

Physician-Assisted Suicide and Palliative Care Treatments

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*If I were terminally ill (or elderly, paralyzed, in pain, incontinent, etc.),
I would want someone like Dr. Kevorkian to help me die –
Comment taken from a brochure entitled “Assisted SUICIDE - Caring or Killing?”*

On November 8, 1994, the state of Oregon legalized physician-assisted suicide (PAS) by passing Measure 16. Though voters passed this measure by the narrowest of margins, it still set the precedence of authorizing the killing of human beings by doctors in the United States. In assisted suicide, especially PAS, the whole concept of the medical professional being a healer comes into question. “ ‘Physician-assisted suicide turns the healers into death-dealers, charged with the role of judging someone’s quality and quantity of life. The only guide will be their own very fallible judgment’ ” (Stewart et al, p. 22, 1998).

In November of 1997 a measure (Measure 51), which would have repealed the 1994 Oregon law, was solidly rejected by its voters, allowing the continued practice of PAS. It seems that Oregonians did not learn from past lessons of other cultures, societies or nations which accepted the intended death of patients. For example, Holland allowed euthanasia to be practiced for a number of years, and then a government study was conducted to review the effects of the practice.

The results of the study are contained in the official report of the Dutch Committee to Investigate the Medical Practice Concerning Euthanasia released late in 1991. Since the study involved professionals reporting how ethical or unethical their use of it was, probably more ethical lapses existed than were reported. Even so, the study documented nearly 6,000 cases annually where patients were killed without their consent! (Kilner and Mitchell, p. 130, 2002)

Even with the evidence showing Dutch doctors actively killing patients without their consent, the Netherlands parliament in 2002 still enacted a law legalizing and regulating euthanasia for certain specific cases.

It is common these days to hear people say they wouldn’t want to live if they had to be hooked up to life support systems or experienced extreme physical suffering. Fear of psychosocial, mental suffering, future suffering, indignity, being a burden, loss of control or other uncontrolled symptoms may be the catalysts for patients to request PAS. Though not as obvious, but still a subtle contributor that could influence individuals to consider or accept PAS, is the ethics of the patient’s good and the ends of medicine.

If medicine takes aim at death prevention, rather than at health and relief of suffering, if it regards every death as premature, as a failure of today’s medicine - but avoidable by tomorrow’s - then it is tacitly asserting that its true goal is bodily immortality...

Physicians should try to keep their eyes on the main business, restoring and correcting what can be corrected and restored, always acknowledging that death will and must come, that health is a mortal good, and that as embodied beings we are fragile beings that must stop sooner or later, medicine or no medicine (Kass, p. 244, 1980).

In other words, medical science should not be a collaborator or source of suffering in its pursuit to smite diseases, but should recognize its capacity to provide a level of care that can effectively relieve the pain and suffering of terminally ill patients. If physicians only look at people as diseases to conquer, and do not connect the dots between the relief of suffering and the cure of disease that is truly dedicated to the care of the sick, the resultant attitude of the general public will be shaped by seeing end-of-life care as a place where only suffering resides. End of life care should not involve experiences of noxious chemotherapy, clinical trials of experimental therapy that offer more benefit to researchers than to patients, or disillusionment with life as a whole. Such experiences could cause patients to seek methods such as assisted suicide, which might appear to be good alternatives to pass from this life to the next. End-of-life care should be a place where people are cared for and made comfortable as they prepare for physical death.

The challenges of finding the right balance between relief of suffering and the cure of disease that are hindering the medical community from providing correct patient care can be overcome with a new focus on what is known as comfort or palliative care. Though this discipline has been part of medicine for many years, its overall philosophy and effectiveness has not been appreciated by a large segment of the medical community, and by default has not been experienced by the patients in their care. The issues of suffering and pain that cause people to gravitate toward PAS can be dampened by proper palliative care and education, yet there are those who believe certain palliative or comfort care approaches (e.g., terminal sedation) are nothing more than a slower approach to PAS. Is it possible from a Biblical-Christian perspective to build a case that in limited circumstances PAS could be considered as comfort or palliative care, and would be a viable solution in relieving suffering and pain?

Before addressing the question above, it is important to define what is and what is not PAS. The phrase “assisted suicide” or “doctor-assisted suicide” has been used time and time again in the attempt to differentiate it from euthanasia. John C. Wilke, M.D., bluntly makes the statement in his book entitled, *Assisted Suicide & Euthanasia past and present*,

We should not commonly use the phrase “assisted suicide” but rather call it what it truly is - euthanasia. Even so, the term is everywhere today, and so let us look at “assisted suicide.” This distinguishes the cases where someone else assists with the killing from those who do it themselves without anyone’s help.

In other words, PAS is a form of euthanasia packaged under a different name.

Euthanasia is derived from two classical Greek words, eu meaning “good” and thanatos, meaning “death.” Euthanasia literally means “good death.” In general, euthanasia refers to the process by which people’s deaths are caused or intentionally terminated by themselves (i.e., suicide) or others (i.e., assisted suicide or mercy killing). Euthanasia is usually associated with individuals wanting to end their lives because of terminal illness or unbearable suffering. The most common terms for euthanasia are: voluntary, involuntary, nonvoluntary, active, passive, direct and indirect euthanasia.

Advocates of PAS continue to spread the myths of one's right to die, or a person's right to choose assisted suicide, if he or she is suffering from intractable misery and pain. PAS is by no means a right, and it is not protected by our Constitution, yet the success of PAS in Oregon, as well as in the state of Washington, the "right to die" mantra, fueled by the fear of present or future physical suffering from terminal illness, only enhances the desire of those who want to legalize other forms of euthanasia. The urgency of educating and practicing symptom management for patients suffering from uncontrolled pain and other symptoms throughout their illnesses is one of the key cornerstones in palliative health care. Once palliative care becomes a fixture within the entire medical community and filters down into the treatment of patients, the arguments for PAS will become less convincing.

Palliative care is interdisciplinary care that aims to relieve suffering and improve quality of life.

Patient care should not be bounded by the limits set by the managerial organization of hospice, hospital, or primary care teams. Rather it should be oriented around and towards the patient and be delivered by input from members of many interlocking teams (Randall and Downie, p. 89-90, 2002).

Palliative or comfort care focuses on whole person care, which equates not only to the physical, but also to the psychological, social, spiritual and practical needs of the patient. Services that are available to patients as well as family members range from supportive care such as pain and symptom control to hospice and bereavement care.

For many, end-of-life care brings up images of hospice where the patient has less than 6 months to live and dies in a home setting. Palliative care, if done correctly, starts at the time of diagnosis. Instead of waiting to the very last stages of treating a terminal illness, a continuum of care is established that allows a team of specialists and the patient to establish goals for the needed care. These goals include the patient's expectations from the physician and health care team, opportunity to express what gives life meaning, desire to have life support or not, opportunity to use advance directives, and on-going dialogue concerning the burdens and benefits of treatments. A palliative consult should not occur when a patient's symptom issues become an overwhelming challenge to a doctor. As soon as a patient is diagnosed with a long or short term terminal illness, there needs to be a shift initiated away from curative, restorative care to comfort care.

Palliative care gives the patient, family members and the health care professionals the time to prepare for the inevitable and the permission to speak of the unspoken; that is, to talk openly about death and the process of closing out one's life as one who has lived. Being open and honest, and maintaining hope to find realistic goals for end of life care will not only reduce the levels of anxiety for patients and family using the palliative approach, it will also facilitate a system of support that can be modified with changes in health status, advancing illness, and treatment preferences. Communicating the prognosis of those who are terminally ill helps patient and family cope better and plan for inevitable changes in areas such as treatment options when symptoms of pain become a greater challenge. It is in this area of pain management that palliative care can be extremely effective, yet it is misunderstood, especially within the medical community.

Proponents of PAS continually make the point that a patient has the right to self-determination, especially when suffering from extreme, constant pain. Although a patient does have the right to accept or refuse any treatment, even if refusal leads to death, they do not have the right to do whatever pleases them. “The right to self-determination is a very important precept of modern medical ethics, often ignored by or even denied by paternalistic physicians of the past. However, it does not offer adequate justification for the legalization of assisted suicide” (Orr, p. 133, 2001). Palliative care that provides pain management rather than PAS is the more compassionate alternative that sets realistic goals for patients to live their lives as well as possible. Unfortunately, many physicians are notoriously ignorant or lack the will to better understand or educate themselves on proper pain management techniques. “Despite excellent resources too numerous to cite and despite practice guidelines...this clinical inadequacy continues...physical pain among the terminally ill exists because doctors lack the will, not the way...” (Orr, p. 135, 2001).

Along with this hesitation or lack of interest by a certain segment of the medical community concerning pain management in palliative care, there is also some controversy concerning certain newer technologies that have been adopted by doctors who practice aggressive pain management techniques. Some of these methods use high doses of opioids, such as morphine, that could have the negative side-effect of suppressing one’s respiration, which could lead to the patient’s death. Hence, many in the PAS movement enthusiastically point to this and other types of palliative care as nothing more than delayed or “slow” processes of medically assisted suicide. The evidence actually shows that narcotics used in medically controlled environments do not hasten death, yet many doctors are hesitant to use opioids in helping to reduce patient suffering. Is this type of palliative care actually a rare form of PAS that Christians can accept, or is it not PAS, but an acceptable method of care that has both good and bad effects?

Another controversial method that raises ethical questions concerning the hastening of death in a clinical setting is the use of terminal sedation. This practice provides narcotics to a dying patient expecting that he or she will succumb to death due to dehydration. Those who advocate PAS call terminal sedation “slow euthanasia,” and believe this type of palliative care, along with high doses of opioids, does more to hasten death than allowing patients to live longer with less suffering. Some may think this controversy is a modern day dilemma, and to solve the problem it is best to seek the counsel of experienced ethicists. However, in reviewing the writings of a 13th Century scholar, Sir Thomas Moore, especially his “rule of double effect,” it is possible to understand that intent holds a key position in defining the role of advocate or proponent of PAS.

The rule of double effect

...is a form of reasoning that says it is morally permissible to do an act that has both a good effect and a bad effect if all of the following conditions exist: (i) the act must be inherently good or at least morally neutral, (ii) the bad effect may be anticipated but not intended, (iii) the good effect must not be achieved by means of the bad effect, and (iv) there must be a proportionately grave reason for allowing the bad effect (Orr, p.136, 2001).

Therefore, if the doctor’s intent is clearly to hasten death in providing a patient high doses of morphine or terminal sedation, then the result is in the domain of PAS. Conversely, if the doctor’s maximum effort has not relieved the suffering of a patient whose death is imminent,

then methods like terminal sedation are ethically appropriate even if the side effect causes an early death. These comfort-only or palliative care techniques are not geared to terminate life, but to allow life to continue as comfortably as possible as the patient journeys from earthly life to eternity.

When people become seriously ill or experience extreme amounts of physical or mental anguish, it is quite natural for their desire to live to be temporarily lost. In fact, Arthur J. Dyck writes in *Life's Worth: The Case against Assisted Suicide*, "Research indicates that 95 percent of those who committed suicide had a major psychiatric illness at the time." So to counter those who believe PAS should be a constitutional right there should be a firm understanding, especially within the medical community, that "Laws against assisted suicide presume that there is a positive desire to live and where it is temporarily lost, individuals need to be protected by law, and, when seriously ill and in pain, should receive the care that will restore the desire to live" (Dyck, p.85, 2002).

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