

## ORIGINAL ARTICLE

# Euthanasia as a safeguard for living: Anticipation and incurable cancer in a Colombian context

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## Abstract

This article builds on years of ethnographic conversations I sustained with my father, 89, who lives in Colombia. Soon after getting diagnosed with an incurable Multiple Myeloma—a cancer known for unleashing prolonged and painful agonies—he withdrew from oncology treatments and secured access to euthanasia (assisted-dying) on his own, bypassing medico-insurance guidelines created to regulate this medical practice and prevent abuses. Eight years after withdrawing treatments, my dad is still alive. His case shines a light on how securing access to euthanasia may have had unintended therapeutic effects on existential fears, pain perception, and quality of life on his way to dying. My storytelling also seeks to discuss the ethical and legal dimensions of assisted-dying in Colombia, especially for patients who do not consider life as biological deterioration, and who are caught between aggressive treatments and painful agonies, on the one side, and burdensome medico-insurance bureaucracy, on the other.

## KEYWORDS

anticipation, cancer, Colombia, euthanasia

The butterfly counts not months but moments, and has time enough.

Rabindranath Tagore

## INTRODUCTION

Dad was diagnosed with Multiple Myeloma at age 79. This is a cancer of the bone marrow, typically incurable, extremely painful, and fatal—especially for patients his age. Seeking to palliate symptoms

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and prolong life, his oncologist offered a series of chemotherapy intravenous infusions (iv) prescribed indefinitely into the future. Not long after initiating the treatment at a private hospital in Colombia, however, Dad would not return to the infusion hall ever again. He discontinued the chemotherapy regimen and opted for euthanasia, a modality of Medical Assistance in Dying (MAiD) that is legal in this country. Perplexed by his decision, I flew from Northern California—where I was completing my PhD in Sociocultural Anthropology—to Colombia in 2015 to be with him one last time.

But there's a catch to his story.

Eight years later, now 89, Dad is still alive.

Despite his cancer being deeply embedded in his bone marrow and continuing to grow, “something had changed,” Dad insisted. Puzzled by his words, I asked him to elaborate further. He explains: “It's simple. I stopped worrying about the long and painful agony doctors had been warning me all along,” Dad shrugged. “Knowing that euthanasia is within arm's reach became my Xanax<sup>1</sup>, my anxiolytic,” he said with a tone of relief. “The resulting peace of mind has allowed me to think more clearly and make decisions without the fear of a painful agony clouding my judgement. And that's a game changer! However— and here's the tricky part,” Dad rushed to clarify, “I still need to be prepared and ready to schedule the procedure before it's too late.” He paused for a few seconds, as if building the suspense that often precedes an important revelation. “You see, Camilo, good timing is everything, especially when you are my age. Twenty-four hours for me is the equivalent to several months for you.”

I nodded in silence.

His insight about time and preparedness at the end-of-life had baffled me. Even though he feels less anxious after having secured access to euthanasia, he says he is ready to act. After all, Dad is hoping to live enough, but never too long that he ends up experiencing a drastic cognitive decline or a painful agony—or both. To execute his plan, Dad would need to alter the odds that forecasted a dreadful ending. He clarifies: “Because withdrawing oncology treatments is such a risky wager, I need a ‘life vest’ to keep me afloat and in control if things go wrong.” Drawing on philosopher William James (1956) as interpreted by Katrin Solhdju (2021), a wager entails placing a bet on an improbable outcome and crafting the necessary conditions and fabulations<sup>2</sup> to transform an apparently impossible idea into a feasible reality. Dad's wager started with his cancer prognosis, allowing him to adjust, embrace, and anticipate dying. He contrasted expected outcomes with imagined scenarios, envisioning new possibilities for living with incurable cancer. This approach became a lifeline that increased his sense of control and reduced existential anxiety (see Lemos Dekker, 2021; Nicolaidis, 2006). And lowering his anxiety proved therapeutic, as it is crucial for the immune system's efficiency in managing diseases and responding to treatments (Sapolsky, 2004).

This euthanasia story is not the one that gets the most attention in popular media as a life-ending act. I am interested in euthanasia as a practice that is not actualized; specifically, I seek to reflect on euthanasia requests that are initiated but their provision deferred. Echoing Frances Norwood's ethnographic work on euthanasia in the Netherlands (2007, 2020), I examine the unintended palliative benefits of securing access to euthanasia in Colombia, a country with entrenched socioeconomic inequalities. The article explores how enhancing the perception of control and predictability can transform euthanasia, a practice typically associated with death, into an emancipatory safeguard for living. My gesture toward euthanasia represents an “opening” of sorts. Inspired by Lochlann Jain's concept of *Elegiac Politics* (2013), which acknowledges the inevitability of cancer within the United States's contradictory environmental and economic landscapes, this “opening” refers to the quest for euthanasia where the focus is not on its actualization. Openness describes an emancipatory disposition that allows patients to make bold medical decisions without the fear of prolonged agonies. It allows life-threatening diseases

to be just as they are, from moment to moment, making patients more available to them. As palliative care physician Dr Robert Twycross (2005) would have put it, such a stance has the potential to add life to our days, not days to our life.

For Dad, adding life to his days would require practicing time work, defined by sociologist Michael Flaherty as micro practices to manage—promote or suppress—temporal experiences (Flaherty, 2010, 2020). This practice revolves around anticipation. Anticipation, I suggest, is the act of looking forward to something like a euthanasia procedure, preparing for it, and making sure it happens. In Dad's case, he would rehearse a speech to persuade the doctor to support his euthanasia plan, or set aside a time and day for the procedure—ensuring it won't interfere with the family's Christmas celebrations, for instance. Importantly, anticipation is not an event that happens in the future, but a process whereby present practices and priorities shift in relation to something we call the future. Echoing Lemos Dekker's discussion about patients in the Netherlands, I show that "anticipating euthanasia might be more important than its realization" (2021, 4). Preparing for death can help us live in the present. It can prevent us from rushing into healthcare choices or clinging to relentless hope that might lead to unnecessary pain and suffering. By coordinating, scheduling, and deferring euthanasia on his own, Dad transformed this medical practice into insurance for an uncertain future (see Hannig, 2023; Norwood, 2007).

Crucially, Dad's story unfolds within the realm of private and top-of-the-notch hospitals, and health insurance premiums for individuals who could afford them. By leveraging his economic and social capital, he circumvented euthanasia government guidelines and obtained legal advice from an NGO dedicated to defending and promoting the right to die with dignity, contacted a euthanasia physician on his own, secured out-of-pocket payments, and scheduled the date of his death, only to find himself deferring the procedure multiple times. Unlike Dad, most Colombians—especially low income—must follow government guidelines, navigate burdensome bureaucracy, and engage in frustrating efforts to convince euthanasia gatekeepers about their unbearable pain and suffering.

My father's story illustrates what makes the Colombian case particularly unique and valuable for the standard North American bioethical discourse. In the United States, discussions about euthanasia have evolved into a modern form of medical ethics, emphasizing the moral aspects of the patient-physician relationship and the central value of individual liberty within the medical-legal framework. In contrast, the discourse on euthanasia in Colombia centers around questions of justice, highlighting how socioeconomic disparities shape patients' lives on their way to dying. This shift in focus, from individual liberty to social justice, provides a critical perspective that enriches broader medical anthropology conversations on euthanasia. Understood as a quest for justice, hence, euthanasia in Colombia unveils the pernicious class politics that have permeated public health policy since colonial times and continue doing so.

Writing this autoethnography about Dad's experience with cancer is a story I wish I did not have to tell. However, my training as a medical anthropologist compelled me to do so. I meticulously began documenting the conversations I had with Dad over the years, along with detailed descriptions and reflections on family discussions about his deteriorating health. Janelle Taylor's "On Recognition, Caring, and Dementia" is my muse (2008). Taylor's emphasis on the relational aspects of care and the emotional labor involved in caring for her mother with dementia has inspired me to reflect on my own role as the son and observer of a beloved father with incurable Multiple Myeloma. This has allowed me to delve into the complexities of anticipatory grief and dying (Lemos Dekker 2022), as well as anxiety's physiological effects at the end-of-life. Following the lead of Taylor, I have framed my narrative in a way that not only honors my father's journey but also contributes to a deeper understanding of the human condition in the face of terminal illness.

A clarification. This article does not seek to suggest that Dad's unexpected and gentle decay is the result of his treatment withdrawal nor discredit biomedical knowledge and its practices. As I have written elsewhere (2024), if I were to be diagnosed with cancer today, I would likely consider standard oncology treatments—like chemotherapy, radiotherapy, and surgery. Instead, I contend that securing euthanasia and preparing for death, may have paradoxically contributed to Dad's perceived improvement of his quality of life.

## ANXIOUS INEQUITIES

There are two basic mechanisms under the umbrella of Medical Aid in Dying (MAiD). The first mechanism is known as “euthanasia,” which is the term I use throughout this article. The word euthanasia comes from the Greek words *Eu* (good or well) and *Thanatos* (death), meaning a good death. During a euthanasia procedure, a physician is present and administers drugs in lethal doses to cause the person’s death at the desired time at the person’s request, by means of an easy, painless, and peaceful passing (Buchbinder, 2021; Mendoza-Villa & Herrera-Morales, 2016). The second procedure is medically assisted suicide (MAS). During MAS, the patient must be fully conscious and physically able to hold and swallow the lethal medications on her own.

In 1997 the Constitutional Court in Colombia ruled that individuals may choose to end their life via euthanasia and that doctors cannot be prosecuted for their role in helping them do so. Historically quite conservative, Colombia was until recently the only “developing” and Catholic country<sup>3</sup> in a small group of localities worldwide where euthanasia is also legal (Battin et al, 2024). Because the guidelines to codify euthanasia and prevent abuse were lacking, however, this medical practice was thrown into a legal limbo for almost two decades. During this interim, euthanasia became an underground practice, primarily provided by doctors who maintained a low profile, and were known to patients by word-of-mouth only. Therefore, most euthanasia petitioners at that time had to rely on their social networks and financial resources to pay for doctors’ fees and government-regulated medications.

Seeking to render euthanasia more accessible, in 2014 the Constitutional Court enacted bill *T-970* and instructed Congress (Republica de Colombia, 2015a) and the Ministry of Health to create a technical protocol for regulating this practice (Republica de Colombia, 2015b). This protocol was designed to guarantee free of charge access to euthanasia for individuals who requested it and met requirements like:

- Having a terminal diagnosis—understood as a patient who has 6 months or less to live, or an incurable bodily injury or illness.
- Expressing consent in a free, unequivocal, and informed manner.
- Making the case that the suffering is incompatible with the person’s definition of a dignified life.

To prevent abuses, the government designated health insurance businesses, known as *Empresas Promotoras de Salud* (EPSs), as the main euthanasia gatekeepers. These EPSs, which can be public, private, or mixed for-profit entities, were created following the neoliberalization of the national healthcare system in 1993 (Abadía-Barrero, 2022; Sanz, 2024). In addition to their original mission of managing healthcare funds and guaranteeing access to medical services for all Colombians, EPSs are now responsible for guaranteeing the right to die with dignity. Through “death with dignity committees,” a multidisciplinary group of gatekeepers composed of one physician, one clinical psychologist or psychiatrist, and a lawyer,<sup>4</sup> EPSs evaluate, approve, or deny euthanasia applications based on the protocol created by the Ministry of Health.

Even though Colombia has made major progress in its efforts to guarantee the right to die with dignity via EPSs,<sup>5</sup> most individuals must navigate a maze of legal requirements, insurance bureaucratic procedures, and, often, religious pushback. Petitioners and their family members must repeatedly submit requests for euthanasia and take legal action to justify their reasons when asked to explain their desire for it. Hospitals and EPSs have systematically opted for a restrictive interpretation of what the Constitutional Court has stated. Medical providers and insurance representatives are demanding requirements that the court has not imposed, like redundant medical assessments performed by psychiatrists and/or psychologists, or the demand that the petitioner **must have** gone through palliative care, when in fact it is expected that palliative care is actually **offered** to the patient (Correa Montoya & Jaramillo Salazar, 2021). After all, nobody wants to be held accountable for a type of death where the lines between suicide and murder are often blurred—especially in conservative and Catholic countries like Colombia. In addition, patients who secure euthanasia via EPSs must abide by the insurances’

scheduling choices and physicians' availability, ultimately losing control of the timing of their dying process. Unless petitioners have a strong network of support, most of them would lack the bandwidth to take on the logistical or emotional costs of figuring out how to navigate the law and secure euthanasia (see Hannig, 2023).

Multiple stories of frustrated euthanasia requests have made it into Colombian news outlets. One of these stories revolves around Mr. Ovidio, a man whose cancer was eating through his face and inflicting unbearable pain and suffering. In 2015, he became the poster child of the obstacles Colombians face in their desperate quest to end their lives. Despite his condition, it took two euthanasia requests and one tutela<sup>7</sup> filed against his hospital. The first time the euthanasia was approved by his EPS, his wife and family had made all the necessary arrangements for the event, contacted the funeral home, and bought his coffin. When he and his family members were heading to the hospital, they received a call from the medical staff informing them the patient's euthanasia had been cancelled, and no one knew whether it would be rescheduled, if at all. The hospital argued that the patient was not "terminal enough" (Cosoy, 2015).

These experiences of waiting, frustration, and exhaustion are typical for most Colombians when navigating the national health care system. In my ethnographic analysis of biomedical cancer care in Colombia (2024), I explore how these challenges are exacerbated by the government's reliance on a market-based health insurance industry. This system frequently delays and denies care, particularly for unemployed and low-income individuals, until cancers have advanced beyond effective treatment. In contrast, patients who can afford higher insurance premiums can circumvent these obstacles and shorten their waiting times.

Patients like Mr. Ovidio represent these longstanding inequalities with a new twist: individuals with the social and economic means can hasten their death through what is colloquially known as "Eutanasia Privada" or private euthanasia.<sup>8</sup> This is a modality of euthanasia through which petitioners avoid hospitals' regulations, EPSs burdensome bureaucracy, and their numerous gatekeepers. "Private euthanasia" allows patients to schedule the procedure on their own, defer it multiple times if desired, and choose their provider and the location where they wish to end their life. These "perks" typically come at a cost that may often go up to US\$2000, which includes the physician's honorarium and the required medications.

For Colombians who cannot afford private euthanasia, the default option is to follow government protocols. Upset and in pain, these patients often spend their last days filing tutela writs against hospitals and EPSs that would not comply with their euthanasia requests. It is no surprise that dying via euthanasia becomes a privilege "reserved for the chosen few with the resources to make it happen" (Hannig, 2023, 239).

In response to the physical and emotional suffering of patients like Mr. Ovidio, in 2021 the Colombian constitutional court eliminated the "terminal disease" requirement. Along with Canada, the Netherlands, Belgium, Switzerland, and Luxembourg, Colombia emphasizes patients' current suffering to qualify for the law—rather than their projected expectancy, like the United States (Hannig, 2023). This means that assisted dying legislation in Colombia permits more open-ended prognoses and, under certain conditions, even allows psychological suffering.

In a country with one of the most progressive euthanasia legislations, however, Colombians who have consistently struggled to access timely medical services rarely consider euthanasia as an option. Here I follow Anita Hannig's book *The Day I Die* (2023), specifically her discussion about the relation between systematic discrimination and access to euthanasia in the United States.<sup>9</sup> She argues that individuals who have historically faced mistreatment and have become accustomed to receiving substandard health care and being denied medical services are more likely to opt for aggressive life-prolonging measures when they become available. These individuals, she writes, [...] "are also less likely to trust a physician to have their best interests in mind, especially when it comes to stopping treatment" (2023, 27). When pernicious class politics and discrimination shape medical encounters in marginalized communities, [...] "and when death itself may be the result of deep-seated health inequities, then an expedited death might not seem very appealing" (27).

Likewise, patients in Colombia who endure systematic treatment deferrals and bureaucratic obstacles, tend to be more focused on relentless hope and keeping their treatments (once they manage to access them, often via Tutela) rather than reducing therapeutic efforts, transitioning to palliative care, or requesting euthanasia. During the long stretch of ethnographic fieldwork that informs my book (2024), for instance, the low-income cancer patients I met at public hospitals were laser-focused on accessing treatments that had proven elusive. Their efforts became a vindictory practice in and of itself, regardless of prognoses and treatment outcome. The point of gaining access to treatments was to exercise one's rights. This often overshadowed the consideration of whether these treatments were still beneficial or had become harmful.

This article does not seek to argue that euthanasia is the right public policy intervention to make a significant impact in improving end-of-life care for the largest number of people (see Buchbinder, 2021). This would be an over-simplistic and perverse rationale—to say the least, which would imply that it is easier to just die from cancer rather than attempting to fix a dysfunctional health care system. As Hannig has written, “an assisted death is not the easy way out. Hastening the end of your life is an act of will that demands improbable courage. It means accepting the hard truth of your mortality and walking towards death with clear, open eyes” (2023, 29).

## ENDLESSLY INTO THE FUTURE

It all started with a stabbing back pain, occurring at the intersection of top-tier private hospitals and health insurance plans for Colombians who can afford higher premiums. At this intersection, patients usually access continuous medical services, avoid EPS bureaucracy, and reduce waiting times (Sanz, 2024). However, even in resource-rich settings, patients suffer as a result of market imperatives that shape how cancer treatments ordinarily unfold.

“I was home doing my daily practice of *sun salutations*,”<sup>10</sup> Dad explains, “when I suddenly felt as if something had cracked on my back,” he vividly recounts. “The pain felt so intense that I fell to the ground and screamed for help.” Unable to stand back up by himself, Dad was immediately rushed to an emergency room at a private hospital in Cali. There, physicians examined his back and ordered x-rays to assess the possibility of vertebral fractures. The images, however, could not confirm such suspicion. Instead, Osteoarthritis<sup>11</sup> was diagnosed along with a “muscular contracture.” As part of the therapeutic plan, Dad was referred to physical therapy (P.T.). Staying active and doing light physical exercises were the only means to alleviating the symptoms of his newly diagnosed conditions—clinicians assured him.

Yet Dad's pain would only get worse after each P.T. session. Not even the combined effects of strong pain medications such as Lyrica (to be taken as needed) and oral morphine (every 4 h) were effective.

Frustrated and in distress, he sought a second medical opinion. “P.T sessions were making me scream,” he complained. “I could not bear it, not anymore.” Two of my siblings drove him back to the hospital, hoping physicians would conduct a more thorough examination of his back. Because x-rays are limited in what they can show to the naked eye—black and white, low-resolution images, physicians moved up in the hierarchy of diagnostic imaging. A magnetic resonance imaging (MRI) of his spine was promptly performed. When the results came back, physicians had to reassess the viability of the initial diagnosis. Based on the bone MRI, clinicians found “unambiguous” evidence of “micro-fractures” in four vertebrae: T7, T9, T11, and L1. The compounding effects of his yoga practice, the ensuing P.T sessions, and his rampant Osteoarthritis were now to blame. Yet doctors could not tell with certainty.

To alleviate his pain and prevent his vertebrae from collapsing further—which could leave him bedridden, Dad was promptly wheeled to the inpatient wards and scheduled for surgery the next day. Through a procedure known as Vertebroplasty, his four vertebrae were injected with a type of cement into the cracked or broken spinal bone. The surgery was deemed a success. After spending 3 days at the hospital, it was time for him to begin the post-surgery rehabilitation. Getting up and around as soon as possible would guarantee better results.

As part of the rehabilitation plan, physicians ordered standard lab tests to monitor his overall health and ensure he regained as much physical mobility as possible. While most of these test results fell within acceptable ranges, there was one that didn't: white blood cell counts. The numbers were simply too elevated to ignore. According to standard biomedical knowledge, any increase in the number of these immunity cells could be driven by a multitude of factors, including infections, problems with the immune system, or, perhaps, a bone marrow disease. Considering his age and a past diagnosis of in-situ prostate cancer (which was thoroughly removed 10 years ago), the possibility that another cancer could be nestled in his body was being seriously considered (see Dumit, 2012). Dad was promptly referred to an oncologist. During the appointment, he was introduced to such risk and learned that a hip bone biopsy would be needed to rule it out—for peace of mind. Right at the consultation room, a local anesthetic was administered to his lower back, followed by an incision through which the oncologist collected a bone tissue sample. This sample was then sent to a pathology lab for an expedited microscopic analysis.

His Multiple Myeloma diagnosis was rendered official. The oncologist presented him with two options: to begin an aggressive chemotherapy regimen to prolong life and manage symptoms—which may also kill him, or not to do anything and face a painful death. The proposed treatments would be mostly comprised of a chemotherapy cocktail to be pumped into his bloodstream every 2/3 weeks, with interspersed “resting” periods to allow Dad to recover from the harsh side effects of each infusion. In addition, he was put on a series of medications to alleviate nausea provoked by the treatment, prevent further bone fractures, and lower inflammation.

But, for how long?

The oncologist could not tell.

Instead, the physician warned Dad that, if left untreated, the Multiple Myeloma would continue eating through his bone tissue, potentially spreading to vital organs like the kidneys, and unleashing a painful agony. His cancer, echoing Susan Sontag, was framed as an emergency for which no sacrifice would ever be excessive (2001). In a capitalist society where illness is frequently framed with military metaphors, the idea of relinquishing even the smallest chance for more time is often perceived as an early surrender (Hannig, 2023).

Dad's case highlights the painful effects of a polarized decision between either heroic/aggressive treatments or patient abandonment, “fighting” or embracing “defeat” to cancer. Elsewhere I describe how patients and their physicians at private hospitals in Colombia tend to accelerate the pace of medical services and engage in slow transitions into palliative care (2024). This highlights a common belief in standard biomedicine that death from diseases like cancer is only considered clinically and morally acceptable after all possible interventions have been exhausted; that is, when biology has been pushed to its limits, and mental faculties have deteriorated to a point where family members struggle to “recognize” the patient.

Yet Dad's cognitive functions seemed remarkably well for a person his age. One of my siblings often remarked, “*su cabeza esta entera* [his mind is sharp]. He's got to take the treatment.” This phrase transformed Dad into someone not worth dying; someone whose perceived sense of personhood appeared intact. As discussed by Janelle Taylor (2008), the judgment of mental acuity informs treatment options and helps physicians and family members make decisions on behalf of patients. In the case of dementia, memory—the capacity to “recognize” people, words, and things—is seen in the biomedical world as the decisive “carrier of personhood” (Leibing, 2006, 258). As long as this “personhood” is recognizable by family and caregivers, fighting to prolong life may be expected to be the default option.

By contrast, when patients' personhood becomes difficult to recognize by family members, conversations about letting go may feel more appropriate. In the case of hospitalized people in the United States who are attached to various kinds of life-sustaining technologies, Sharon Kaufman has noted,

the judgment that a person with dementia is “as good as dead” may serve as a powerful rationale for facilitating death or allowing it to happen (2005). As I will describe later in the context of euthanasia, however, patients’ dwindling mental faculties may turn into a red flag that disqualifies them from hastening their death.

Without much hesitation, Dad agreed to begin the prescribed chemo regime, which would extend endlessly into the future. From bursts of anxiety the night before each infusion to the discomfort of waiting until the drugs are thoroughly forced into his body via iv drip, each visit to the infusion hall was physically and emotionally taxing. Nurses reminded Dad about the drugs’ side effects. On top of that, they were expected to be skillful. If needles are not inserted correctly into veins, chemo drugs may leak and burn patients’ muscles and skin tissue. They must also be cautious to protect themselves with face masks, face shields, gowns, and gloves. Chemotherapy cocktails, after all, contain a wide variety of medications that include cytotoxic (cell-killing) agents that are known to be occupationally hazardous.

“I asked my doctor if there was a less toxic and painful option,” Dad mused. The answer he got was not entirely satisfying. “He offered to insert a catheter over my collarbone and into the jugular vein.” Typically, a catheter would grant nurses direct access to his bloodstream without having to prick Dad’s arms multiple times—preventing potential infections, injuries to blood vessels, blockages, and clots. Upon being presented with such an open-ended treatment regimen, Dad realized it was time to act and influence his odds. “A catheter into my jugular vein?” he said with a mix of sarcasm and awe. “Hell no! I could not keep doing it indefinitely into the future. I was really hoping to see the finish line at some point,” he complained. “That’s when I knew I had had enough,” he shrugged. Four months of bi-weekly iv infusions, burnt skin, and nausea had left him exhausted and frustrated. On top of that, he was immunosuppressed; any ordinary infection could easily kill him.

In her book *Testing Knowledge: Toward and ecology of diagnosis* (2021), Alice Rivière describes her existential crisis upon learning she is a carrier for the genetic mutation for Huntington’s, a rare neuro-evolutionary disease. For her, the genetic test [...] “rendered medicine into the provider of singular forms of truth, truth-which-cannot-lie, the specificity of which is to crush all others” (29). This power is such, she further writes, that once [...] “caught within its cogs it becomes difficult to disentangle and defend oneself” (31). From testing for neuro-evolutionary diseases to living with incurable cancer diagnoses, destiny-making practices do not necessarily inform us. Quite the contrary—paraphrasing Rivière, they have the potential to transform us. Probabilities-turned-matters-of-fact, can either make us sick, increase pain, or allow us to tinker with our own bodies on our way to dying. “It all depends on what we do with them” (Rivière, 2021, 9).

Like Rivière, Dad would transform—albeit inadvertently—the relationship with his disease and the clinical data predicting a painful agony; he lent it consistency of its own. He would secure direct access to euthanasia and use it as an emancipatory practice, a stopgap that allowed him to tinker with his deteriorating body at his own pace, lowering existential anxiety associated with predicted outcomes. As the English neurosurgeon Henry Marsh has written about his own journey with cancer (2023), peace of mind may not cure this disease, but it helps patients to feel better in the present. And the present moment, he writes, is most important when bodies begin deteriorating.

## SCHEDULING EUTHANASIA...

Because Dad was planning to secure euthanasia on his own, he quickly became familiar with the “right to die” in Colombia and reached out to an NGO for legal advice. Soon after, a nephew of his—who is a physician—conducted some preliminary inquiries among his colleagues and received multiple references for a clinician I call Dr W. This is a family medicine clinician who has more than a decade of experience with “private euthanasia.” Dad explains: “Once the bridge with Dr W was established, I was given the green light to call. His secretary asked for my contact information and the reason for the appointment. When I told her I was calling by way of my nephew, she immediately knew what it was all about. She went ahead and scheduled my first telephone conversation with the doctor.”

Although Dad had managed to “cut the line” and bypass the official and bureaucratic route, he still needed to discuss his decision with Dr W and clarify why his situation was “unbearable” enough to justify euthanasia. Anthropologist Frances Norwood (2007) refers to this practice as “euthanasia talk,” [...] which are “discussions that help individuals process the meaning of life and death” (164), and may even slow down the process or encourage further dialogue about the plans<sup>12</sup> (Hannig, 2023).

As highlighted by Norwood (2007), using the right language is crucial. Dad took the time to rehearse and polish his arguments: Firstly, he emphasized his advanced age, while being careful not to display concerning signs of cognitive decline. After all, patients must convince euthanasia gatekeepers—like doctors and EPSs—that their decision to end their life is personal and autonomous, and that they have enough “mental competency” to make such a decision.<sup>13</sup> Secondly, Dad made it clear that his cancer was incurable and would lead to a painful agony. He explained to Dr W that if it weren’t for his Multiple Myeloma, he wouldn’t have chosen euthanasia.<sup>14</sup>

This level of talking serves another important purpose. It helps draw the boundaries with suicide. While suicide is often a sudden, covert, and violent act that involves police and leaves family members with pain and trauma, euthanasia is different. Anita Hannig notes (2023, 95), with psychiatrists Bostwick and Cohen (2009), euthanasia is a “collaborative and socially sanctioned process.” This openness may help bring [...] “a once taboo topic into the light of public scrutiny and social control” (Norwood, 2007, 163).

“Dr W was quick to understand I was neither suffering from dementia nor having suicidal ideations,” Dad said with a tone of relief. “The physician did not ask for clinical details. I assume that my nephew had already relayed the technical details to him. Dr W was on board with my plan, but wanted to monitor my condition for the next couple of weeks. Above all— the doctor mused, he loves life, and what really matters to him is not so much dying with dignity, but having lived a long and fulfilling life.”

The physician had one more request for Dad: his closest family members would need to be informed about the plan. The time had come for an open family conversation about death and dying. It would be our first. Dad called a family meeting, his tone grave as he prefaced the discussion by warning us the subject would be uncomfortable. For those of us who still held onto hope that his life retained enough meaning to continue fighting, his words carried a particular weight. Together for the first time, we double-checked the terms of his exequial insurance policy. We also reviewed options around cremation and underground burial, and fine-tuned logistical details about the memorial service.

He gave us detailed instructions on what to do with his body upon his passing: “I refuse to let my casket linger at the funeral home for hours. I don’t want folks stopping by to express their sympathies.” In his typical darkly humorous style, he made a request that sounded more like a warning: “The sooner my body gets transported to the crematorium, the less likely I will tug at your feet during your sleep. And regarding my ashes,” he said, “just make sure you find a nice place in nature where to scatter them.” In addition, he prompted us to address financial matters and set up an appointment with a civil lawyer to complete his will. “I sought to make sure all the bases were covered,” Dad mused. “I had never discussed with your mother whether she would want to stay in our house after I am gone or sell it and downsize to an apartment. For the time being, I have urged her to move with her sister,” he mused.

A heavy weight had been lifted off his shoulders.

## ...JUST NOT YET

Dad found himself spacing out the morphine dosages from every 4 h to once every 12 h and discarding his box of Lyrica. He even resumed some of the activities he used to enjoy, like hanging out with friends for lunch or drinks, going out to the movies with Mom, sitting on the porch to watch the sunset, and even attempting chair yoga—a gentler practice tailored for those with limited mobility. Almost simultaneously he began postponing his euthanasia appointments. Once, he had it scheduled for the end of the year, but Mom objected, saying it would ruin the family Christmas. The procedure was then moved

several months, but it was delayed again because one of his grandkids was graduating from college. On a different occasion, Dad deferred it once more when he came to know about my travel plans to Colombia.

Considering the seemingly routine postponement of his euthanasia and the years that have transpired since he stopped oncology treatments, I was curious to know if hastening his death was still on his radar. During my latest visit to Colombia in 2024, I asked in a nonchalant way: “So, when are you going to schedule it?” Displaying a facial expression of disbelief, as if I had asked the unimaginable, he answered: “I will schedule my euthanasia— but not quite yet. I will do it when I want to.” He paused for a few seconds before continuing with his spiel. “Why your insistence? What are you insinuating?” he pushed back, visibly obfuscated. Startled by his reaction, I quickly realized I had unintentionally intruded into a space where I wasn’t welcome. When talking about end-of-life decisions, I quickly learned that the boundaries between death and life, suicide and euthanasia, helping and killing—or wishing death to a beloved father, are often blurred. I was walking on a tightrope.

“I apologize for my question,” I managed to say. “I just meant to ask if you still consider euthanasia as your life vest.”

“Well, yes, Camilo. It is my life vest. What else could it be?” Dad answered. “When you go on a boat ride, you put on a life vest in case your ship capsizes. You are just being cautious and anticipating anything that could go wrong. I don’t think you go on a boat trip with the sole purpose of wearing the life vest. Had you known in advance about a future accident, you would not have hopped on the boat to begin with. A life vest gives you peace of mind, especially when you don’t know what the future brings. For instance, today I am feeling okay— all things considered. Tomorrow, however, I may wake up with more aches and pains than usual, which signal it’s time to put my ‘life vest’ on before it’s too late. Hence the need to remain vigilant and ready.”

In her ethnography among dementia patients in the Netherlands (2021), anthropologist Lemos Dekker explores how anticipation brings the future into the present, while at the same time, it keeps the future at a distance as a perpetual “not yet.” She describes how the prospect of decline motivates these individuals to request euthanasia within a specific window of time<sup>15</sup>, “as the request must be made before they lose their ability to understand and confirm the request” (Lemos Dekker, 2021, 1). While Dad currently does not seem to have signs of dementia, he is fully aware that anything can suddenly happen at age 89. Such risk had prompted him to engage in time work, aiming to avert “unwanted futures” (Aarhus, 2023). Medical anthropology literature on anticipatory practices has highlighted that future scenarios play a crucial role in shaping present actions (Aarhus, 2023; Adams et al., 2009; Stephan & Flaherty, 2019). For Lemos Dekker “anticipating a future of suffering means not only to imagine it but also to engage with that suffering in the present, to fight it, to postpone it, and, ultimately, to put an end to it before it arrives” (2021, 7). This modality of time work is often rooted in memories and past experiences (Flaherty, 2010, 2020), like the unbearable pain episodes Dad went through at the early stages of his cancer journey—when physicians had confused Multiple Myeloma with a muscular contraction.

My father’s drive for securing access to euthanasia and deferring its provision, thus, could be understood “as a continuous renegotiation of the temporal distance between the future and the present” (Lemos Dekker, 2021, 2). In other words, the work of anticipation may be seen as an attempt to gain control over the future and the process of dying, “not only as the act of looking forward that pulls us into the direction of the future” (Bryant & Knight, 2019, 28). Talking about euthanasia and preparing for death may have allowed Dad to focus on his present rather than wondering what is around the next turn.

## DYING TO LIVE

I have sought to contribute to medical anthropology debates on euthanasia, anticipation, and predictability in the context of Colombia, a country with one of the most progressive euthanasia laws,

and one of the most unequal, with regard to access. My father's story serves as a poignant reminder of the complex interplay between patients' socioeconomic conditions, individual autonomy, and the pursuit of a dignified death in this country.

His decision to opt for "private euthanasia," and the resulting palliative effects he experienced, offer three important lessons. Firstly, cancer patients who experience high levels of stress and anxiety are more likely to experience severe metastases, and their medications seem to lose effectiveness (Androulidaki et al., 2009; Chang et al., 2016). These patients often undergo accelerated biological aging, understood as the rapid wear and tear of the body. Furthermore, clinical studies have suggested that cancer patients who experience persistent financial concerns or intense existential fears tend to report higher levels of pain (Filipponi et al., 2023; Sapolsky, 2004; Woo, 2010; Xia et al., 2024).

Secondly, Dad's case may help envision a path forward to provide care when a cure is not possible, particularly for patients whose definition of quality of life is incompatible with rapid biological deterioration, and who are caught between the rock of aggressive treatments and the hard place of painful agonies. For those who frame their experience around the need to "fight" for extending life—often seen as their only option—my hope is that their choice is not driven by the "fear of the painful and physically disfiguring consequences of diseases like cancer" (Sanz, 2024, 121).

Thirdly, and building on one of the main arguments of my book (Sanz, 2024), addressing the impacts of a market-based healthcare system, and entrenched socioeconomic inequalities, requires more than just improving access to life-enhancing and life-prolonging medical services. It also involves providing alternatives that transcend the struggle to obtain care, including the right to refuse it. Alternatives like euthanasia may help us acknowledge that time is limited, rather than engaging in relentless hope and fighting that limited time.

I have not sought to propose euthanasia against anything—against diseases or medicine, for instance—but rather as a practice for building something that does not yet exist, whose absence exacerbates suffering and encourages patients to *fight* against diseases, especially those conditions known for bringing about painful endings, like cancer. Approaching euthanasia as an "opening" may help to make cancer "livable and dieable" (Jain, 2013, 220). Cancer, after all, paraphrasing Jain, must be okay for people who are dying. And dying, I would add, needs to be okay for patients who have metastatic or terminal cancers.

## FOLLOW UP

Worried about Dad's ability to schedule his euthanasia before it is "too late," my siblings, mother, and I reached out to Dr W. The physician advised updating his Advanced Medical Directives (AMD) to include a notarized clause confirming his wish for euthanasia if his mind falters and memory fades. Doing so would help clear any ethical and legal hurdles for both him and Dr W and provide peace of mind for us—his family, ensuring we wouldn't have to make difficult decisions on his behalf. Anticipating these potential obstacles became our Xanax. Yet, AMDs might not necessarily be a solution for every case. As cardiologist Sandeep Jauhar recently wrote in a *New York Times* Op-ed about his father's journey with dementia, [...] "a contemporaneous desire to live, even in a person with dementia, must be taken seriously, despite what that person might have previously written" (2023). After all, our priorities and boundaries may be more likely to shift as we approach the end-of-life, allowing us to find contentment even with diseases that are forecasted to bring painful endings. Maybe this is one of the lessons Dad is teaching us.

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## ENDNOTES

- <sup>1</sup>Xanax is the brand name of alprazolam, a medication commonly used to treat anxiety and panic disorder, among other conditions.
- <sup>2</sup>This concept echoes Donna Haraway's speculative fabulation (2016), which she describes as a "mode of attention" or tool for contrasting "predetermined" paths with stories of how things could be otherwise.
- <sup>3</sup>Ecuador legalized euthanasia in 2023.
- <sup>4</sup>Once the committee has been informed about the petition, its members have a maximum of 10 calendar days to resolve the request and inform the response. If the procedure is approved, the Committee must ensure that it is carried out on the day the person indicates or at least 15 calendar days after the patient reiterates their decision. However, this timeline often extends weeks or months when a procedure is denied, and patients (and their family members) engage in legal arguments and writs to protect their right to die with dignity.
- <sup>5</sup>The year 2022 saw record numbers of patients whose requests to die via euthanasia were granted. By October 31st of the same year, for instance, a total of 99 euthanasia procedures were authorized and performed (in a country of 55 million people) (Correa Montoya and Jaramillo Salazar, 2022).
- <sup>6</sup>Akin to the paradox of control explored by Lemos Dekker in the context of dementia patients in the Netherlands (2022).
- <sup>7</sup>Tutela is a writ created in 1991 to protect Colombians' fundamental rights, such as life, health, and death with dignity, whenever these are threatened.
- <sup>8</sup>While this euthanasia modality has been followed by patients since it was decriminalized in 1997, the term "private euthanasia" only became popular in 2015 when the euthanasia protocol was promulgated.
- <sup>9</sup>In Oregon and California, for instance, most of the decedents have been White. According to state census data, in Oregon, 97% of those who sought an assisted death in 2020 were White (Oregon Health Authority 2023). A look at a more diverse state like California confirms this trend: 87% of decedents in 2019 were White (California End of Life option Act Data Report, 2019).
- <sup>10</sup>A dynamic sequence of yoga poses in which practitioners bend their backs in various directions.
- <sup>11</sup>A type of arthritis that occurs when flexible tissue at the ends of bones wears down (common in elderly individuals).
- <sup>12</sup>In the state of Oregon, US, Hannig explains that the law includes a 15-day period between a patient's first and second oral request, intended as a period of reflection or "cooling off" (2023, 75).
- <sup>13</sup>In countries like the United States, dementia may automatically disqualify patients from securing medically assisted suicide.
- <sup>14</sup>Cancer is the most common disease in euthanasia cases, partly because its trajectory or decline is more predictable compared to other conditions. In 2022, 80.4% of all euthanasia procedures (259 cases) in Colombia had been provided to cancer patients in a country of 52 million. Non-oncologic diseases represent only 19.6% of all euthanasia procedures (Correa Montoya and Jaramillo Salazar, 2022).
- <sup>15</sup>This is referred to as the "five-to-twelve problem" by Lemos Dekker; the need to request euthanasia "too early" before it is "too late."

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