

Editorial: what the people want!

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In the recent general election, New Zealanders were given the opportunity to vote to legalise cannabis and euthanasia, i.e. [1- Cannabis legalisation and control referendum](#), [2- End of Life Choice referendum](#).

New Zealanders voted for End of Life Choice bill ([euthanasia](#)); but the vote for the legalisation of cannabis was closely [rejected](#) (48.4% for, 50.7% against).

Politics and policy development are about convincing the masses to change their behaviour. Thus, developing and adopting favourable policies on euthanasia and cannabis will lead to behavioural changes. Such policies may appear to simply providing a 'choice', however, the consequences of change can be unforeseen and unintended long-term and latent changes in human behaviour, e.g. health, law and order. These are not simple single dimensional issues. Personal attitudes, perceptions, experiences and preferences form the social and demographic dimension of policies on euthanasia and cannabis. During the debate and campaign period, other dimensions surfaced, such as public health, the economy, politics, jurisprudence, law and order and religious doctrines. These dimensions may, independently and together, form individuals' choice outcomes.

But in the end, it is plausible that 'emotion' won the debate. During the debate, heart rending and emotionally charged stories were shared by a number of politicians and the public about their loved ones who were experiencing excruciating pain and wanting to die, and claimed a wish for their loved one to have died with dignity. Such presentations, through raising public sympathy, repainted euthanasia as dignity in death, attempting to re-engineer public attitudes for assisted suicide to be more socially acceptable.

What does dignity in death mean? Does it mean that a death is dignified if the time and place is decided by the person (this implies that all other deaths are undignified)?

The irony is that (i) billions are spent on medical technology and medical intervention in order to extend life, (ii) there is an embargo on reporting and a public discussion of suicide, (iii) suicide is not a criminal act in New Zealand, and (iv) like the rest of the world, the government has spent vast amounts of resources to reduce rising suicide rates without success. Yet, the campaign for euthanasia openly promoted suicide as an off-the-shelf solution to a problem at a time when suicide prevention is one of the biggest challenges for the government.

Similarly, promoting drug-taking at a time when the government has been spending vast resources in attempting to reduce drugs-related crime, accidents and ill-health (including smoking and alcohol).

The consequences of engineering behavioural change are the lifting of social barriers, shifting of personal boundaries and of social and political norms. In 2008 the Guardian newspaper in a special edition (28/08/2008) published the story of a woman who euthanised. The story headline read: I am going to die on Monday at 6.15 pm (also see Shahtahmasebi &

Shahtahmasebi, 2010). The lady in question chose the time and venue to die rather than the 'unknown' time and venue determined by her diagnosed illness. It seems that the role, if any, family and close friends and the public had was to respect her wishes.

The representation and reporting of euthanasia creates a perception that suicide is an off-the-shelf solution to life's problems, which in turn simplifies and trivialises death. The question is what makes a wish to die by suicide different to a wish to die by euthanasia? While, they both appear to be the same solution to a problem, we are told to intervene and stop suicide in the former, but respect the wishes of the person in the latter.

There is, in my mind, a lack of clarity about whose wishes to respect: is a wish to relieve the person of their pains and provide dignity through euthanasia that of the family and relatives, or that of the suffering person?

This is not to say that we should resist change – change is inevitable, but it must be in a human-appropriate direction. We seem to put all our eggs in the intervention basket. Vast amounts of resources that are used in advancing medicine and medical technology to intervene and extend life, have not made much progress in reducing rates of morbidity and mortality; as heart and respiratory diseases and cancer are still the top ten cause of mortality (WHO, 2018). On the other hand, such advancements have consequences which we often do not consider until after the intervention. For example, multiple organ transplants are now routine medical procedures, but in order for one person to live another must die. So should we follow a policy of [farming body parts](#), rather than develop prevention policies to change behaviour. It is possible that social apathy and risk taking behaviour has become the norm, because of the social perception that medical technology can resolve any problem. Thus, making it much easier to justify holding onto lifestyle vices, e.g. smoking, drinking, experimenting with drugs, rather than adopting a more preventional 'healthy' lifestyle.

Governments and universities are in a unique and privileged position to help move away from an interventional-centred policy development approach to a more preventional approach (Shahtahmasebi, 2006).

References

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