

To Be Or Not To Be ... Some Musings About Physician-Assisted Suicide

“They shoot horses, don’t they?”

That aphorism expresses the feelings of many who advocate physician-assisted suicide, another term for requested active euthanasia. Indeed, many people express their frustration about this subject by stating that we often seem to treat our terminally ill pets more humanely than we treat our terminally ill family members and other loved ones. Unlike our pets, though, many of our terminally ill specifically request that their lives be ended—and this request generates a multitude of ethical dilemmas, some of which are explored here.

Framing the Issue: Two scenarios from life and literature

The famed psychoanalyst Sigmund Freud himself was unafraid to die and was receptive to euthanasia. This attitude is shown by an account of Freud’s death, excerpted here from an article published in the *Archives of Internal Medicine*:

According to Schur’s first-person account of Freud’s final hours, he grasped his physician’s hand and said, “My dear Schur, you certainly remember our first talk. You promised me then not to forsake me when my time comes. Now it’s nothing but torture and makes no sense any more.” Schur indicated that he had not forgotten his earlier promise. Freud “sighed with relief, held my hand for a moment longer, and said ‘I thank you,’ and after a moment of hesitation he added: ‘Tell Anna [Freud’s daughter] about this.’ All this was said without a trace of emotionality or self-pity, and with full consciousness of reality.”

I informed Anna of our conversation, as Freud had asked. When he was again in agony, I gave him a hypodermic of two centigrams of morphine. He soon felt relief and fell into a peaceful sleep. The expression of pain and suffering was gone. I repeated this dose after about twelve hours. Freud was obviously so close to the end of his reserves that he lapsed into a coma and did not wake up again.

... Freud’s professional interest in death as a spiritual human event was deep; the prospect of his own mortality was surely the object of extensive reflection, following the diagnosis of cancer and the much earlier (probably incorrect) diagnosis of heart disease. Ironically, in what seems almost like a modern fear of anticipated criticism from this act of what some might consider a physician-assisted suicide, publication of Schur’s account was delayed until following his own death.^{1:1522a}

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Freud’s choice of what would now be termed voluntary active euthanasia is relevant to the ongoing, heated debate over physician-assisted suicide. Exerting control over his life and death—as well as honesty in medical decisions—had a growing importance to Freud in the last decades of his life, and this importance mirrored changes that were already occurring in our society’s views of contemporary medical care. Just as Freud chose to live as long as he considered life personally meaningful and to die at the hand of his trusted physician, Max Schur, an increasing number of terminally ill patients today are demanding that their physician assist them toward a quick, controlled, and reconciled death when they believe that their life’s potential is exhausted and that death is imminent. The same article ends on a dismal note:

Even in the most predictable of circumstances, death is mostly a complicated and unpredictable event. Unless we take our own life, no matter how carefully we describe and document our wishes for terminal care, we cannot prevent circumstances in which a stranger

or ill-informed relative will make decisions that conflict with our intentions. Planned deaths will always constitute a small minority of the dying encountered in medical practice, but for individuals like Freud who insist on writing their own life’s script, a controlled and reconciled death is of grave importance.^{1:1524b}

I have often wondered why anyone would purposefully choose death—oblivion, the unknown—instead of choosing life. If the choice is motivated by physical pain or by emotional suffering such as clinical depression, then these entities should be directly addressed. But perhaps some people are truly motivated by some existential angst; perhaps they believe in a “far, far better world” that they will go to when they die. This belief in an afterlife, belief in a more perfect world—belief that one must suffer in this life in exchange for an everlasting life of ecstasy after death—is so real to some people that for these people, savoring a moment of life in their bodies now is “[l]ike paying for an afternoon in the coin of life to come.”^{2:129} For example, many passages in Toni Morrison’s novel, *Beloved*,² present a message of death in life and of life in death. Speaking of another character in the novel, Paul D says, “... I hope she didn’t die hard.” Sethe replies, “... Soft as cream. Being alive was the hard part.”^{2:7}



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Other passages in the novel touch on these feelings about death:

... it embarrassed them and made them sad; that secretly they longed to die—to be quit of it—that sleep was more precious to them than any waking day.^{2:17}

Singing love songs to Mr Death, they smashed his head. More than the rest, they killed the flirt whom folks called Life for leading them on. Making them think the next sunrise would be worth it; that another stroke of time would do it at last. Only when she was dead would they be safe.^{2:109}

Also pertinent to this subject is a question: Where does assisted suicide end and active euthanasia begin? In the same novel, *Beloved*, Sethe thinks:

... if I hadn't killed her she would have died and that is something I could not bear to happen to her.^{2:200} [She goes on to maintain that] ... what she had done was right because it came from true love.^{2:251}

Choosing to end life: Individual and societal views

What kind of person most typically seeks to have his or her life ended by a physician?

Mark S Goulston, MD, a psychiatrist in Santa Monica, California, relates a story³ about a 64-year-old man who had become housebound from end-stage Parkinson's disease and who had asked a "well-known" suicidologist to "be put out of his [the patient's] misery." The patient was reduced to asking for this help because "He was unable to

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get out of bed to retrieve his stockpile of pills or his handgun."³ Earlier, the man had been a successful professional athlete and until the previous two years out of eight, he had been able to continue working as a sports coach while hiding his symptoms from his players and children; he said he did not want to be pitied. Even though the man had exhausted most benefits of the anti-Parkinsonism drugs, his neurologist believed the patient was years away from reaching end-stage disease. Dr Goulston introduced himself to the patient and informed him that he had come at the request of both the previous doctor and the patient's wife. The patient responded: "They probably want you to talk me out of doing away with myself. They think I'm depressed. I'm not. I'm just realistic. How do you think you'd feel, if you were hostage to this disease? ... Each day lasts forever, and I don't know how much longer I can hold on."³

Various kinds of psychiatric therapy (personal, medical, and family therapy) could not dissuade the patient from choosing to end his life.³ A final treatment option for the patient—electroconvulsive therapy (ECT)—was presented to the family and was reluctantly accepted. Inpatient ECT was given, and the patient had a striking remission not only of his previously denied depression but also of many Parkinsonism symptoms. Thereafter, the patient received one main-

tenance treatment of ECT per month. At publication of the article, the patient and his family expressed the feeling that life is worthwhile after all.³

Any discussion regarding "physician-assisted suicide" must consider not only the personal sanctity of human life but also the value society bestows on it. The ancients did not seem to view life as such a desirable thing that it should be protracted at any cost: Socrates himself took hemlock rather than stop teaching the youth of Athens. Aristotle proclaimed that "Doubtless the noblest kind [of death] ... is death in battle, for in battle a man is faced by the greatest and most noble of dangers. ... Properly speaking, therefore, we might define as courageous a man who fearlessly faces a noble death and any situations that bring a sudden death."^{4:69-70} Yet Aristotle goes on to say, "... to seek death as an escape from poverty, love, or some other painful experience is to be a coward rather than a man of courage."^{4:71-2} Given this statement, one would think Aristotle disapproved of suicide. The Epicureans taught that death was not a bad thing and was not to be feared. Epicurus taught that this fear must be banished to make "the mortality of life enjoyable"^{5:197} and paradoxically said:

And often, on the account of the fear of death, such a hatred of life and of seeing the light seizes human beings that, in their state

of agony, they commit suicide, forgetting that it is this fear that is the source of their anguish.^{5:197}

The Stoics practiced desensitization of the emotions, believing that "... one could still appropriately be motivated to avoid death and other dispreferred indifferents. If they come, one will not mind; but one can sensibly avoid them."^{5:399} Nonetheless, the Stoics actually praised suicide as a noble and heroic action in situations where it is considered necessary. Seneca expressed the strongest approval of suicide: "... by the courage and dignity of his own death he [ie, Seneca] punished the emperor [Nero], cheating him of the pleasure of watching his own suffering and humiliation."^{5:437}

The Judeo-Christian ethic expresses a clear position about suicide in any form. That ethic holds that our bodies are not ours to take but instead are merely loaned to us by our Creator. We are admonished to treat our bodies as sacred. As stated in Corinthians,

Shun immorality. Every other sin a person commits is outside the body, but the immoral person sins against his own body. Do you not know that your body is a temple of the Holy Spirit within you, which you have from God? You are not your own; you were bought with a price. So glorify God in your body.⁶

The philosopher Immanuel Kant believed strongly that each person has a duty to preserve his or her life. In addition to affirming that "... suicide is not inadmissible and abominable

because God has forbidden it; God has forbidden it because it is abominable in that it degrades man's inner worth below that of the animal creation,"⁷ Kant asserted that the moral act is not to preserve one's life when one has the immediate inclination to do so; the moral act is instead to preserve life, especially when one yearns for death.

... when adversity and hopeless sorrow have completely taken away the relish for life; if the unfortunate one, strong in mind, indignant at his fate rather than despondent or dejected, longs for death and yet preserves his life without loving it. [If he does this] not from inclination or fear but from duty, then his maxim has a moral worth.^{8:145}

In the debate on physician-assisted suicide, the Utilitarian method of John Stuart Mill⁹ could be used to argue either pro or con on the principle that a person must do the right thing to produce the greater good. In this context, "right" actions are those that produce more happiness than unhappiness. Actions are to be judged as "right" or "wrong" solely by virtue of their consequences: "right" actions are defined simply as those that have the best consequences, and nothing else matters.

Moreover, in Utilitarianism, "happiness" means intended pleasure and the absence of pain; unhappiness means pain and the absence of pleasure. A case could be made using the assertion that people who are in pain and unhappy at the end of their lives should have their lives shortened to relieve this pain and suffering and to de-

crease the resultant monetary costs to society. This scenario attempts to represent a "win-win" situation. Another case could be made using the assertion that "the right thing" would be to use any means necessary (short of death) to relieve pain and suffering and to both renew and reaffirm each patient's importance to himself or herself and to society. The book *Utilitarianism* contains only one reference to death or dying:

To those who have neither public nor private affections, the excitements of life are much curtailed, and in any case dwindle in value as the time approaches when all selfish interests must be terminated by death: while those who leave after them objects of personal affection, and especially those who have also cultivated a fellow-feeling with the collective interests of mankind, retain as lively an interest in life on the eve of death as in the vigor of youth and health. Next to selfishness, the principal cause which makes life unsatisfactory is want of mental cultivation.^{9:20}

Other notable views of mortality

Acclaimed writer James Baldwin, in his essay "Stranger in the Village,"¹⁰ elegantly expressed the value and worth of any life and even the sanctity of that final human condition we call death:

There is often something beautiful, there is always something awful, in the spectacle of a person who has lost one of his faculties, a faculty he never questioned until it

was gone, and who struggles to recover it. Yet people remain people, on crutches or indeed on deathbeds ...^{10:118}

Even though screen actor Christopher Reeve suddenly became quadriplegic after a fall from a horse,¹¹ he did not lose all sense of self. Although unable to perform even the most mundane activities as he did before, he holds on to life; in fact, he directs films, delivers speeches, and has become a great philanthropist and advocate in the area of disabilities—all the while maintaining a visibly pronounced presence of self.

Jean-Dominique Bauby was the 43-year-old editor of a popular French magazine when he suddenly experienced nearly total body paralysis (brain stem stroke) and could communicate with others only by the blink of one eyelid—yet he preserved not only a sense of self but also a sense of hope.¹² Written while he was in this stricken state, Bauby's memoir (published posthumously) is a testament to his love of life—a love he retained even though his body was left with much pain and little usefulness.¹² An excerpt, written shortly before his death, attests to his love of life:

Finally we reach the farthest point of our journey, the very end of the promenade. I have not insisted on coming all this way just to gaze at the flawless seascape. I have come to gorge on the aromas emanating from the modest shack by the path leading away from the beach. Claude and Brice bring me to a halt downwind. My nostrils quiver with pleasure as they inhale a robust odor—

intoxicating to me but one most mortals cannot abide. "Ooh!" says a disgusted voice behind me. "What a stench!"

But I never tire of the smell of french fries.^{12:88}

Most people hope for a "good death" however they may define it.

When faced with mortality, we all react in different ways. Most people hope for a "good death" however they may define it. Some spiritual traditions emphasize the importance of conscious preparation for death as a way to show respect for and acceptance of life's final adventure. Contact with death often gives us an opportunity to become more aware of spiritual realities. In "The Art of Living,"¹³ Thich Nhat-Hanh encourages us to savor or taste the moment, to be in it, to experience it to the fullest extent possible:

If we think of the future—of what we want to realize—or if we think of the past—our many regrets—we will lose our steps, and that would be a pity...

... Looking at a tangerine in this way [that is, with the practice of mindfulness], you will see that everything in the cosmos is in it—sunshine, rain, clouds, trees, leaves, everything ...

This is an exercise in the art of living. Everything we do can be like this.^{13:243}

Death is not the opposite of life—it is the opposite of birth.

With this concept in mind, realizing that dying is just another—albeit the final—stage of life, why would we choose to shorten it? Why not savor and learn from it what we can? If life itself has any meaning, then does its end have any less meaning? Death is as much a stage in life as birth; death is not the opposite of life—it is the opposite of birth. And like birth, death may be associated with pain, loss of control, and loss of personal dignity. Yet, we celebrate birth—why should a natural death be treated differently? Why not celebrate the dignity of life instead of “death with dignity”? Rabbi Yaakov Menken reminds us:

This fundamental truth applies to every human life, and at every moment. What we might perceive as the “quality” of life pales before the radiance inherent in the very existence of that life, regardless of illness or disability. (personal communication, October 7, 1999).^c

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Dilemmas for physicians, legislators, and interest groups

Freud himself once said that any true ethical choice involves agony. For the physician, a conflict exists between both the urge and the mandate to relieve pain and suffering and the centuries-old taboo against medical

killing, a taboo understood by many to be a fundamental of medical ethics. This taboo is the force that prevents physicians from administering lethal injections, even in those US states that allow capital punishment.

This taboo is specifically proscribed in the Hippocratic Oath, where it stands as a fervent promise of professional self-restraint: “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect ... In purity and holiness I will guard my life and my art.”¹⁴ This pledge clearly proscribes the practice of euthanasia and even the assistance or encouragement of a willing patient to commit suicide. The oath has also been reaffirmed in the professional codes of modern medical societies; the American Medical Association’s code of Medical Ethics, for example, explicitly precludes physician-assisted suicide, on the grounds that it is “fundamentally incompatible with the physician’s role as healer, and would make it difficult or impossible to control, and would pose serious societal risks.”¹⁵

On the other hand, the Hippocratic Oath and modern medical ethics understand well the limits of our medical art: To prolong the natural process of dying is inappropriate when death is unavoidable. Sometimes a fine line may exist between letting someone die and actively causing his or her death. Some decisions can be made only by the physician in consultation with both the patient and specifically permitted members of the patient’s family. Accordingly, to protect our desires and wishes,

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it is incumbent on all of us to compose living wills and advance directives. Forms to assist in composing these documents are available from most state medical societies and from the states they represent.

I believe that to legislate physician-assisted suicide may soon take us down that “slippery slope” from physician-assisted suicide to active euthanasia. One need only view the manner and extent to which economic incentives have recently affected our medical care system. Abuses committed by some HMOs are in the news almost daily. If physician-assisted suicide laws were enacted, would not these incentives soon convince others that they could avoid huge economic costs (or perhaps achieve financial gain) if a demise were to occur earlier rather than later, especially where an inheritance will be eroded by the expense of caring for long-lingering illness? Relatives and physicians may be influenced by these temptations even without being consciously aware that they are operating. In addition, regardless of whether the patients themselves are depressed (a common occurrence in lingering illness), they are invariably sensitive to—and even dependent on—the perceived desires of their loved ones. Patients fear possible loss of love; they fear abandonment and “want to do the right thing” so that they avoid becoming a burden either to their families

or to society. This sentiment was expressed memorably by the fictional character Willy Loman in the play “Death of a Salesman.”¹⁶ Believing that his family would be better off without him, Willy thought how the twenty thousand dollars from his insurance policy would solve all his family’s problems.

Some have suggested that the “slippery slope” danger has been exaggerated. These commentators assure us that the option of legalized assisted suicide would be reserved for mentally competent people who are terminally ill. However, definitions of both those concepts—“mentally competent” and “terminally ill”—are themselves subject to debate. For example, my son-in-law’s father was diagnosed as having terminal liver cancer and was given about a year to arrange his affairs in preparation for imminent death. Five years later, his main complaints are short-term memory loss and a different, real kind of difficult loss: his license to drive. The Hemlock Society, major proponents of the “Death with Dignity” movement, issued a press release favoring involuntary euthanasia of incompetent people. Dated December 3, 1997, the press release stated that courts should grant families permission to kill “when it is necessary to hasten the death of ... a demented parent, a suffering, severely disabled spouse or a child.”¹⁷ And this statement is not an aberration: On July 27,

1998, the Hemlock Society released another press release calling for legalization of assisted suicide for people with “incurable” conditions.¹⁷ Later that year (on October 15), the World Federation of Right-to-Die Societies issued the “Zurich Declaration,”¹⁸ which stated that “... all competent adults suffering severe and enduring distress [should be eligible] to receive medical help to die ...”¹⁸ Enacting either of these proposals into law would in effect create a right to receive assisted death on demand.

Oregon is currently the only US state that mandates availability of physician-assisted suicide. Twenty-seven reported legal assisted suicides occurred in 1999—up from the number (15 cases) reported in 1998 and nearly twice the number reported in the first year after the law was enacted.¹⁹ But as the report itself admits, “underreporting cannot be assessed, and noncompliance is difficult to assess ...”^{19:603} The primary reasons listed for justification remain consistent with those reported in 1998: fear of losing autonomy and inability to engage in enjoyable activities.¹⁹ Only seven of the patients whose lives were terminated had feared receiving inadequate pain control, and none of the patients had killed themselves because of uncontrollable pain¹⁹—the supposed reason for originally legalizing assisted suicide.

Perhaps even more interesting is the observation that more than half of these patients chose death to avoid becoming a burden to their families. “Thus, rather than being an act of ‘last

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resort’ when proper treatment doesn’t work, as the law was sold to Oregon voters, assisted suicide is becoming an alternative to proper treatment.”²⁰ Eighteen of the patients went to two or more physicians before finding a doctor willing to administer lethal drugs. In these instances, the patient-physician relationship was reportedly as short as two weeks. One patient, who had cancer and dementia, was found incapable of understanding the implications of her request. Her daughter pressured her mother’s health maintenance organization (HMO), which located another psychologist, who, while professing reservations, approved the assisted suicide.²⁰

For another patient, who suffered from amyotrophic lateral sclerosis (Lou Gehrig’s disease), the poison was delivered via Federal Express. However, the patient was unable to swallow the pills, and his brother-in-law was forced to come to the patient’s aid. Because of this event, a deputy attorney general wrote an opinion letter stating that Oregon might have to provide “reasonable accommodation” under the Americans With Disabilities Act. If the law becomes modified to allow active assistance in administering lethal drugs, we will have crossed the line from assisted suicide to voluntary euthanasia.²⁰

Organizations such as the Hemlock Society have stated²¹ that the threat of progressing from physician-assisted suicide

to unauthorized euthanasia is highly exaggerated and amounts to “scare-mongering,” but early reports from Holland arouse my apprehension. The following is taken from a report by Kass and Lund²² in the December 1996 issue of the magazine, *Commentary*:

Although assisted suicide and voluntary euthanasia by physicians are technically still against the law there, their practice has been tolerated, even encouraged, for nearly twenty years, under guidelines established by the medical profession. And although the guidelines insist that choosing death must be informed and voluntary, a 1989 survey of 300 physicians disclosed that over 40% had performed non-voluntary euthanasia and over 10% had done so five times or more. Another survey, this one commissioned by the Dutch government, provides even more alarming data: in 1990, besides the 2300 cases of voluntary euthanasia and 400 cases of physician-assisted suicide per year, there were over 1000 cases of active non-voluntary euthanasia performed without the patient’s knowledge or consent, including roughly 140 cases (14%) in which the patients were mentally totally competent. (Comparable rates of non-voluntary euthanasia for the United States would be roughly 20,000 cases per year.) In addition, there were 8100 cases of morphine overdose with the intent to terminate life, of which 68% (5508 cases) took place without patient knowledge or consent.

And why are Dutch physicians performing non-voluntary euthanasia? “Low quality of life,” “relatives’ inability to cope,” and “no prospect of improvement” were reasons physicians gave for killing patients without request; pain or suffering was mentioned by only 30%. Is there any reason to believe that Dutch physicians are less committed than their American counterparts to the equal dignity of every life under their care?^{22:24 d}

On February 26, 1999, California State Assembly Member Dion Aroner introduced Assembly Bill 1592, also known as “the Death with Dignity Act” (legislation similar to the abovementioned Oregon law).²³ Even though this bill died on February 3, 2000, and currently remains in the inactive file, we can expect similar legislation to be introduced in the future.

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Some suggestions on how to proceed

Patch Adams, MD, best expresses my feeling about the best way—not only for physicians but for all of us—to approach death and those who are dying:

Whenever I spend time with a dying person I have, in fact, found a living person. The young who are dying have been most vocal about this. I remember an 11-year-

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old girl who had a huge bony tumor of the face with one eye floating out in the mass. Most people found it difficult to be with her because of her appearance. Her pain was not in her dying but in the loneliness of being a person others could not bear to see. She and I played, joked, and enjoyed her life away. This is when I made a commitment to enjoy the profoundly ill and act normal around them.^{24:81}

Dr Adams' contention is that "Dying is that process [which occurs] a few minutes before death when the brain is deprived of oxygen; everything else is living."^{24:82} He would advocate a natural death, at home if possible; an intimate death experience planned by the family together could act as a form of cement, perhaps gluing back the family structure which is experiencing a major breakdown in contemporary society.^{24:84}

In the face of ever-escalating economic, legal, and technologically driven pressures, it is becoming increasingly more difficult for the medical profession to uphold its own ethical standards and for individual physicians to maintain their moral balance. Nowhere is this more important than in caring for those who are dying. As physicians and as a society, we must be both willing and able to provide adequate comfort and care for all our dying patients. As Kass & Lund²² point out, we should be trying:

"... to reverse the dehumanization of the last stages of life, instead of giving dehumanization its final triumph by welcoming the desperate goodbye-to-all-that contained in one final plea for poison..."

... Should we cave in, should we choose to become technical dispensers of death, we will not only be abandoning our loved ones and our duty to care for them; we will also exacerbate the worst tendencies of modern life, embracing technicism and so-called humaneness where humanity and encouragement are both required and sorely lacking.^{22:29 d}

At least to me, the moral, ethical, compassionate solution to pain and sickness entails improved caring, not sanctioned killing. ❖

^a Archives of Internal Medicine, July 26, 1999;159(14):1522. Copyrighted 1999, American Medical Association.

^b Archives of Internal Medicine, July 26, 1999;159(14):1524. Copyrighted 1999, American Medical Association.

^c Rabbi Yaakov Menken, Project Genesis, Baltimore, MD

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