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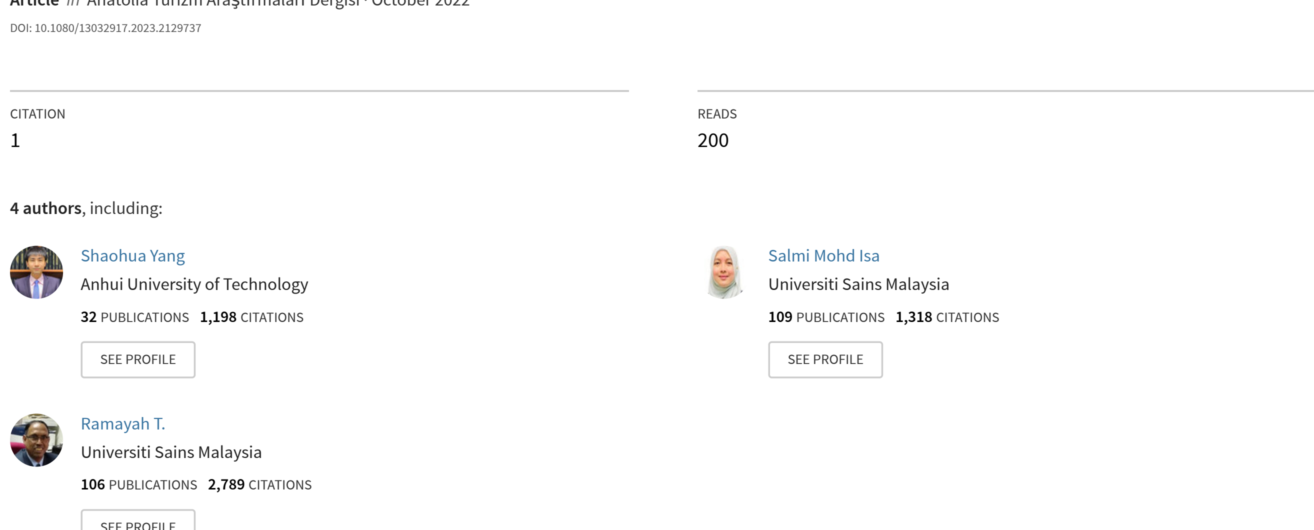

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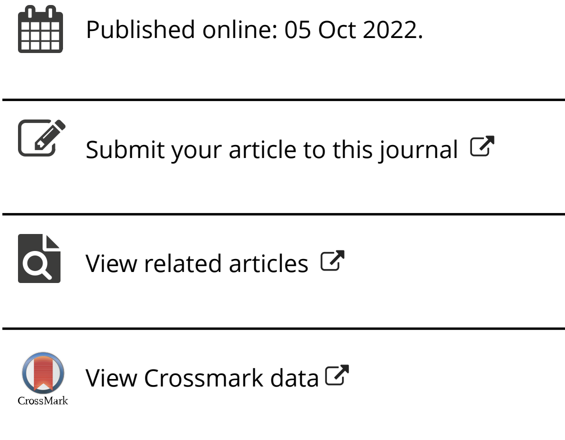

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Where does physician-assisted suicide tourism fit in the tourism discipline?

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ABSTRACT

The emerging phenomenon of suicide tourism has aroused intense debate among scholars, especially in terms of defining physician-assisted suicide (PAS). However, the conceptualization of suicide tourism remains unclear. Given relevant concerns, this opinion piece seeks to provide insight into whether PAS should be included in the tourism discipline. PAS tourism is characterized by severe illness, avoidance of pain, and a sense of depression. Ethical, moral, and legal concerns are incongruent with the present definition of tourism; therefore, PAS is argued to have no place in the tourism discipline. Further work is recommended to revise definitions of PAS tourism by employing various research methods and behavioural theories.

Keywords

Suicide tourism; physician-assisted suicide; voluntary euthanasia; self determination theory; ethical principles; one-way ticket

Introduction

At present, suicide-related tourism programs represent a swiftly expanding tourism market segment. The number of deaths by euthanasia is growing in many countries (Borasio et al., 2019), with assisted suicide gaining greater attention in the popular media as of late (Zhi et al., 2019). No method is yet available to predict or prevent suicide in tourism contexts (Klonsky, 2019). Thus, the emerging phenomenon of suicide tourism will likely remain a subject of fervent debate among scholars and practitioners. Tourism is typically defined as personal travel to a specific destination in pursuit of enjoyable experiences rather than due to one's intentions to end their life (Yu et al., 2020). Under this traditional definition, travellers visit a particular destination for various purposes, including pleasure (de Bloom et al., 2017), education (Glover, 2011), and religion (Heidari et al., 2018). Yet tourism is not necessarily associated with pleasurable experiences; trips can also involve depression or darker goals, such as travelling to engage in physician-assisted suicide (PAS) (Yu et al., 2020). In this case, tourists – as patients seeking PAS – are often suffering from symptoms of illness or ageing and wish to end their lives in a certain destination (Richards, 2017). Some may see PAS as a way to avoid being a burden on society.

The topic of suicide has been thoroughly studied in disciplines such as psychology and sociology (Phillips et al., 2002; Van Order et al., 2010). However, the conceptualization of suicide tourism remains ambiguous. Only a handful of studies have defined this phenomenon, and operationalizations are inconsistent. For instance, Cantrell et al. (2010) framed suicide tourism as a person travelling to an international destination to end their life. Higginbotham (2011) argued that,

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from the perspective of medical treatment theory, assisted suicide represents a niche target in medical tourism. Tikkanen (2005) and Tourism Research and Marketing (2006) proposed a conceptual framework that failed to provide a clear understanding of assisted suicide tourism in medical tourism. The framework included four main components – illness, reproduction, enhancement, and wellness – specific to medical contexts. Song et al. (2020) pondered whether tourism should include PAS. Given these discrepancies, this opinion piece considers whether PAS should be integrated in the tourism discipline.

Reasons to include physician-assisted suicide

Voluntary euthanasia (i.e. PAS) involves the choice to end one's life of their own volition (Lewis, 2007). Individuals who engage in PAS may be chronically or terminally ill, suffering from dementia, or elderly (Richards, 2017). Several theories have been employed to explain PAS behaviour; for example, PAS represents a humane way to ameliorate incurable disease and even appears in the theory of self-determination (House of Lords, 2005). Per the self-determination framework, part of one's motivation to commit suicide is to avoid pain in the dying process and to pursue the meaning of life (Yu et al., 2019). Under the theory of planned behaviour, empirical evidence suggests that PAS involves a key attitudinal component: the desire to end one's suffering and to die with dignity (Goh et al., 2021). However, the theories that Yu et al. (2019) and Goh et al. (2021) adopted to explain PAS were relatively simple, whereas PAS antecedents can involve a constellation of seemingly countless components (Franklin et al., 2018). Both the theory of self-determination and the theory of planned behaviour are also parsimonious (Knabe, 2012; Ryan & Deci, 2000), making them ill-suited to explain a complex phenomenon such as suicidal behaviour (Klonsky, 2019). Meanwhile, patients may have many reasons for choosing voluntary euthanasia (i.e. PAS). Research has shown that individuals who are ill and interested in PAS can be influenced by their social surroundings; that is, their consideration of PAS is informed by their health conditions and social relationships, both past and present (Richards, 2017). PAS also functions as an escape from physical and psychological suffering associated with chronic or terminal illness in addition to presenting an avenue to fantasy or the illusion of oblivion (Iso-Ahola, 1982).

Physician-assisted suicide in practice

Organized means of engaging in PAS are expanding, along with mandatory documentation requirements to justify one's eligibility for PAS (Richards, 2017). Applying for PAS can take several months from commencing the process to being issued a date for assisted suicide (e.g. assignment of an accompanier). Organized suicide packages cost approximately 12,000 USD (Richards, 2017). From a professional organization, PAS packages involving medical personnel can facilitate prospective clients' decisions while protecting their rights and freedom as human beings. In Switzerland, for example, a PAS candidate must consult with a Swiss physician twice before scheduling the service. The second consultation occurs 3 days after the first to provide the patient time to change their mind. Although PAS physicians must prescribe the required medication, they can be pardoned from the scene of death thanks to Dignitas volunteers. These volunteers will administer the required medication (a lethal barbiturate) 1 hour after prescription in certain areas owned by the Dignitas Organization. After being given the medication, patients lose consciousness in 2–5 minutes and pass within 20–30 minutes (Richards, 2017).

Conclusion and implications

Given the nebulous nature of PAS tourism, this piece attempts to provide insight into the debate around whether PAS should be included in the tourism discipline. PAS is generally motivated by physical/mental illness, the desire to avoid pain in the dying process, a patient's social conditions,

and a wish to pursue the meaning of life. These aspects clearly reflect health and medical concerns. However, patients can participate in an informational journey regarding PAS in specific tourism destinations (i.e. presently Switzerland, certain states in the United States, the Netherlands, and Belgium) where PAS is legal. Although PAS tourism can be arranged by private organizations, several arguments distinguish PAS and tourism. First, PAS tourism might not fully occupy a place in the conceptual framework of tourism. In certain countries, PAS is illegal and considered murder (Guillod & Schmidt, 2005). Under Islamic law, voluntary euthanasia is strictly prohibited due to the Muslim belief that death merely marks a transition between life on Earth and thereafter (Yu et al., 2020). Therefore, PAS can only be realized in countries where the practice is legal.

Second, PAS does not align with many ethical principles or moral judgements; the act of physicians killing patients inevitably poses medical and ethical challenges and can compromise the doctor – patient relationship. In business terms, it is socially unacceptable to sell or trade one's right to die. It also defies comprehension that a person would sell death to others on purpose. Practically, marketers should ensure that they provide value for their clients. Upon framing PAS as a viable segment of the tourism industry, selling death may damage not only the industry but also destination image. Tourism destinations that receive PAS patients could become less appealing to other prospective visitors.

Therefore, the preceding arguments for and against PAS tourism suggest that it currently has no place in the tourism discipline. Tourism revolves around leisure and recreation, bounded by destinations' legal and ethical guidelines. In cases of PAS tourism, the presence of severe illness, avoidance of pain, a sense of depression or hopelessness, and ethical and legal concerns are incongruent with the present definition of tourism. Although knowledge of PAS tourism continues to grow, studies are needed to investigate PAS tourism – related perceptions, motivations, and behaviour through methods such as ethnographology. Resultant insight should enable scholars to revise and improve the definition of PAS tourism. Moreover, this opinion piece refers to key terminology in PAS tourism, although slight differences exist between the notions of PAS tourism and PAS-related travel; PAS-related travel involves a "one-way ticket" (e.g. PAS completion vs. an informational journey). Patients who engage in PAS may have different outcomes, such as ending their lives and never returning home (e.g. as cremains) or being flown home upon death. Even though Yu et al. (2020) constructed a framework differentiating suicide tourism from suicide travel, their conceptualization had no empirical support. Further work is thus required to distinguish PAS tourism and PAS-related travel more clearly.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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