Physician-Assisted Death Should Remain Illegal: A Debate

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The following article is the text of arguments delivered in a public debate at the University of Alabama at Birmingham on the topic: "Physician-Assisted Death: Should It Remain Illegal?"

OPENING STATEMENT

The issue of optimal medical care and the most appropriate ways of dealing with pain and suffering, while maintaining human dignity as debilitating diseases bring us toward the ends of our lives, is extremely important, and one that warrants much more public discussion than it has received. It is an issue that strikes at the core of what it means to be a physician, and what it means to treat and heal persons. I will argue that there has never been a time in human history in which the means to take one's life were unavailable - they have always been at hand - and yet only in the last several years has there been a public call for legalization of physician-assisted death (PAD). It is ironic, in fact, that this call comes at a time when we have better means than ever for treating pain. For this reason and others, I will argue that the call for PAD is not being made now primarily out of fear of a prolonged, painful dying process or of a loss of dignity and control in the face of advancing technology. Although each of those plays a part, the call for PAD arises from a shift in society's view of what determines the value of life and a growing mistrust of the commitment of physicians and family members to provide attentive care when one reaches a state of debilitation and decline. I will attempt to communicate a vision for life in which value is based on objective truth, transcends the boundaries of birth and death, and is therefore independent of ability; and a vision for caring and compassion that will virtually obviate the need to consider assisted death. I will also argue that because the call for PAD arises from the concept of a life not worth living (not just from pain), the legalization of PAD will lead subtly but definitely to the concept of a life not worthy to be lived. This concept will seriously jeopardize the rights of many persons in society whom some consider to be unproductive and burdensome.

DEFINITIONS

The term physician-assisted death is not specific. I will take it to refer to two things: physician-assisted suicide, in which a physician provides the means, or access to the means, by which a patient can end his life, and voluntary active euthanasia (a term used by the American Geriatrics Society), in which the physician or some other agent, but not the patient, administers the means of death. As I use the term physician-assisted death, I will be referring to both of its forms. The position I will argue tonight is that both forms of PAD are killing, and should remain illegal.

Let me be equally clear about what I do not oppose. I will argue that terminally ill persons should be allowed to die, and that treatments that a terminally ill patient deems useless or excessively burdensome should be withdrawn or withheld in order to avoid unnecessary prolongation of the dying process. When extending life has become impossible, the appropriate course of action is not blindly to attempt to postpone death by using every last technological tool available to us, to squeeze in every possible moment of biological life. There are many in this room who will attest that I have promoted this view over the last decade. For example, I would not argue that the state should have required that William Bartling, a patient with severe end-stage lung disease, must continue being treated with a mechanical ventilator when he had requested that it be

discontinued. Although I am not entirely comfortable with all aspects of the decisions made in the well known cases of Karen Ann Quinlan and Nancy Beth Cruzan, the patients in persistent vegetative states whose families petitioned to have their mechanical ventilator and enteral tube feeding discontinued, respectively, I would argue that after providing sufficient safeguards, the state should not prevent these treatments from being discontinued when the wishes of the patient or of a properly designated proxy are clearly known to favor discontinuation. These cases involve allowing to die rather than killing, and should be allowed. I will apply the terms withdrawing or withholding therapy to these situations, in order to distinguish them from PAD. In these cases, the decision is about the benefits and burdens of therapies and not about the benefits and burdens of lives, a distinction that will be crucial to my arguments.

Nor will I be arguing that one should be overly cautious in providing pain relief out of the fear that it may hasten death. When pain medications are given to a patient with terminal cancer or another painful condition in order to alleviate suffering, even when the doses required may risk shortening the patient's life, they are permitted be-cause the intention is to alleviate suffering rather than to kill. Caring for a dying person means assisting her through the sometimes painful and frightening process of dying, but caring does not permit killing. Allowing to die is courageous and admirable, and should be taught and modeled for and by physicians; killing is not and should not.

FOUNDATIONS OF THE CALL FOR PHYSICIAN-ASSISTED DEATH

Of the three major aspects of ethical issues, the normative, the situational, and the existential (motivational), most persons probably assume that the current pressure to legalize PAD arises from the situational. Many people are greatly concerned that as their health declines and medical technologies are applied to them, they will lose control over what is done to them. They are also concerned that if they experience pain, it will not be adequately treated, and they will be abandoned to die an undignified death, in excruciating pain. Indeed, a Dutch government-sponsored survey on the practice of euthanasia in the Netherlands, where it is officially tolerated, indicated that the principal reasons patients there request euthanasia are loss of dignity [in the face of modern technology] (57% of cases), pain (46%), unworthy dying (46%), being dependent on others (33%), and tiredness of life (23%).[1]

However, I would submit that this is only as it appears on the surface. The fact that a call is being made now for PAD is only partially related to pain itself, for though we have always had very effective means for ending life when we chose to do so, never before have we had methods at our disposal for the treatment of pain that are as good as those we have now. Hospice practitioners, who are experienced in and committed to the use of adequate pain control and other palliative measures for dying patients, insist that no one needs to die in extreme discomfort or indignity. One of these, Dr. Joanne Lynn, "has cared for over 1000 hospice patients, and only two of these patients seriously and repeatedly requested physician assistance in active euthanasia. Even these two patients did not seek another health care provider when it was explained that their requests could not be honored.'[2] It has been asserted that in England, where palliative care is emphasized, requests for euthanasia are rare. In Holland, on the other hand, where euthanasia is easy to obtain, palliative care is said to receive lower prionty.

Rather, the fact that PAD is being called for now is evidence of a normative choice that western society made long ago, to reject the concept of objective universal truth. Having done this, men and women themselves have become the arbiters of what is true and right, and accountability to anyone other than oneself has been rejected. We have decided that we are not stewards of our lives, as western culture believed for centuries, but that we have dominion over it. It is not a gift that we have been given in trust, but is something we possess as our own, and over which we have absolute autonomy. This principle of human autonomy leads to patient autonomy, and forms the essential foundation for the call for PAD. Richard McCormick has noted that this absolutization of autonomy tends to eclipse moral reasoning, because "the sheer fact that a choice is the patient's tends to be viewed as the sole right-making

characteristic of the choice.'[3] He points out that this total accommodation to the patient's values and wishes ignores, or rejects, the fact that there are good choices and bad choices, and that particular features make them so. When one engages, therefore, in PAD, one is not just taking a small step further in relieving pain and anguish, but is acknowledging that a subtle but giant leap has already been taken in which the creature has supplanted the creator.

PAD is little more than a logical consequence of the presupposition that the meaning of our lives and our deaths is determined by ourselves and by no one else, including God.

This being the case, the important and practical problem that arises, and the point from which I will now argue against PAD, is that if God does not exist, everything is permitted (this was Sartre's point); nothing is finally impermissible on these grounds. As I now describe what could be the untoward consequences of the acceptance of PAD by our culture, keep in mind that they are consequences of the foundational presuppositions. In my mind the only certain way to avoid the consequences, to reverse the trend, is to abandon the presuppositions and embrace objective truth. PAD should represent an "ethical stop sign" warning us of a cliff ahead. If we ignore it and fail to stop, we may find ourselves over a precipice. A slight turn of the wheel or a small change in velocity will be no substitute for coming to a full stop.

CONSEQUENCES OF LEGALIZED PHYSICIAN-ASSISTED DEATH

A cardinal feature of the call for assisted suicide is the assertion that the value of a person's life is diminished if the person's ability to be active or productive is impaired, or if suffering becomes substantial. Such a life, it is asserted, may not be worth living. To accept this notion will have profound implications beyond PAD, for the culture that, in its ethical autonomy, has sown the conceptual seed of a "life not worth living" will reap the harvest of a cheapened view of life in general.

Consider this: many requests for assisted suicide represent a cry for love, for touching, and for caring, out of a fear that when one reaches a point of disability and dependence on others, they may begin to consider one's existence a net burden to them. Many ethicists have pointed out that in this context, ready acceptance of a request for assisted death could be disastrous if interpreted by the patient as confirmation of her worthlessness. Over time, after legalization of PAD, this dynamic would progress to an anticipation by persons with advancing disease that they will be considered by others to be worthless, and perhaps to have lives unworthy to be lived. This could result in preemptive suicides and involuntary euthanasia.

I remember well a young resident physician for whom I had the opportunity to care a number of years ago here at UAB. He was diagnosed with cancer of the colon during his internship, and by the end of his residency it had progressed to the point where his intestines were obstructed by entanglement in a matted mass of tumor in his pelvis. But he was otherwise still quite strong, and able to be active in the hospital, mainly teaching medical students. So we began treating him with total parenteral nutrition in order to maintain his nutrition and hydration. After about two months of the therapy, when he was still rather active, Alex suggested that perhaps there was no point in continuing with it further. Sensing that he was really asking whether his wife and physicians and others still cared for him, and whether we still considered his life to have value - crying out for love and caring - I encouraged him that there was every reason to continue on, that there was no reason to consider his life of less value, and that we would all be by his side until the end. He continued the therapy for another eight months, during which time he was able to support his wife as she dealt not only with his illness but with a serious illness in her father as well. The way he valiantly responded to his progressive suffering discontinuing the therapy shortly before his death be-cause it was obviously no longer prolonging his life, but not asking for assisted death deeply touched all of those who cared for him. We will never be the same again. But, if we had acquiesced to his suggestion eight months earlier that there was no point in continuing further, he would likely have died feeling abandoned, and those who survived him would have missed a great blessing.

More specifically, various ethicists enunciate the following serious adverse consequences of legalized PAD.

1. Distortion of the healing relationship

The knowledge that PAD is a possible course of action, even if its use is unlikely in a given case, will seriously distort the relationship between a physician and her patient. The first aspect of this is that PAD will represent a fundamental change in the calling of physicians, and alter the "internal morality" of medicine, or the moral obligations that have always been inherent in medical care.4 The purpose of medicine, which has always been to restore health when it is possible, and to enable the patient to cope with disability and death when it is not, will be undermined. The second aspect of it is that the doctor-patient relationship is "ineradicably grounded in trust." It is fundamentally important for the patient to trust that the physician will always act in an attempt to heal, and not to consider even the possibility of removing the need to heal by killing him. In Dr. Edmund Pellegrino's words," How can patients trust that the doctor will pursue every effective and beneficent measure when she can relieve herself of a difficult challenge by influencing the patient to choose death?"[4] The availability of PAD will only magnify the uncertainty, mistrust, and even suspicion that are already too prevalent today in the healing relationship. Consider the scenario of a person who may or may not have a terminal condition (prognostication is an extremely difficult art), and may not feel as though- she is receiving a great deal of communication from her physician (an all-too-common and unfortunate occurrence). If PAD is known by both physician and patient to be a legal option, the patient will inevitably begin to wonder whether her physician is still giving her care due consideration. Even changing nothing, in the current medical climate, she may justifiably wonder whether the physician really has her best interests in mind. She may wonder whether he is frustrated over her case, emotionally spent, or (looking toward the future) pressured by a government health care alliance to lower the costs he incurs in caring for his patients.

Without question, in many situations physicians will be tempted to accept assisted death as an easier course of care, and this will undercut the incentives to provide attentive care to suffering persons. Medical training and experience already have the effect of desensitizing physicians to witnessing the loss of life; will not legal PAD only inure them to it further, and make it an all-too-welcome alternative? Again, Pellegrino: "If [assisted suicide] is known to be a viable option at the outset, it cannot fail to influence the patient, the physician, and everyone else involved in the patient's care. If it is not known at the outset, the patient is deprived of the clues needed to interpret her physician's actions."5

I have treated many patients in my years as a physician or medical student. Although I trust that those I have cared for, and those whom I have worked with in doing so, would consider me a compassionate and caring physician, I know my own heart well enough to know that I fully have the capability to be tempted, when feeling frustrated and helpless, to make a therapeutic decision that suits my own selfish desires before the needs of my patients. In a recent conversation Dr. Pence [a philosophy professor who moderated the debate] described physicians to me as being "incredibly self-serving." While he cited this fact as a reason used by physicians to opposed legalized PAD (perhaps because they don't have the courage to deal with it or don't want their incomes reduced by decreasing their patient populations), I believe any self-serving tendency physicians may have, as all persons have, provides a compelling reason why you and he should insist that PAD remain illegal. You see, while the observation that physicians can be self-serving only qualifies them as ordinary human beings (it could equally be applied to philosophy professors!), I think it is true. Ladies and gentlemen, I do not ask you to opposed PAD because you need to be protected from someone else. I ask you to oppose it because you need to be protected from me. Do not entrust me with a prerogative that I may very well use to your detriment. Do not ask for your relationship with me to be altered in such a way that I could decide, and even convince you, that the best I can do for you is to provide you with the means of a certain death, at your hands or mine: for I will be tempted to do just that, even if it is not the best I can do.

2. Abuses against persons, and abrogation of rights

Once we have crossed the line that has prevented us until now from practicing PAD, we will have abandoned the historic tradition of "state's interest" in human life.4 We will have embraced the concept that there are lives that should be ended, and open our society to grave moral and social consequences. Abuses of vulnerable members of society will increase; we will witness the abrogation of the rights of "unproductive" persons who are thought to represent a "burden" on society - impoverished persons, mentally handicapped persons, very old and especially demented persons, others with disabilities that keep them below some acceptable level of functional ability, and persons in persistent vegetative states year after being confined to a bed and wheelchair for many years because of a spinal cord injury. He felt powerless and chronically vulnerable, and was terrified over trends he saw in society that have the potential to disenfranchise disabled persons.

Increasing concerns over the costs of medical care, and progressive involvement of impersonal health care networks serving as surrogates of the federal government, will amplify this risk. This is especially true with regard to the elderly, as the distribution of our population shifts toward an inverted pyramid, with a smaller number of persons in the workforce supporting a growing elderly population. While some have expressed fear that the federal government might forcibly prolong our dying process, surely the opposite is far more likely as the temperature of cost-consciousness and health care rationing increases in our climate. On a smaller scale, abuses by families and other care-givers will likely increase as well, toward persons who they think should request PAD but do not.

If you doubt the validity of this argument, let me ask you to consider two things. First, I would ask, once we have removed from one segment of our community the time-honored protection to which all (adult) life heretofore has been entitled in the U.S., by what standard will you argue that it should not be removed from others? For instance, there are more than a few persons in society who argue in favor of labeling mentally handicapped individuals as non-persons. It is asserted that this label is used as a justification for the use of involuntary euthanasia with individuals who have severe and even moderate intellectual disabilities.[6] If voluntary euthanasia were legalized, the practice of euthanasia on retarded persons could easily receive further justification. The line of reasoning may go something like, "if persons who are competent to request euthanasia or assisted suicide can now do so legally, why should persons who are incapable to express their wishes be deprived of the opportunity?" Following this reasoning, the late novelist and physician Walker Percy asserted that "once the line is crossed, once the principle is accepted -juricially, medically, socially - innocent human life can be destroyed for whatever reason."[7] If God is dead, everything is permitted.

Second, I would ask you to consider that in Holland, the best example of a country that has officially tolerated (though not legalized) euthanasia, the practice has progressed to include non-voluntary euthanasia. Cases of "life termination by [a physician] administering lethal drugs without an explicit and persistent request from the patient" were estimated by the 1991 Dutch government survey to represent up to a third of all cases of euthanasia there.[1] In interviewing the families and physicians of Dutch patients who had been euthanized, Dr. Carlos Gomez came across the case of a 56 year old man who was given a lethal injection of potassium chloride in an emergency room after suffering massive trauma.[8] Not only was the patient unconscious and unable to express his wishes, but the physician did not even wait for the family to arrive in order to interview them, much less to give them the opportunity to see him before the end came. They never knew their loved one had been euthanized. In this instance the physician acted in what I can only interpret as a paternalistic way, a practice that PAD is intended to minimize by maximizing patient autonomy. Nevertheless, the physician who performed euthanasia felt totally justified in what he did, and defended his decision vigorously. He did not admit that he had ventured Outside the Dutch guidelines, which require repeated documented requests for euthanasia from the patient be-fore it can be performed.

Other aspects of Gomez's research make a strong case as well for the notion that euthanasia is unregulatable. From his extensive interviews of persons who are involved in euthanasia in the Netherlands, he documents the extremely intricate and often ambiguous nature of informed consent for assisted death. Questions such as who first suggested it as an option (was it really the patient who requested it, or did the physician first suggest it? if the latter, how much was the request truly the patient's?) and who will blow the whistle if anyone abuses the practice (dead persons cannot testify, prosecutors are unlikely to be present, and physicians [being self-serving!] virtually never inform on each other) will be almost impossible to answer. Perhaps most telling is the report that elderly persons generally oppose euthanasia in Holland because they fear being involuntarily euthanized.[8] Elderly Dutch physicians reportedly fear being admitted to the very hospitals where they have practiced, for the same reason.[4] There is obviously great concern in their minds that physicians will not only not always act in their best interests, but that physicians in fact may not always follow their wishes. What began as an expansion of patient autonomy has in their minds become a dangerous expansion of physicians' power.

Dr. Pellegrino sums it up, "The Dutch experience shows that even when euthanasia is not legal but is tolerated, expansion of its boundaries - from voluntary to involuntary, from adults to children, from terminally ill to chronically ill, from intolerable suffering to dissatisfaction with the quality of life, from consent to contrived consent - is inevitable."[4]

But as I have alluded, physicians are not the only ones who will use the issues surrounding PAD to serve their own interests. One of the most ardent and well-known proponents of euthanasia, Mr. Derek Humphry, the author of Final Exit and founder of the Hemlock Society (an organization whose mission is to help persons who wish to end their lives to do so), was accused by his wife and co-laborer in the cause of forcing his agenda on her, to her detriment and ultimate demise. The suicide note of his wife, Ann Wickert Humphry, accused him of abandoning her, harassing her, and trying to hasten her death when she refused euthanasia after she was diagnosed with cancer.[9] She also accused him of having suffocated his first wife, Jean, whose celebrated "suicide" energized the right-to-die movement. Regardless of the accuracy of her claims, it is clear that assisted suicide can create serious interpersonal tensions even among its most ardent proponents, and does not always eventuate in "death with dignity." Rather, the call for PAD arises from and will result in a general devaluation of life that will prove correct Albert Schweitzer's assertion that if a man loses reverence for any part of life, he will lose reverence for all of life.

3. Intolerance of dependence on others

A third side effect of legalized PAD that McCormick attributes to the absolutization of autonomy is a progressive intolerance of dependence on others. Autonomy limits the definition of "death with dignity" to death in my way, at my time, and by my hand. Yet, interdependence has always been one of the most noble features of human relationships, as has the sharing of pain and suffering in order to alleviate it. McCormick quotes the Anglican Study Group:

There is a movement of giving and receiving. At the beginning and at the end of life receiving predominates over and even excludes giving. But the value of human life does not depend only on its capacity to give. Love, agape, is the equal and unalterable regard for the value of other human beings independent of their particular characteristics. It extends to the helpless and hopeless, to those who have no value in their own eyes and seemingly none for society. Such neighbor-love is costly and sacrificial. It is easily destroyed. In the giver it demands unlimited caring, in the recipient absolute trust. The question must be asked whether the practice of voluntary euthanasia is consistent with the fostering of such care and trust.[10]

As such, McCormick insists that "assisted suicide is a flight from compassion, not an expression of it. It should be suspect not because it is too hard, but because it is too easy."[3] If we reject interdependence with others and embrace PAD, we will fail to see assisted death for what it so often is: an act of isolation and abandonment.

Robert Spitzer descries this as "the total decline of culture. It is the epitome of a culture that no longer recognizes love or goodness to be the value of life. It is a culture that values only one thing: convenience, function, some kind of production beyond consumption. That is a crass utilitarian culture. And that is the culture we are trying to prevent."[11]

POLICY ISSUES

Although they represent a minor plank in my argument, I think PAD could be ably opposed on policy issues. I am not convinced, for instance, that PAD needs to be legalized in order for it to occur in the way that its proponents wish. Indeed, to this date the Dutch have said as much, since they have not legalized euthanasia. Many physicians write many prescriptions for enough narcotics that, if taken all at once, would result in the patient's death. Undoubtedly some prescriptions - who knows how many? -are written expressly for this purpose. In light of this potentiality, the main change that may occur with legalized PAD, as I have argued earlier, is the explicit acceptance of the concept of a life not worth living, and the removal of the most important obstacle preventing the declaration of a class of persons whose lives are not worthy to be lived. This will result in a net reduction of patient autonomy at the expense of self-serving physicians or cost-cutting health care alliances and government operatives. It will threaten the very goals the proponents of PAD are attempting to reach.

Secondly, even if PAD is accepted by society, in light of the deleterious effects I have insisted will occur in doctor-patient relationships, why should doctors necessarily be the ones to perform it? Although I opposed any legalization of assisted death on the principles outlined earlier, it would seem to be strategically important for its proponents to suggest that someone other than physicians be designated to carry it out, thus protecting patients from ambiguity and suspicion in their relationships with their physicians.

KILLING VS. ALLOWING TO DIE

At the root of my case against physician-assisted suicide and voluntary active euthanasia is a subtle but monumentally important distinction between killing and allowing to die. It is based on two very important differences.

First, in killing and in PAD, it is the instrument one administers that effects the demise of the patient, whereas in allowing to die, one removes a therapy that is ineffective at restoring health, and the disease kills the patient.

In the first instance it is a person's action that kills, and in the second the person acts in order to allow the disease to kill. Second, in killing and in PAD, the death of the patient is the intended result of one's actions, whereas in allowing to die, the intended result is that ineffective or excessively burdensome impediments to the patient's death should be removed.

In allowing to die, one is making judgments about treatments, in PAD one is making judgments about lives. I maintain that because itisagiftandatrust. Life-even one's own - is a thing about which we are not at liberty to make value judgments. On the other hand, therapeutic technologies invented by our ingenuity have benefits and burdens, and we can and do legitimately make judgements about the balance of those. As the Ramsey Colloquium put it, "Our decisions, whether for or against a specific treatment, are to be always in the service of life. We can and should allow the dying to die; we must never intend the death of the living. We may reject a treatment; we must never reject a life."[12]

CONCLUSION

Physician-assisted death is not an appropriate means of avoiding the prolongation of dying (to do so is to play God), of alleviating suffering (other means are sufficient for this), or of relinquishing life when it is no longer possible to maintain a grasp on it (allowing to die accomplishes this). To embrace PAD as a means of maintaining dignity and control over one's fate will result in a further cheapening of life and will establish dangerous precedents. Once we have decided that life is a thing that can be taken away voluntarily, on demand, it will be a very small step to take it

involuntarily, on command. One who grants requests for PAD thinks that he does so in Rather, if we recapture the belief that life is a gift and a trust whose value extends beyond the time the heart stops beating - that meaning transcends biology - and if we reaffirm that the sort of caring for a person that is truly noble includes touching, holding, enduring, maintaining vigil, and medicating, then the call to end one's anguish by ending one's life will become unnecessary. We must reaffirm out commitment "always to care, never to kill."[12] Requests for PAD that are met in this way are truly met by love.

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