatives in the context of precarious medical situations. The side effects and complications inherent in

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<sup>2</sup> This book is a reference in terms of ethics and is highly recommended.

this practice are most often irreversible. To claim that, in this case, the sedation is “controlled” displays a lack of honesty, as death very often occurs within 72 hours (6), (7). From all the evidence, the “palliative filter” that some would impose on all patients requesting euthanasia is neither a medical nor an ethical guarantee...

The other fear advanced by opponents is that of by-products, of the “slippery slope.” This would be nothing more or less than mass killings, carried out for social reasons (the poor), economic reasons (the elderly), or medical reasons (the very ill, the disabled, the mentally ill), implying that by legislating, and by legalizing euthanasia, the legislature would enable health professionals to feel free to act without constraint. By all evidence this is hugely contrary, as if a law would supplant all moral reflection, all ethical analysis. In effect, it is like saying that doctors generally work without “conscience” and that only the law (“which forbids euthanasia”) protects patients from arbitrary decisions taken by their doctors while at the same time these detractors, opposed to all legislation, claim for example that no doctor wants to carry out euthanasia. This is another undisputed manifestation of the manipulation of opinion and bad faith, based on lies. Neither Belgian nor Dutch experiences, which provide official data, have led to the by-products mentioned. On the contrary, since 2002, there has been no “explosion” of euthanasia or similar acts, in Belgium. All patients had a long and hard medical past, thus demonstrating their will to fight as long as possible against the disease. (For more details, see reference 3)

The approach adopted by Jean-Yves Goffi (pp 29-42) on the theme of the “slippery slope” is among the most interesting (8). For him, those who fear this ineluctable by-product “in fact demonstrate their inability to perceive the imperceptible, and their argument is made at the cost of a certain number of confusions regarding arbitrary attributions of causal relationships.” Their systematic references to Nazism is furthermore an error in evaluating the problem and the erroneous attribution of the same term (“euthanasia”) to two completely different situations, namely a political choice on the one hand and an individual choice on the other. Should we say that the Nazi Party usurped many symbols and themes, turning them away from their initial function.

J-Y Goffi continues by clarifying “that we must revise downwards the claims of the argument (of the slippery slope), which is reduced to recording the fact...that the use of certain concepts in ethics is particularly delicate and can lead to abusive interpretations.”

For our part, we would add that this “Newtonian” vision of risks (slope, etc.) is related to a heuristic sense of fear and has no place in rational medical practice. It eludes the moral sense of patients and doctors and at the same time condones the adherence of the masses to genocidal behaviour.

The work of J-Y Goffi certainly deserves paragraph, both for its originality and for its relevance. His chapter “Euthanasia and virtues” is in this case a very good demonstration on the subject, tackling it by means of virtues, of consequentialism, of aretism (virtue ethics). He concludes, but without really concluding: “In exceptional although inevitable circumstances, death can become a desirable end; and the most virtuous attitude consists of assisting others to pursue this end.”).

Finally, it must be repeated that from what we know of the issue, carrying out euthanasia is not an ordinary act and is never done emotionless. No doctor desires to carry out euthanasia, but when his patient’s request is clear, when the issue is declared as unbearable for the patient, helping him to die without suffering, sparing him a painful and pointless agony, assumes such a human dimension that refusing to carry out this act would be still,

much more painful. Refusal is in our view a desperate exhibition of the doctor's existential anguish much more than a proof of respect for deontology and ethics. The only valid argument advanced is an argument with moral value, very often with religious connotations. But then, what value does it give to the suffering of the patient? How far must this suffering go so that the patient would be listened? For how long?

A question remains unanswered: is it conceivable to consider that patients die without dignity when the euthanasia they requested is refused. In our opinion, undoubtedly yes. As long as a patient makes a request for euthanasia that complies with the legal framework (conscious and competent patient with incurable condition, suffering that cannot be eased, repeated request), to refuse him in the name of personal moral or philosophical principles without proposing a solution that satisfies the patient (suggesting another doctor for example, as set forth by law) consists of no longer recognizing the patient's dignity and of protecting the doctor's conscience, which takes precedence for him over the wishes of his patient. Although no doctor is constrained to carry out an euthanasia, to place the person who requests it in an impasse is an attack on respect for this person and his independence, using him as a tool for one's own morals, for one's own conscience, “denying” personal dignity. This argument is, in our view, fundamental for considering the act of euthanasia not only as a respectful act, full of humanity, but also as the unconditional recognition of the dignity of the patient.

In a context of medical practice, respectful for the patient, the ethics in force take priority over the doctor's personal morals, even if these are overturned. Despite the difficulty in transgressing certain moral concepts, in particular religious ones, health professionals must refer to the ethical values of the moment, considering that the decision to be taken is the “least bad” one for the patient. Paula La Marne (pp 116-117), in the conclusion of her book on *“Ethics and the End of Life,”* writes: “Nothing can prevent someone from choosing his death, provided that this choice is firm and clear, and that the doctor is sure of this.” (9) She insists on the importance of developing palliative care, and mentions the fact that patients requesting death are rare. But the notion of “rarity” is not synonym with insignificance. To help one, two or five patients has no countable value in my eyes. These are major events in the life of a doctor, events that cannot be neglected and that are more than simple statistics. It is at these moments that clinical experience, but also wisdom and respect for others, cannot be subjugated to a current of dominant thought, to diktats that suppress dialogue. The words used by Bernard Baertschi are clearly along these lines: “...euthanasia appears to be an ultimate means of satisfying the aims of moral enterprise: leading a happy life, or at least preventing it from becoming radically unhappy or even worse infra-personal.” (10)

We have met many patients who have spoken of their suffering, of their wish, not to go beyond a certain limit that they have fixed, who have asked us “calmly and repeatedly” to be present at the last moment and to help them to leave with dignity, *their* dignity. For all these people, we think that we have acted in the best way possible with the feeling that the act carried out was what had to be done. At this moment, concepts of dignity, independence and ethics were all present, but free of any passion or sterile rhetoric. In medicine, there is no “right time” to start asking questions about the meaning of what one is doing. It is a reflection of each moment which certainly becomes richer over time, but which can never be carried over to the next day. A little experience is worth much more than any blind certitude.

## 2. Dignity - morality

An universal term, of which we speak a lot, but for which, when you think about it, there is no definition that really satisfies or at least for which there is no disagreement depending on points of view.

Dignity is sometimes linked to virtue, to a certain social class ("dignitaries"), sometimes to an attitude, to a bearing ("a noble and dignified allure"), sometimes to respect for the autonomy of the person ("retaining self-esteem despite adversity"), sometimes to the inherited quality of the individual ("the fact of being simply a human being"). Among these different concepts, how do we interpret the notion of dignity in medical practice? For some, like Ruth Macklin, the notion of dignity appears even useless or at least should not be evoked in medicine. In an article published in 2003, she writes that it is a bad use of the term, in the place of "respect for individuals and their independence, which concerns essentially obtaining the informed consent, respecting the confidentiality, and the need to avoid abusive discrimination." While radical, this argument should not be accepted as it is and should even be reassessed. (11)

One can, according to Roberto Andorno, distinguish between an inherited, "static," intangible, immutable dignity that is present in the "being," and a "dynamic" dignity, which is present in the "acting." (12) In any case, it can be seen that dignity remains an absolute concept that exists only because of what derives from it and therefore, because of its universal character, is unalienable whatever the circumstances.

Consequently, expressions such as "a life worth living" or "a dignified death" are in themselves meaningless as dignity cannot be lost; this can depend only on the person (independence, respect).

It can be understood that as a concept, dignity can be limited to one of these aspects alone and that a reductive approach leads to confusion. We must therefore be clear about the terms. In the opinion of Bernard Baertschi, it is possible to tackle the question as follows: dignity is a question of "morality" (what one does), a "personal" question (what one undergoes), and a "human" question (what one is). On the other hand, indignity is evidently related to humiliation and using people as tools. All these elements coexist in everyone, but without any one affecting the others. This ranges from self-esteem to the image that one projects of oneself to others. There is often a moral sense that will give either a respectable image, or a feeling of shame or remorse in relation to what one has done: theft, lies, insults. There is the personal dimension, which can be noble, but can also cause a feeling of debasement as is the case with mutilating or degenerative conditions, in the case of pain or when a patient is placed in a situation of inferiority with clear comparative strength: i.e. patients infantilised. These two dimensions do not relate to the third, the one that is most often the issue during ethical debates and that is at the centre of the Declaration of Human Rights.

This is the human sense of the concept of dignity, which cannot in principle be lost, unlike the first two. That said, it is evident that there are no clear boundaries between moral sense, personal sense and human sense; on the contrary, the existing interconnections justify the term dignity as a concept. Thus an act that is undignified in the moral sense of the term will detrimentally affect human dignity: the act of one who lies or steals, or who uses others as a means in human experimentation without consent, or torture. However, nothing that anyone does or undergoes deprives him of his human dignity; but the latter may be violated or ridiculed.

A person physically and/or morally violated or ridiculed will feel humiliated, used as a tool, according to Kant's first imperative: “Act so that you treat humanity as well in your person as in the person of all others always at the same time as an end, and never as a means.” This philosopher in his time discarded the foundations of contemporary morality and his works remain references for the occidental philosophy, particularly with regard to the human person, even if one could reproach him for imposing only reason as a fundamental element of morality. Kant's “Categorical imperatives” remain the bedrock of many arguments.

Using people as tools and humiliation thus represent major attacks on human dignity and are by their nature unethical. Can such attacks be observed in medical practice?

Recent history has shown us the degree of ignominy that certain doctors have attained, especially during the Second World War: experiments without the aim of progress, without improving treatment, brutality, refinement of torture, contempt for humans in the name of a nauseating ideology.

We think that one must consider dignity, in the sense of not using humans as tools or humiliating them, as an essential element enshrined in medical practice. These are nuances permitted by rhetoric, but in the particular case of a patient, these nuances appear highly relative. The feeling of humiliation in fact relates more to an attack on self-image - “personal dignity” - than an attack on “human dignity,” but for the person concerned there is no difference. He feels unbearably affected, which is how one measures that which degrades or injures. To tell him that his “dignity” is intact, that there is no reason to feel humiliated, is at the same time a semantic error and above all a clear lack of common sense.

However, some would argue the contrary by claiming that one must make a distinction between relative (or moral or personal) dignity and absolute (human) dignity, as an alteration of the first does not affect the second, even going so far as to evoke camp prisoners to justify their suggestions: “...their immense eyes that truly express beauty, the dignity of the human being that no offence, no cruelty...can reduce.” These same arguments are sometimes used to claim that palliative care provides the only response that is humanly “dignified” in response to the “anguished claim for the right to die with dignity”! (13) It can be understood that this semantic game is not innocent, that it can serve as fertile ground for opponents of the decriminalisation of euthanasia and moreover that it is manipulative, removing the patient from the debate without telling him.

In medicine, the respect must go beyond the patient's independence, sparing him the shame, the humiliation, the feeling of being used as a tool, that is by recognizing his dignity as conceived by him.

Dignity has a multidimensional value, which is part of the individual history of a person who cannot be understood by one of its aspects alone. By being rhetorical about a concept, the latter ends up being empty of meaning. In other words, we must consider the patient individually and assist him without imposing on him moral standards that do not stand up to reality and bring difficulties and conflicts when taking decisions.

### **3. Independence - self-determination**

Absent from the Hippocratic Oath (it is interesting to note on this subject that Hippocrates did not take into account the patient's point of view when drafting his oath), the patient's independence is however part of the ethical code. This independence defines our capacity to choose our lifestyle, our behaviour and our values, but cannot be at the cost of moral and

ethical reflection. To respect individual independence is to respect the basis of free, informed, advanced consent, essential before any experimentation (the Nuremberg Code, the Declaration of Helsinki, the Belmont Report), is to ensure that the patient is involved in decision-making processes, that he understands the information given to him.

The doctor cannot decide for the patient, even if the latter does not make the best choice from a medical point of view. A patient suffering from pancreatic cancer in an inoperable stage may, for example, refuse chemotherapy even if encouraging results are presented to him, and prefer exclusively palliative care. Treatment must be oriented in accordance with the patient's objectives and priorities. The situation can be more complex in the case of an unconscious patient. If the latter was not able to make his wishes known beforehand (advance declaration), the doctor has to judge whether the care provided will bring relief, or even an improvement, of the clinical situation. Bioethical principles are then to be taken into account while obviously avoiding therapeutic obstinacy, which can be condemned as an unethical attitude. If arrangements have been made beforehand, they must be respected.

In the case of a weakened patient, made vulnerable by illness or an accident, the situation also requires many precautions, mutual confidence and confidentiality. The patient goes to his doctor in the hope that the latter will act in his best interests and will respect his dignity. This is the case of patients suffering from a progressive disease of which certain complications may alter their judgement capacity.

One can see independence as a risk of harming, if circumstances impair the patient's full judgement, if his *freedom* to judge is no longer really so, hence the importance, in good time, of dialogue and expression of the wishes of the patient, who has furthermore been duly informed of his condition. It remains the question of free choice, of due abandonment of the paternalistic position of medical ethics in favour of an autonomist model. (14) (Marzano pp 23-24)

In a very complete work on ethics and the end of life, Paula La Marne (9) evokes the principle of independence by clarifying that this is the indispensable, reasonable condition of dialogue with the patient, the latter clarifying his conceptions of a valid existence in relation to his body and maintaining his life. The doctor's benevolence, however noble, should not have a bearing on the patient's freedom, which is nothing more or less than a fundamental right. "The duty of compassion (*Agape, brotherly love*), etc.) on the doctor's part encompasses respecting the patient's choices (respecting his independence). It is the patient who has the last word," she writes in chapter II concerning "Face to face with therapeutic obstinacy and euthanasia."

In order for there to be independence, there must obviously be appropriate information, ensuring free, informed and conscious consent on the part of the patient. Consequently, the patient may choose what he sees fit: treatment, intervention (specific or experimental), or refusal of care.

The patient's independence is more a starting point than an end point, thus condemning all paternalism. The ever more frequent use of "information forms" in clinical studies, protocols or interventions is one of the most obvious manifestations of this. It remains to clarify what takes precedence depending on the case, taking into account that the doctor must respect the patient's dignity as well as his independence (his self-determination), without forgetting the three other main principles of bioethics, namely: doing good, not doing bad, and (distributive) justice, as presented by Beauchamp and Childress.



#### 4. And to continue...

In particular, it will be necessary to demonstrate that carrying out euthanasia, within an established framework as set forth by (Belgian) law, is neither an exception nor an ethical transgression.

Opponents of euthanasia advance arguments rooted sometimes in

1. religious precepts (“Thou shall not kill”), sometimes in
2. Kantian categorical imperatives and deontologism, sometimes resting on
3. the slippery slope argument (see above), or even on the fact that
4. carrying out euthanasia is in total contradiction of practising the art of healing (“Killing a patient is immoral,” “I didn’t do my studies for *that*,” etc.), that it contradicts
5. the Hippocratic oath “Do not prescribe or counsel a lethal product” Art. 4), that
6. euthanasia is suicide in disguise.
7. A law will give an absolute power to the doctor.

While one can understand these arguments, again they must be considered at a supra-personal level, which places the opponents in a decision-making impasse, obliging them literally to abandon the patient in need. We think that for each of these arguments, it is possible to demonstrate that they have been advanced wrongly or at least that they lie in the field of meta-ethics. So as not to lengthen the text, we propose to deal with each of them in the discussion by setting against them the counter-argument that I consider most relevant.

1. The adage advanced is of course respectable, but it has never prevented anyone from killing his neighbour, nor prevented conflicts, nor of course religious wars. And here also, the word “kill” is loaded with meaning and does not relate to clinical reality. Moreover, we find in the founding texts writings that mention assistance to die with compassion...
2. As mentioned earlier, the act of acceding to a request for assistance to die in a precise context is not in contradiction of a Kantian imperative. I will repeat in particular that not respecting a patient’s wishes is in itself an attack on his dignity.
3. The “slippery slope” is an argument that has its limits and in this case is advanced wrongly. To mention the risk of the slippery slope is indirectly to demonstrate the inability to react faced with what would be ineluctable. Belgian experience demonstrates that there is no slope and that nothing slips...
4. Assisting a patient until the end of his life is an integral part of care. Preferring “natural” death to medical aid that guarantees comfort is dubious. Imagining that nature will be more moral than health professionals shows a lack of grasp of the subject. In addition, the semantics used are among the most biased: “Put to death,” “Kill,” “Terminate,” etc.)
5. The reference to the Hippocratic Oath is habitual but forgets that this text has been “transgressed” for a long time (abortion, surgery, etc.). Likewise its text must be read as a set of ethics for life and not for death. Furthermore, the recourse to “poison” concerns essentially suicide, condemned by the Pythagoreans, and not assistance to die.
6. Analysis of actual cases experienced shows that a request for euthanasia is clearly different from suicide, in its conceptualisation by the patient, in what motivates the decision, and in its execution.
7. Because of a law, discussion about end-of-life is now open without clandestinity and a law will never erase or avoid professional conscienciousness.

These various points are not exhaustive and should be subjected to more in-depth analysis, but that lies outside the scope of this work.

### **5. Veil of ignorance...**

Every day brings its new set of declarations. On reading the “collective” work of Luc Ferry and Axel Kahn (16) one cannot help but be struck by the lack of acuity and even intellectual honesty with regard to the subject of euthanasia. Coming from such respectable and influential people, this is worrying. Ferry speaks among other things of a “supposed humanitarian act that consists of killing...” Kahn considers that “euthanasia is a transgression of the law,” and that “the “Leonetti law” avoids transgressive euthanasia.” Although in meta-ethical matters one must above all analyse statements logically and reflectively, abstaining from all moral judgement, such comments are in my view highly debatable and very far from an approach in line with cases actually experienced (casuistic ethics, etc.).

After reading this work, we wondered whether one could not apply John Rawls’s famous theory of justice and the fiction of the veil of ignorance to reflect on the question of the decriminalisation of euthanasia (17). Of course, Rawls is thinking first of all of the functioning of institutions and the practices of contemporary societies. However, why not do the exercise of searching on the one hand for what represents an equal right for everyone to access the broadest set of fundamental liberties (compatible with a set of liberties for all) and on the other hand how to respect social and economic inequalities, and make it such that they are not an obstacle to personal choices.

Still with Rawls, and considering his 1992 “u-turn,” the “consensus by overlapping” would also enable the various moral principles found in our plural societies to be brought together. As pointed out by Ludivine Thiaw-Po-Une (pp 1063-1071), “moral disagreements do not result from the irrationality of some or other persons. They are rather the inevitable result of the exercise of reason in conditions of liberty.”

To resort to the fiction of the “veil of ignorance” does obviously not mean, “To veil one’s face.”

**Référence D before to conclude**

### **6. Conclusions**

We will say for the moment simply this, that to help a patient to die without suffering, respecting his philosophical, religious and spiritual choices, is an integral part of the role of the doctor and that to refuse the help requested at any level whatsoever is at best an error but above all a lack of respect for others.

Euthanasia raises and will continue to raise many questions relating to ethics, spirituality or even ideology.

Although it is not possible for everyone to adhere to the same single attitude with a universal value, it is however inappropriate to disdain the reflective work already accomplished.

The subject tackled concerns everyone even if is the act only of “some” in practice. In addition, on this matter it is obviously not the numbers that count.

Euthanasia must not be considered in terms of Good or Bad, Moral or Immoral, but in terms of what is right, both for the individual and for society, and it is there that the ethical approach comes into its own.

Finally, it would be useful if the opponents would familiarise themselves with the reports by the Federal Commission for Evaluation and Control before launching into alarmist speeches, mentioning by-products, clandestine euthanasia, elderly people fleeing abroad, etc.

Although medicine cannot do without morality, ethics, deontology or law, it should be noted that it inevitably has the nature of philosophy, in its complexity but also in its relevance. Although one can philosophise without being a doctor, it nonetheless seems inconceivable to practise medicine without philosophical reflection.

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No one really wants to die, or do they? From classical times to our post-modern era of medical high tech, societies have struggled with the thorny issue of euthanasia, and what it entails. Who shall be entitled to a "good death" and in what form shall it arrive? This book provides the reader with insight and enlightenment on the medical, philosophical, social, cultural and existential aspects of "good death" amid our digitized, individualized and ageing society, hampered by rising health care costs but unchained from one standardized level of care.

### **How to reference**

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