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"DOCTORS SHOULD NOT PARTICIPATE IN ACTIVE PHYSICIAN ASSISTED KILLING"

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of

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in

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All eyes were on the Oregon ballot this past November 8, as Proposition 16 was introduced to the public. Should the Proposition pass, Oregon would become the first state to legalize physician-assisted suicide. At first glance, the Death with Dignity Act appears to offer the terminally ill patient additional freedom in deciding his or her destiny, but it in fact gives a free license for physicians to prescribe death with little if any scrutiny, responsibility, prosecution and even conscience.

Oregon is not the first state to make such a bold move toward legalizing physician-assisted killing. It is in fact the third state to do so. In 1991, Washington State proposed Initiative 119 which was essentially the same as the Oregon act; it met with defeat. Only one year later, California attempted the same thing with Proposition 161. It, too, failed.

The unfortunate outcome of the Oregon Act, however, is that it passed. With a small majority, Oregon has become the first U.S. jurisdiction to allow doctors to play an active role in killing a patient.

In order to understand the possible implications of such a proposition becoming law for the entire United States of America, we need only to look at the country of Holland which has allowed physician-assisted suicide for over ten years. The report of the Dutch Government's Committee to Investigate the Practice of Euthanasia provides us some alarming figures: "More than 1,000 cases per year of direct voluntary euthanasia- i.e. patients given a lethal injection without their knowledge or consent; 8,100 cases of morphine overdosage intending to terminate life, also without the patient's consent. In nearly half the cases of termination without consent, the families were not consulted or informed."1 Although the guidelines insist that choosing death must be informed to the voluntary, more than 40% of Dutch physicians have performed involuntary euthanasia. It must be further pointed out that the Dutch safeguards surrounding physician-assisted killing are more stringent than the proposition in Oregon.

Is the typical doctor in Holland more dedicated to the lives of his or her

patients than the typical American doctor? Is there any evidence that physicians here in America will avoid the same problems the Dutch have discovered with physician-assisted killing? Do we want our doctors to be agents of death rather than agents of life? Do we want to allow, even encourage our doctors to prescribe death to people racked with pain, depression and sickness rather than improve the quality of life? Do we really want to find out what our doctors will do once the laws against killing are removed? The law which passed in Oregon does not address these questions, nor make it possible for us measure these risks. The reporting requirements are inadequate at best. The verdict, "Death by physician-assisted suicide" will not appear on any death certificate. The words "Good Faith" protect all physicians against prosecution; perhaps even in cases of neglect or manslaughter. These are inadequacies that must be addressed before we allow our doctors to prescribe suicide.

Perhaps one of the least controversial and questionable characteristics of

the Oregon law is the requirement that anyone prescribed suicide must first request it. On further inspection, it is discovered that this requirement does little if anything to protect the patient and general public against poor judgment, mistakes and even subtle coercion. Most requests for death come during times of extreme duress and depression. It is during these times that an angry plea for death must be taken the least seriously. Who among us would not opt for an overdose of morphine when suffering from intense pain, severe depression, family burden or even financial hardship?

The answer to the problem of those suffering from such symptoms is not death. Doctors who are often the only constant contact for such patients would easily be able to engineer decisions for the patient by manipulating information in such a way as to paint a much better picture in favor of suicide. I am not suggesting in any way that the physicians of America are malevolent persons who have a desire to terminate their patients, but when we allow them this avenue of choice, we deal a fatal blow to the very trust that is the doctor

patient relationship. How easily will they be able to care wholeheartedly for their patients when killing them is always a possible route to take? Physicians tire of treating patients who are difficult to cure, or who resist their efforts. Wouldn't it become very tempting for a physician to think that death is the best answer for the derelict with no family dumped on his table from the emergency room? "Even the most humane and conscientious physician psychologically needs protection from himself and his weakness, if he is to care fully for those who entrust themselves to him."2

A much better solution to the above named symptoms would be rigorous training in pain control for our doctors. This is perhaps the most neglected part of a physician's training in our current system. A much more aggressive and personal program aimed at treating depression is the answer we need to find in lieu of killing those depressed. In cases of loneliness and financial hardship; company, care and love are much more desirable avenues for us to pursue rather than proposing death as an escape to every challenge.

Another point to the Oregon law which is not contested in any great degree is the confinement of the option of suicide to those who have less than six months to live. At first glance this seems an acceptable guideline to most people, but on closer examination, it is once again discovered that there is much room for abuse. What exactly does "less than six months to live" mean? Does it mean six months with active physician treatment? Does it mean six months with no treatment at all? Does it mean six months with active involvement in sustaining life such as feeding tubes? These questions are not adequately answered by the Oregon proposal. Furthermore, these predictions of how long a patient may live are notoriously inaccurate and easily proven wrong by thousands of people every year. Imagine the implications of a physician incorrectly diagnosing a disease, prescribing death and discovering at a later date that the problem was an ulcer rather than stomach cancer. We are not yet able to bring people back from the dead, and under the provisions of the Oregon law, this physician may not be prosecuted for such an error.

Would the family member of such a victim initially in support of physician-assisted killing be so now?

Upon even closer inspection of the "requested death" rule, it is found that those most eligible for such a humane death are those unable to request it for themselves. Persons with Alzheimer's Disease, senility, retardation, mental illness, or comatose are not able to voice such a request as death, and even in the event that they could, it would not be responsible medicine to allow such a request to be viable. We do not allow these people to be taken advantage of by the law, by criminals, by business deals or even family members who would exploit their condition. Why should we then allow doctors the possibility of doing just that? According to Doctor Leon R. Kass, "Lawyers, encouraged by cost containers, will sue to rectify this inequity. Why, will they argue, should the comatose or demented be denied the right to assisted suicide? Court-appointed proxy consenters will quickly erase the distinction between the right to choose one's own death and the right

to request someone else's.

Clever doctors and relatives need not wait for such legal changes. Who will notice when the elderly, poor, crippled, weak, powerless, retarded, depressed, uneducated, demented or gullible are mercifully released from their lives?"3

It seems the more scrutiny the Oregon law endures, the more alarming and far-reaching the consequences appear.

It is at this point that a clarification must be made regarding the situation of those who are in such degrading circumstances as to warrant death. There are those times when a patient is in such a degree of pain, suffering and humiliation that to artificially suspend life is as inhumane as the thought of taking life. It is in these cases that a distinction between active and passive euthanasia must be made.

The Oregon law opens wide the door of active euthanasia which carries with it the consequences explored above. However, for two thousand years,

doctors have allowed patients the right to die in extreme cases with little controversy. Is there a difference between killing someone and letting them die?

There are many today who conclude that there is no philosophical and theological difference between the two. Those who support the right to die, but strongly resist the actual killing of a patient are forced to answer within themselves why the one is acceptable and the other is not. The distinction is not easy to make. For example, let us assume that there are two cousins who have a wealthy uncle. Upon the Uncle's death, the elder of the two stands to gain a great fortune. There are few people who would **not** cry murder if the younger of the two cousins was to drown his elder cousin in the bathtub. But suppose the younger cousin merely watched as his elder cousin slipped, hit his head, and was drown of his own accord, merely refusing to offer assistance? Is the person in the second scenario any less guilty of murder than the first? This is a difficult question to answer. Glanville Williams, a renowned British

legal scholar, realized this difficulty when he said, "A toehold for euthanasia is provided by the practice of letting die, or what is now called the practice of euthanasia.....If this distinction between act and an omission is thought to be artificial, its artificiality is imposed on us by our refusal to accord the same moral freedom for action as we do for inaction. Pending a change of thought, the concept of an omission is a useful way of freeing us from some of the consequences of overrigid moral attitudes."4

While the distinction between passive and active euthanasia may in fact be hazy, there is a workable difference between the two. Ceasing medical intervention differs greatly from mercy killing. The cause of death in one case is the illness, in the other it is the physician. In ceasing treatment, the physician need not intend the death of the patient even if death follows. Death does not necessarily follow in all cases, either. In the case of Karen Ann Quinlan, she lived almost ten years after the court allowed her life sustaining respirator to be removed.

In the example of the two cousins, the victim was not depressed, in great pain or coerced into his position. Certainly we do not wish to kill patients with the same circumstances, but even in cases where they do exhibit these conditions, many times the answer is treatment other than death.

The pernicious benefactor in the case of the cousins had a nefarious motive to see his cousin terminated. While I will agree that it is **possible** for the same results to be obtained by the family member of a wealthy patient today, it is very unlikely under the rules of passive euthanasia.

Perhaps the late Joseph Fletcher said it best when he declared "Though the alleged difference between passive and active euthanasia is not a real one ethically or philosophically or theologically regarded, it is arguably possible to separate them for pragmatic reasons of prudence and workability."5

No one is going to argue that there is never a case where a physician or family member should not allow the natural progression of death to overtake a loved one, but it is quite a different thing to legislate an entire policy based on

a few exceptions to the rule. That is exactly what has occurred in Oregon.

This may not be a tidy ending to the debate surrounding the difference between active and passive euthanasia, but it is the ground that most people in America have come to stand upon when declaring their feelings regarding the euthanasia debate. Also concurring with the public majority is Yale Kamisar of Yale Law School who summed up his argument of euthanasia in these words: "This is not the conclusion I would have arrived at, but it seems to be the compromise position our society has reached in the struggle to preserve as many traditional restraints against killing as we can consistent with taking a humane approach toward seriously ill patients. This is not the way I would have liked to resolve the controversy, and I very much doubt that it is the way most logicians or philosophers would resolve it--but it may nevertheless be a pragmatic and defensible way to do so."6

To further investigate the possible difference between active and passive euthanasia and perhaps why a physician should never actively assist in killing

a patient, let us look at the analogies of other occupations. For example, why is it obvious to us lawyers are not allowed to perjure or disclose client relationships? Why is it scientists are not allowed to falsify data found while experimenting? When closely inspecting the role of a teacher, we find that their job is to teach, inspire curiosity, encourage, and arouse intellectually. Why is it reprehensible for a teacher to oppose learning, humiliate the sincere student, ridicule those who would learn, or **actively** oppose even the stubborn or slow student? The role of a physician is similar. In the Hippocratic Oath which every physician accepts, it simply states, "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this affect."7

The thought of a physician **actively** administering death to a patient is as reprehensible and affronting to medicine as a teacher opposing the learning of any student.

Many difficulties with the proposal in Oregon have been examined to this point, and it would appear that there is little argument to support such a

policy change. Why then the support for active euthanasia? A possible answer emerges when one examines the need for mercy killing. Many people today know of someone or have a loved one in a position where the inhumane suspension of life is distasteful. In their fear of no avenue for a humane release from this situation, many Americans feel that a law such as the one in Oregon is needed. The first inconsistency with this thinking emerges when we try to gauge the so called need for mercy killing. Evidence to support active euthanasia can only be gathered if the category of "euthanizable" people is clearly defined. This is very difficult information to quantify, however, if we precisely define this category, the need for mercy killing seems greatly exaggerated.

Another reason for the support of active euthanasia stems from a philosophical argument advanced by the proponents of mercy killing. Why, they argue, do we put animals out of their misery, but cringe at the thought of doing so with our fellow man? Are we humane only toward animals? Why is

it the veterinarian has no ethical problems with such behavior? The answer lies in the distinction between man and animals. It is precisely because they are not human that they are treated only humanely--not humanly. An animal does not know it is dying-therefore we put it to sleep. Because and animal cannot live deliberately, we must make decisions for it. This is not the case with humans. We are able to live deliberately and consciously. When a human being asks for death, he displays something that differentiates him from the animals. Humanity is owed humanity. In the words of Leon R Kass once again, "What humanity needs most in the face of evils is courage, the ability to stand against fear and pain and thoughts of nothingness. The deaths we most admire are those of people who, knowing that they are dying, face the fact frontally and act accordingly: they set their affairs in order, they arrange what could be final meetings with their loved ones, and yet, with strength of soul and a small reservoir of hope, they continue to live and work and love as much as they can for as long as they can."8

We must not allow our doctors to kill those persons who have challenging circumstances or failing health merely as a supposed convenience. We must find other ways to deal with the challenges of pain, loneliness, financial hardship and other problems associated with humanity. We must not adopt an attitude of "If you can't cure me, kill me." This is also the feeling that the physicians of Oregon have as well. To date, Proposition 16 has been repealed by the state of Oregon, and is under reconsideration. We must not allow such a proposition to become law in America.

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