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ASSISTED-SUICIDE TOURISM: IS IT TOURISM?

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The purpose of this paper is to employ basic social psychological concepts in the interrelated fields of recreation, leisure, and tourism in an effort to examine if the medical tourism segment of assisted-suicide tourism is in fact a valid form of tourism. The comparative analysis reveals that although possessing an intrinsic motivation and an element of perceived freedom, travel for assisted-suicide is detached from the rewarding outcomes one normally receives from recreation, leisure, and tourism. Moreover, the consumption of tourism products is imparting an impression of actual tourism, whilst in reality the assisted-suicide experience is very much uninvolved in the true recreational and leisure aspects of tourism. The results of this paper are valuable for medical tourism and the tourism industry by helping both to avoid sectors that do not theoretically fit under their designations.

Keywords: *Assisted-suicide tourism; medical tourism; leisure; social psychology.*

JEL Classification: *L83, M1, O1*

INTRODUCTION

In the struggle to attract tourists in the contemporary competitive tourism arena, destinations are continuously developing new and sophisticated attractions as their *raison d'être* for tourism. As a result, the tourism literature is frequently confronted with new forms of tourism or "new tourism" (Poon, 1994) as examples of how products and services, not originally linked to tourism, are now being commodified into key tourism attractions.

As founded upon the observations of Connell (2006), medical attractions are emerging in response to the growing need to travel for medical intervention in a country other than one's own. While there is a growing consensus on what medical tourism involves, there is less agreement on what types of treatment should be incorporated under this concept (Tourism Research and Marketing, 2006). Thus, this paper will

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analytically compare the concept of assisted-suicide tourism with basic social psychological themes in recreation and leisure in an attempt to rationalize its overall applicability.

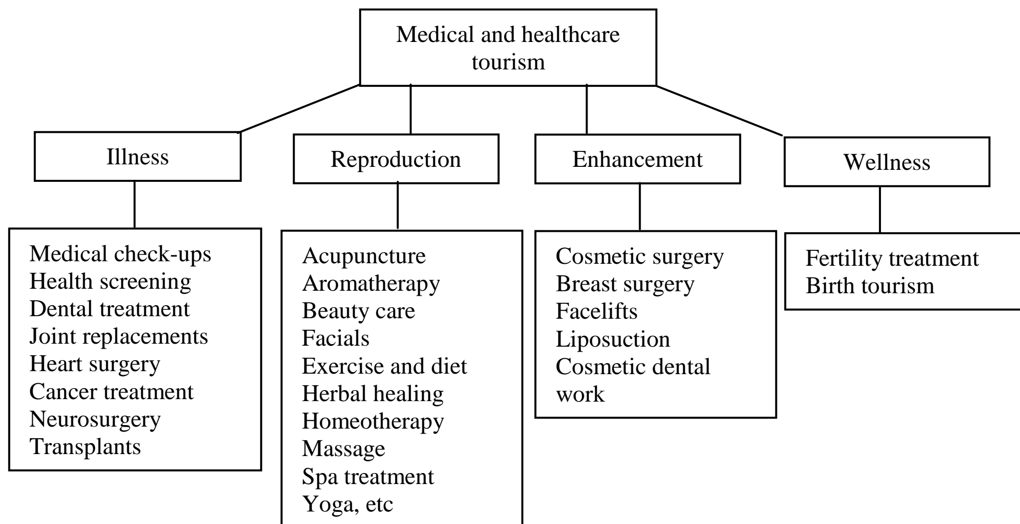
ASSISTED-SUICIDE TOURISM: DEFINITION AND IMPETUS

As a form of medical treatment in theory, assisted-suicide would qualify as both a niche segment of medical tourism and as a subcomponent of international tourism. Yet, assisted-suicide tourism does not occupy a place in the overall conceptual framework of medical tourism revised recently by Tikkanen (2005) and Tourism Research and Marketing (2006) (see Figure 1).

The current academic literature on assisted-suicide from a strictly tourism perspective is in essence non-existent. The only working definition of assisted-suicide tourism in the tourism literature has been posed by Huxtable (2009). In discerning the fine lines between suicide tourism and assisted-suicide tourism, the latter came to be defined as "assisting the suicidal individual to travel from one jurisdiction to another, in which s/he will (or is expected to) be assisted in their suicide by some other person/s" (Huxtable, 2009: 328). The central clarifications put forth by Huxtable (2009), in his judgment, are only meant to stimulate rather than stifle the ongoing debates surrounding the understanding and scope of this very complex concept.

Countries and states all over the world have long debated the question of whether or not doctors and other health-care professionals, in certain circumstances, should participate in intentionally causing the death of a patient, and whether society as a whole should ethically accept this practice (Vilela and Caramelli, 2009). Switzerland is the only nation in the world that permits foreigners to seek physician and non-physician assisted-suicide. Yet, this is only under the provision of Swiss law requiring that assisted-suicides be conducted for altruistic reasons (Humphry, 2002). The country's main non-medical right-to-die organization *Exit Deutsche Schweiz* and its subgroups of *Exit International*, *Dignitas*, and *Exit ADMD* have been prescribing lethal doses of sodium pentobarbital drugs for self-administration since 1982 (Bosshard, Ulrich, and Bär, 2003). In a related case, there is Mexico, which, like Switzerland, is quickly becoming a recommended assisted-suicide tourism destination. For approximately seven years now, *Exit International* has been providing information to interested individuals looking to legally purchase veterinary barbiturates from over-the-counter pet pharmacies in the northern parts of Mexico (Donaldson James, 2008).

Figure 1 Medical tourism segments



Source: Tourism Research and Marketing (2006) (adapted after Henderson, 2003)

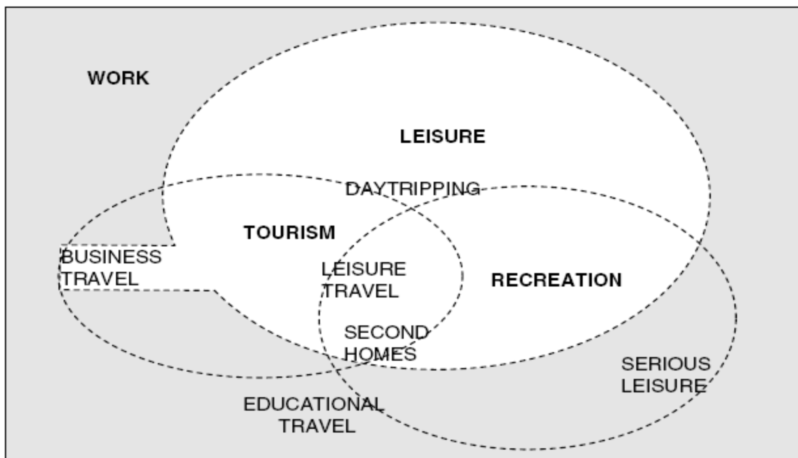
RELATIONSHIP BETWEEN TOURISM, RECREATION, LEISURE

In early research, the amount of tourism definitions astoundingly outnumbered the quantity of studies on the phenomenon (Cohen, 1974). Leiper's (1979) efforts to classify these definitions and envisage a single, comprehensive, and widely accepted definition of tourism was perceived as all but overly-ambitious in the position of Smith (1988). Furthermore, Hall and Page (2002) came to the realization that over time new and distinct technical definitions will always materialize in order to suit the varied purposes of tourism research. Today, the extent to which tourism definitions are available in the literature illustrates a high degree of fragmentation. Still, on an overall basis there are some common elements to be found and it is realistic to accept these commonalities.

On account of contributions made by Jansen-Verbeke and Dietvorst (1987), Hall's (2003) common elements of tourism will show that tourism

overlaps with recreation and the wider realms of leisure (see Figure 2). Much like tourism, definitions of recreation and leisure are contested for how, where, when, and why they are used (Poria, Butler, and Airey, 2003). For this reason, it may seem premature to be discussing the relationships between tourism, recreation, and leisure when each field has yet to be clearly defined. However, it must be noted that the presence of a single theory and definition in the social sciences is a very rare occurrence (Moore, Cushman, and Simmons, 1995).

Figure 2 Relationships between leisure, recreation and tourism



Source: Hall (2003)

TOURISM, RECREATION, LEISURE, AND ASSISTED-SUICIDE?

In early psychological analyses of the determinants and consequences of leisure behaviour, Neulinger (1974) identified two major factors that influence the type of leisure state achieved: 1) intrinsic motivation (for competence and self-determination); and 2) perceived freedom.

Intrinsic motivation, within the meanings and limits of self-determination theory, permits a logic whereby an individual, for his or her own sake, has the voluntary right and/or capacity to choose (without external compulsion) to end his or her life. Even though assisted suicide may be intrinsically motivating in itself, it by and large contradicts

theories of intrinsic motivation that advocate for the preservation of human life (Manning, 1998).

Freedom is an essential aspect of what is perceived as leisure in an individual's subjective mindset (Iso-Ahola, 1982). Research by Pearlman *et al.* (2005) suggests that the pursuit of physician-assisted suicide is motivated by the elaborate interplay of physical and psychological effects of a chronic or terminal illness. According to Baumeister (1990), a number of studies have discovered that most suicidal situations possess a common desire of freedom or escape. By applying the framework of tourism and leisure motivation conceived by Iso-Ahola (1982), assisted-suicide may provide an outlet for simultaneously escaping something (i.e. physical and psychological effects of a chronic or terminal illness) and seeking something (i.e. the fantasy and illusion of oblivion).

The above examination has thus far established an understanding that intrinsic motivation and perceived freedom can be present in an assisted-suicide leisure travel experience. Nevertheless, an intrinsic motivation and a perception of escape or freedom at one point in time do not always guarantee leisure (Godbey, 1985). Wankel (1994) finds that experiencing the characteristics of intrinsic motivation and perceived freedom through leisure is conducive to experiencing a subjective state of health. On the one hand, the fact that an individual acknowledges, values, and engages in assisted-suicide, for its own sake, is one way in which leisure travel for assisted-suicide can contribute to health. The dilemma, on the other hand, rests upon a notion that assisted-suicide cannot be used as a tool to achieve any physical, social, or psychological rewards, and thus optimal arousal. In summing up the ideas of Deci and Ryan (1985), intrinsic needs must motivate an *ongoing* process of seeking and conquering optimal challenges for optimal arousal.

These understandings are supported by the assumption that the individual does not have the physical and psychological capacity to survive long enough to subjectively experience and be measured for common rewards like: meaning, interest and enjoyment, greater competency and self-determination, improved health and well-being, and in some cases flow (Iso-Ahola, 1982). In the absence of these outcomes, the assisted-suicide participant is not only unable to continuously interact with his or her leisure environment and sustain intrinsic motivations for optimal arousal across their lifespan, but in doing so they also forfeit a connection to the spheres of tourism, recreation, and leisure.

CONCLUSION AND RECOMMENDATIONS

Much of the tourism industry's *modus operandi* is based upon an assumption that tourists are attracted to the cultural opportunities or special attributes that a particular destination offers (Sdrali and Chazapi, 2007). While the infrastructure of the tourism industry may benefit economically from travel for assisted-suicide, tourism is theoretically not just the purchase and consumption of a product. Pennings (2002), in the context of reproductive tourism, has argued that even though medical travellers are consuming elements of the tourism product (i.e. transportation, accommodation, and hospitality), to attach the label of "tourism" is devaluing the desire motivating the journey by implying that people are travelling primarily for novelty and a cultural experience.

The application of a social psychology approach has exposed assisted-suicide tourism to be neither leisure nor tourism. In actual fact, assisted-suicide may be the antithesis of medical and health tourism. Health is not just the absence of disease, illness or disability; rather it encompasses complete physical, mental, and social well-being (Connell, 2006; Didascalou, Lagos, and Nastos, 2009; Magdalini and Paris, 2009; World Health Organization, 2009). Travel for assisted-suicide, instead, offers an alternative world of physical and psychological escape without any perceptible physical and psychological rewards on health and well-being.

Though the findings of the analytical comparison has made a case for assisted-suicide's place in medical tourism and the tourism industry, future research can still be redirected towards a few interesting areas. Research in travel for assisted-suicide might yield different results by qualitatively studying the perceptions of assisted-suicide as *perceived* leisure in place of the *objective* method employed here. Furthermore, recreation and leisure studies may be interested in the potential causal link between barriers to leisure and the search for the eternal void of mortality. Future studies may also benefit from the examination of the role and significance of relaxation and relationship enhancement in the assisted-suicide travel experience, as this research study understood the terms to be too subjective and interpretational to justify any position. Specifically in relation to tourism, replication of this study from a non-social psychology approach may build upon the insight gained, or refute it altogether.

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