



The Case

PHYSICIAN-ASSISTED SUICIDE

For

Richard T. Hull

In early 1997, the medical community awaited the U.S. Supreme Court's decision in *Taeco v. Quill*. Ultimately, the high court would overturn this suit, in which doctors and patients had sought to overturn New York's law prohibiting physician-assisted suicide. But it was fascinating to see how much attention physicians suddenly paid to the question of pain management while they were waiting.

Politicians and physicians alike felt shaken by the fact that the suit had made it as far as the Supreme Court. Medical

"My lingering sense is that the unspoken problem with physician-assisted suicide is that it puts power where opponents don't want it: in the hands of patients and their loved ones."

schools scrutinized their curricula to see how, if at all, effective pain management was taught. The possibility that physician-assisted suicide would be declared as much a patient's right as the withdrawal of life-sustaining technology was a clarion call that medicine needed to "houseclean" its attitudes toward providing adequate narcotics for managing pain.

The ability to demand physician aid in dying is the only resource dying patients have with which to "send a message" (as our public rhetoric is so fond of putting it) to physicians, insurers, and politicians that end-of-life care is inadequate. Far too many patients spend their last days without adequate palliation of pain. Physicians sensitive to their cries hesitate to order adequate narcotics, for fear of scrutiny by state

Richard T. Hull is professor emeritus of philosophy at the State University of New York at Buffalo. He is editor of Ethical Issues in the New Reproductive Technologies (Wadsworth, 1990).

health departments and federal drug agents. Further, many physicians view imminent death as a sign of failure in the eyes of their colleagues, or just refuse to recognize that the seemingly endless variety of tests and procedures available to them can simply translate into a seemingly endless period of dying badly. Faced with all this, the ability to demand—and receive—physician aid in dying may be severely compromised patients' only way to tell caregivers that something inhumane stalks them: the inhumanity of neglect and despair.

Many physicians tell me that they feel it is an affront to suppose that their duty to care extends to a duty to kill or assist in suicide. If so, is it not even more an affront, as dying patients and their families tell me, to have to beg for increases in pain medication, only to be told that "We don't want to make you an addict, do we?" or that "Doctor's orders are being followed, and Doctor can't be reached to revise them." If apologists for the status quo fear that a slippery slope will lead to voluntary euthanasia, then nonvoluntary euthanasia, the proponents of change already know that we've been on a slippery slope of inadequate management of suffering for decades.

Let's examine some of the stronger arguments against physician-assisted suicide—while keeping in mind that these arguments may not be the deepest reasons some people oppose it. My lingering sense is that the unspoken problem with physician-assisted suicide is that it puts power where opponents don't want it: in the hands of patients and their loved ones. I want to see if there are ways of sorting out who holds the power to choose the time and manner of dying that make sense.

1. *Many severely compromised individuals, in their depression, loneliness, loss of normal life, and despair, have asked their physicians to assist them in dying. Yet later (after physicians resisted their requests and others awakened them to alternative opportunities) they have returned to meaningful lives.*

No sane advocate of physician-assisted suicide would deny the importance of meeting the demand to die with reluctance and a reflective, thorough examination of alternative options. The likelihood of profound mood swings during therapy makes it imperative to distinguish between a patient's acute anguish of loss and his or her rational dismay at the prospect of long-term descent into the tubes and machines of intensive care.

But note that, in stories like the above, it is the very possibility of legal physician-assisted suicide that empowers patients to draw attention to their suffering and command the resources they need to live on. Patients who cannot demand to die can find their complaints more easily dismissed as “the disease talking” or as weakness of character.

2. *Medicine would be transformed for the worse if doctors could legally help patients end their lives. The public would become distrustful, wondering whether physicians were truly committed to saving lives, or if they would stop striving as soon as it became inconvenient.*

Doubtless there are physicians who, by want of training or some psychological or moral defect, lack the compassionate sensitivity to hear a demand for aid in dying and act on it with reluctance, only after thorough investigation of the patient’s situation. Such physicians should not be empowered to assist patients to die. I would propose that this power be restricted to physicians whose primary training and profession is in pain management and palliation: they are best equipped to ensure that reasonable alternatives to euthanasia and suicide are exhausted. Further, patients’ appeals for assisted suicide should be scrutinized by the same institutional ethics committees that already review requests for the suspension of life-sustaining technology as a protection against patient confusion and relatives’ greed.

3. *Euthanasia and physician-assisted suicide are incompatible with our obligations to respect the human spirit and human life.*

When I hear *all* motives for euthanasia and physician-assisted suicide swept so cavalierly into the dustbin labeled Failure to Respect Human Life, I’m prompted to say, “Really? *Always?*” Those same opponents who find physician-assisted suicide appalling will typically excuse, even acclaim, self-sacrifice on behalf of others. A soldier throws himself on a grenade to save his fellows. A pedestrian leaps into the path of a truck to save a child. Firefighters remain in a collapsing building rather than abandon trapped victims. These, too, are decisions to embrace death, yet we leave them to the conscience of the agent. Why tar all examples of euthanasia and physician-assisted suicide with a common brush? Given that we do not have the power to ameliorate every disease and never will, why withhold from individuals who clearly perceive the financial and emotional burdens their dying imposes on loved ones the power to lessen the duration and extent of those burdens, in pursuit of the values they have worked to support throughout their lives?

Consider also that some suffering cannot be relieved by any means while maintaining consciousness. There are individuals, like myself, who regard conscious life as essential to personal identity. I find it nonsensical to maintain that it is profoundly morally *preferable* to be rendered comatose by drugs while awaiting life’s “natural end,” than to hasten death’s arrival while still consciously able to embrace and welcome one’s release. If I am irreversibly comatose, “I” am dead; prolongation of “my life” at that point is ghoulish, and I should not be required to undergo such indignity.

Finally, the question, “What kind of life is worth living?” is highly personal. There are good reasons patients diagnosed

with a wide range of conditions might not wish to live to the natural end of their diseases. How dare politicians and moralists presume to make these final judgments if they don’t have to live with the results? Of course, every demand for physician-assisted suicide must be scrutinized, and determined to be fully informed. To withhold aid in dying beyond that point is, first, barbarically cruel. Second, it only increases the risk that individuals determined to end their lives will attempt to do so by nonmedical means, possibly endangering others or further magnifying their own suffering.

“There are good reasons patients diagnosed with a wide range of conditions might not wish to live to the natural end of their diseases. How dare politicians and moralists presume to make these final judgments if they don’t have to live with the results?”

4. *The time-honored doctrine of double effect permits administering pain-relieving drugs that have the effect of shortening life, provided the intent of the physician is the relief of the pain and not the (foreseen) death of the patient. Isn’t that sufficient?*

Others may find comfort in the notion that the intention of the agent, not the consequences of his or her action, is the measure of morality. I do not. In any case, preferences among ethical theories are like preferences among religious persuasions: no such preference should be legislated for all citizens. For the thinker who focuses on consequences rather than intentions, the fact that we permit terminal care regimens to shorten life *in any context* shows that the line has already been crossed. The fact that physicians must, at the insistence of the competent patient or the incompetent patient’s duly appointed surrogate, withdraw life-sustaining technology shows that physicians *can* assist patient suicides and can perform euthanasia on those fortunate enough to be dependent on machines. It becomes a matter of simple justice—equal protection before the law—to permit the same privileges to other terminal patients. That the U.S. Supreme Court has ruled against this argument did not dissuade the citizens of the State of Oregon from embracing it. States like New York that have turned back such initiatives must bear the shame of having imposed religious majorities’ philosophies on all who suffer. ■■