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Physician-Assisted Suicide: Present Politics and Future Policy

by

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Bachelor of Science in Nursing, 1988

A thesis submitted in partial satisfaction of the
requirement for the degree of

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Abstract

**Physician-Assisted Suicide:
Present Politics and Future Policy**

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Professor Eric Rakowski, Chair

1993

This thesis provides a survey of current debate and offers possible solutions to the pressing question, does a patient have the right to seek the assistance of a physician in ending his or her life? Because the answer to this question is broad in scope and complex in nature, the thesis has been divided into five chapters to make it more workable. After an introductory chapter, the second chapter presents and critiques the strengths and weaknesses of the moral arguments against euthanasia, from which I conclude that euthanasia is morally permissible. The third chapter furnishes the findings of a small opinion survey revealing U.S. physicians' attitudes and practices regarding physician-assisted suicide. In comparison, the attitudes and practices of Dutch physicians concerning euthanasia are portrayed in the fourth chapter. Their experience is unique in that euthanasia has been openly practiced and tolerated in The Netherlands over the past twenty years. Based on my personal observation and research, I conclude that with modifications, the Dutch approach could serve as a model for future policy in the U.S. Thus, the fifth and final chapter concludes by fashioning general recommendations for the inevitable practice of legalized physician-assisted suicide in the United States.

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Present Politics and Future Policy**

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Chris Ciesielski Carlucci

DEDICATIONS

As much as this thesis is a written document,
it has also been an invaluable process --
one that without the support and encouragement of
the following persons, would not have been possible.
I therefore gratefully dedicate this thesis to:

Thomas F. Carlucci, my husband
my thesis committee,
and my dearest friends at the Joint Medical Program.

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efforts,

and

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energy this work took away from them.

I. INTRODUCTION

All's well that ends well.

- *William Shakespeare*

I. INTRODUCTION

CHAPTER I

Questions that arise from contemplating issues of death and dying and more specifically, how to approach human suffering at the end of life are not new. Persons throughout time and across varied cultures have found their own way to address these queries. Each society has made decisions about assisting the dying based on a spectrum of priorities that span matters of survival and resource allocation to upholding religious or philosophical beliefs. This thesis provides a survey of current debate and offers possible solutions to the question of respecting the right of a suffering patient to seek the assistance of a physician in ending his or her life. This introductory chapter outlines how I set out to meet these objectives in subsequent chapters throughout the thesis.

CHAPTER II

Before directly confronting the core question of whether physician-assisted suicide should be tolerated by society, it is necessary to first establish that it may be morally permissible for physicians to take patients' lives in exceptional circumstances when requested to do so. The second chapter examines the validity of current arguments against a physician's either prescribing or administering a lethal dose of medication in response to a patient's request. I will examine the strengths and weaknesses of each objection. After careful examination, I conclude that physician-assisted

suicide is morally permissible. Indeed, under certain circumstances there is a morally compelling argument that there exists an obligation for a physician to assist in the patient's death.

I propose that the necessary components to permit physician-assisted suicide are a request from the patient to end his or her life and the willingness of the individual physician to assist. The justification for honoring a request derives from a conflict of duties, compassion for suffering, and respect for autonomy. A physician who is morally opposed would be excepted from any requirement or obligation to participate. Although, under circumstances where society accepts the right to choose to die, a strong argument can be made that the physician who is morally opposed would have some obligation to refer the patient to another physician whose beliefs are in closer alignment with those of the patient making a request.

CHAPTER III

Given that society does not generally share one universal moral construct, I am naturally confronted with the question, what are we, society, to do? The first step in resolving conflicting viewpoints is to find out what others, particularly physicians, think. Chapter three presents and analyzes a sampling of current physicians' attitudes and practices in the United States on the topic of physician-assisted suicide. The information comes from a modest opinion survey distributed to physicians at an international bioethics meeting in April of 1990. This data, along with similar research reveals physicians' concerns about participating in life-ending activities. The survey results forge a starting point towards

understanding the moral, cultural, and legal implications of physician-assisted suicide should it be legalized in the United States.

CHAPTER IV

Because we are fortunate to be able to directly examine how others are already handling the practice of euthanasia, we are not limited to discussing the topic in an intellectual vacuum. This is made possible through observing the experience in The Netherlands where euthanasia is openly debated by the medical and legal professions, in Parliament, and by the public. Moreover, euthanasia has been tolerated and practiced in The Netherlands for the past twenty years, despite its formal illegality. The Dutch experience is particularly rich in that it provides an opportunity to view the policies designed to further the ends that I argue are morally proper.

This fourth chapter explores the Dutch approach to euthanasia. It consists of interviews in The Netherlands conducted during the summer of 1992, a review of pertinent literature, reporting the findings of a national Dutch governmental study on euthanasia and other medical decisions at the end of life, and updates current Dutch debate. Although this information is presented in a condensed fashion, I emphasize and substantiate my overall impression that the Dutch way of handling euthanasia is working well in that society.

CHAPTER V

The most difficult aspect of this thesis, once convincing moral arguments have been established, is how to practically respond to the requests of dying patients for physician-assisted suicide not having reached societal consensus regarding the appropriateness of legalizing this practice within American society. Chapter five brings the thesis to a cohesive end by exploring what could be, and perhaps should be done with regard to the future practice of physician-assisted suicide in the United States. Finally, I identify the difficulties posed by both American attitudes and practices, as well as the remaining challenges faced by the Dutch as issues that demand further consideration in future policy-making. This final chapter highlights the current legal status of suicide, physician-assisted suicide and euthanasia at the state and federal levels in the United States. The thesis concludes with general recommendations about the potential, likely inevitable, practice of physician-assisted suicide in the United States.

II. MORAL ARGUMENTS

*Razors pain you;
Rivers are damp;
Acids stain you;
Drugs cause cramp.
Guns aren't lawful;
Nooses give;
Gas smells awful;
You might as well live.*

- Dorothy Parker

II. Moral Justifications for Physician Aid-in-Dying: "Do No Greater Harm"

Abstract

Recent events such as Dr. Kevorkian's highly publicized use of his "suicide machine", two state initiative which would have legalized physician-assisted suicide, and several related articles in the *New England Journal of Medicine (NEJM)*, attracting publicity and provoking discussion, have advanced the arguments for and against physician-assisted suicide. Public discussion of abortion over the years provides a parallel.¹ The abortion debate demonstrates that moral positions are not black or white. Claiming to be purely "pro-choice" or "pro-life" is difficult in view of the complexities involved in determining whether abortion is morally justifiable.

Like abortion, positions on physician-assisted suicide at the extreme include pro-life and pro-choice. These span a continuum from unconditionally objecting to physician-assisted suicide to not objecting at all. If someone is a conditional objector, the challenge is to explain why and where he or she would draw a moral boundary at any given point. In this chapter, I examine the merits and shortcomings of arguments against physician-assisted suicide.

In conclusion, I argue that one of the most persuasive moral arguments supporting justification of physician-assisted suicide is based upon the

¹ Rosenblum & Forsythe, 3.

principle of do no greater harm. In short, with the advancement of medical technology, dying is no longer left to mother nature. Because the physician, via medical intervention, often times is responsible for prolonging life, he or she is correspondingly responsible for extending a patient's life to the point where the patient endures suffering that would not have resulted if the patient died earlier. Accordingly, a persuasive argument is made that the physician has a moral obligation to relieve that suffering. Hence, the physician ought not do a greater harm by rejecting the patient's plea to end suffering. For physicians who are willing to participate, I argue that they can act in a way that is consistent with their role as compassionate healers. In substantiating this line of reasoning, I invoke the patient's claim to autonomy, compassion for suffering, the concept of a minimally complicated death, and a physician's conflict of duties. I recommend that physician involvement in physician-assisted suicide be determined by an individualized approach.

Introduction

The distribution of opinions regarding physician aid-in-dying (P.A.D.) resembles a bell shaped curve.^{Note 1} For the purposes of this thesis, I will use the term P.A.D. in general discussion. If I deviate from this, it will be to emphasize one of the more specific definitions. The distribution of stands regarding euthanasia is described in the following way. A limited number of people unconditionally object to all types of P.A.D. Probably the majority of people conditionally object and another minority do not categorically object. Morally speaking, it is important to understand why one takes any

Note 1 See definitions at the end of this chapter.

given stand. Starting at one end of the spectrum, the initial question to be addressed is whether suicide is ever morally permissible. That is, do I have the right to take my own life? Assuming effective arguments are made supporting the moral permissibility of suicide, the question arises, do I have a claim to assistance in choosing to die? Assuming a majority would answer, "perhaps or sometimes", the more definitive question to be answered is where do conditional objectors draw the line, and are their restrictions morally sound?

The objective of this paper is to expose the claims, strengths, and weaknesses of the continuum of arguments against P.A.D., and upon competition, take a stand myself. After rejecting the validity of arguments prohibiting P.A.D., I align myself with those who do not conditionally object. A conclusion is presented which argues that P.A.D. is not impermissible and moreover, that any imposed limitation on who is eligible to receive P.A.D. is superficial to any moral arguments. Finally, I recommend utilizing an individualized review of the circumstances to determine the moral permissibility of physician involvement in P.A.D.

The Question of Suicide

The core question concerning the moral permissibility of suicide is: do I have the right to take my own life? Those unconditionally opposed to suicide, and therefore P.A.D., say no. Objectors argue that life is sacred and thus cannot be taken at will. The rationale for this position varies. Those relying on religious convictions argue that the timing of one's death is not subject to self-determination but rather spiritual predetermination.

This is based on the concept that some believe that only a god who gives life may rightfully take it away.²

For others, the objection to taking life prematurely lies in the significance of experiencing the dying process. They believe it is spiritually valuable to find meaning in suffering. While no one would deny an individual the right to choose this experience, the issue of allowing P.A.D. concerns the person who does not want to explore this option. The pivotal question is whether an individual who believes suicide is inappropriate for himself may rightfully object to others choosing the nature and timing of their deaths. For some, the answer is yes, based on the argument that permitting suicide devalues life.

This position seems particularly harsh and consequently unworkable in a pluralistic society that highly values protection of personal autonomy. This position is further diluted because it runs on a collision course with the secular notion of separation between church and state. For instance, keeping P.A.D. illegal based on religious grounds which are not shared by others is unreasonable. For these reasons not allowing suicide and therefore not allowing P.A.D. based on religious objections alone appears unjustified. In making decisions regarding the end of life, personal autonomy should be protected unless society can demonstrate a substantial reason not to allow it.

Other arguments made against suicide date back to Aristotle who argued suicide undermines commitment to a community.³ To this Hume counters, " a man who retires from life does no harm to society, he only ceases to do good."⁴ Contemporary society has faced a similar issue where

² Devettere, 147.

³ Reichel & Dyck, 1322.

⁴ Donnelly, 43.

the autonomy of the individual directly conflicts with potential state interests: passive euthanasia. In the case of withholding and withdrawing medical care with an inevitable consequence of death, the moral and legal trend appears to support individual rights with limited exceptions. Despite lack of consensus on legalizing P.A.D., there is reason to believe that this precedent of recognizing individual autonomy in making decisions concerning the end of life will not change when applied to active euthanasia.^{5,6} I believe this trend is a morally advisable course, and discuss this further in subsequent sections.

Vaux explains that despite dogmatic doctrine against ending life, religious tradition may permit it in exceptional cases.⁷ The challenge of defining an exceptional case will be addressed later in this chapter. To that end, Hume states "that suicide may often be consistent with the interest and with our duty to ourselves, no one can question, who allows that age, sickness, or misfortune, may render life a burden."⁸ Having dismissed the argument against the interest of the state, the argument of finding meaning in suffering, and given Vaux's exception, it is reasonable to assume that suicide is not an absolute wrong.

I am inclined to respect individual autonomy particularly when, as Hume argues, society is not harmed by the loss of one of its members. Certainly more depth to the arguments against suicide could be offered. However, due to the limitation of the moral argument chapter of this thesis, I establish that the arguments against suicide are not sufficiently compelling to deem it uniformly impermissible. More importantly for the

⁵ Rosenblum & Forsythe, 3.

⁶ Harvard Law Review, 2033.

⁷ Vaux, 20.

⁸ Donnelly, 44.

purposes of this thesis, I will devote more time speaking to the moral permissibility of assistance in suicide.

My intention in writing this chapter is not to persuade someone who does not already share a view that is at least similar to my own, rather it is to inform the reader of the current moral considerations. Therefore, I am taking some liberty in assuming that the reader will grant that for the sake of argument and advancing to further objections that suicide is not an absolute wrong. In short, I defend this assertion as a reasonable one. Considering suicide is not always impermissible, objectors must provide a compelling argument to override my right to commit suicide. I submit they fall short of the mark. Therefore, I will proceed to determine if moral arguments will persuade me to deny the extension of Hume's perspective on the issue of suicide to passive and later to active euthanasia.

Euthanasia is Not the Answer: the answer is pain management

Many physicians, like David Cundiff, author of *Euthanasia Is Not The Answer*, argue that patients would not request P.A.D. if pain could be better managed.⁹ This premise underlies their unconditional objection to P.A.D. I submit that pain management is not exclusively the answer either. Patients frequently make requests when they are pain free, but feel they have lost their dignity. This type of suffering certainly can equal, or perhaps at times even outweigh that of physical pain. The fact that this suffering would influence a patient to choose to die may lead to suicide or to a request for P.A.D. The point is that in either case, pain management does not place a valid halt on exploring the moral permissibility of P.A.D.

⁹ Cundiff, 1992.

Cundiff argues that the issue is not restricted to managing pain itself but also includes managing patients' fear of anticipated pain, physicians' lack of knowledge of the latest pain management techniques, the difficulty or hassle for physicians in prescribing controlled substances such as narcotics, and general access to health care for patients who require pain management. All of these obstacles demand attention; fair enough. Hospice care admirably goes a long way in specifically tackling some of these concerns. Clearly, it could not be morally permissible for a physician to grant a patient's request for P.A.D. if his or her needs for good medical care were not adequately managed.

Unfortunately, the current health care system in the United States does not meet high standards for the already under-served. However, I believe both the issue of adequate access to health care and P.A.D. need to be addressed simultaneously. I see these as both goods, not necessarily mutually exclusive goals. If an under-served patient requests P.A.D. because of suffering, all attempts to meet his or her biopsychosocial needs must be addressed first. Having said that, there is evidence to support the claim that even when valiant efforts are made to meet the patient's medical, psychological and spiritual needs, requests are still made.¹⁰

Requests are not always quashed by the simple issue of pain management. For instance, effective pain management may result in extreme somnolence, at times even to the point of narcotic coma. For some, this is an acceptable expense comparable to any other unavoidable medication side effect. For others, this side effect is intolerable. Some patients would rather die than spend their remaining days in such a non-responsive state. Meaning in life for some is measured by quality not

¹⁰ Van der Maas, et al., (1991) 672.

simply by duration. This group may define the quality of life through the ability to do the activities that they love most. An avid reader, for example, may find a life without the ability to see or read not worth living.

Another reason often given for making a request is the desire to die with dignity. This is a compelling argument. Dignity and quality of life definitions will have as many different meanings as there are patients. I make no attempt to define these terms here. Instead, I offer the factitious case of Mr. D., a young gay gourmet chef.

CASE: Dying Mr. D.

Mr. D. comes to the hospital emaciated. He has no measurable T cell count. Mr. D. was diagnosed HIV positive 7 years ago, and now he has full blown AIDS. He has opportunistic infections including thrush (an oral fungal infection) and Mycobacterium avium-intracellulare (M.A.I.). Because of these, he has painful ulcers in his mouth and esophagus, he is unable to swallow, unable to absorb effectively through his intestines, and has lost control of his bowel function. One of his joys in life as a chef is tasting food, unable to do this he refuses to be fed intravenously. Too weak to move about, he wears adult diapers to prevent soiling his bed linen with bouts of uncontrollable diarrhea. He can't tolerate having his family and the nursing staff clean him after such "accidents." He cries every time he forcibly vomits black bile several times a day. Despite this intermittent discomfort, he feels his pain is being well managed.

He has seen the torment of the final stages of AIDS through close friends of his that have died. Although he grieves the losses he has already incurred and the anticipated losses he expects, he is not clinically depressed. Until this admission he has been a fighter in this battle against AIDS. His sensorium is clear and he is painfully aware of what is likely to come in his remaining days. He has made a thoughtful decision to choose the nature and timing of his death. He feels he is no longer living a dignified life and cannot experience the pleasure in things that were meaningful to him. But now in order to die, he needs assistance.

Mr. D.'s story is realistically similar to many current AIDS patients. The medical team has provided all the curing and caring it can to Mr. D. Yet, his desire to end life stems from a loss of dignity and poor quality of life. Medicine has nothing left in its power to restore that for Mr. D. His decision stands firm.

If the medical community played an active role in providing Mr. D. experimental medications, hope, and encouragement to continue living, the result would be the extension of life for an indeterminate period of time. Where a medical community intervenes to extend life, is it now morally obligated to intervene to end life if requested to do so? In formulating a response to this question consider a commonly referred to legal doctrine which states that if you render aid which leaves a person in a worse position than if you had not intervened at all, you have an obligation to finish delivering the aid. Take the following example:

X is struck in the head by a falling box in a department store. X is knocked unconscious. Y says that she will drive X to the hospital. Other bystanders offer to do so as well, or to call an ambulance. Y nevertheless insists she'll drive X. En route to the hospital, Y recalls that she has a tennis match in ten minutes, so she stops her car and sets X by the side of a building along a deserted street. Nobody happens by for the next hour, and X consequently suffers more serious injury than he would have suffered had he been taken to the hospital directly. Here, X would have a winning claim against Y under all or most states' laws. X would likewise have a moral claim against Y.¹¹

¹¹ Rakowski, correspondence dated January 4, 1993.

In this example, X is left in a worse situation than if Y had not intervened. Thus, Y harmed X. Likewise, if some patients define life by its quality then a solid claim is made that when a medical community participates in extending life beyond a point where quality no longer exists, physicians should have an obligation in eliminating the suffering at the end of life. This analogy will be elaborated upon in a later section entitled "Do No Harm." For the purposes of this section, I have established that even if pain management is achieved, the patient's perception of suffering along with an autonomous decision to end life may constitute a moral basis for physicians to honor a patient's request for assistance in dying.

Good Intentions: a closer look at the principle of double effect

We now turn from the question is it permissible for me to take my own life to is it permissible for you to take my life if I ask you to? Consider this, is it morally permissible for a physician to eliminate Mr. D.'s suffering by injecting continuous doses of morphine if the physician's unintentional secondary result would be hastening his death? Then ask if the same intervention would be morally permissible if the secondary effect was intentional by the patient's request. The Doctrine of Double Effect (DDE) would allow the former, but not the latter. This principle is the first in a series of arguments which offer conditional objections to helping patients die. I offer that this doctrine provides a distinction that does not supply any morally meaningful dissension to allowing P.A.D.

The main components of DDE are as follows: a) the intended final end must be good, b) the intended means to bring it about must be morally acceptable, c) the foreseen bad upshot must not itself be willed, and d) the

good end must be proportionate to the bad upshot.¹² Let us continue to examine the contemporary intervention of administering morphine in analyzing the doctrine. Morphine is administered by continuous intravenous flow (a "drip" method) to relieve pain (intended good end) but in doing so hastens death (the unintended allowed bad upshot). Many physicians see this as an acceptable procedure and rely on their subjective intentions to distinguish between this good action and other disputable bad actions that more directly hasten death. Whether or not DDE can be used to discriminate such actions as being morally distinguishable remains to be seen.

The principle of DDE is flawed in at least two applications with regard to the morphine drip. First, applying it to some cases can lead a dogmatic doctronist down the wrong path and, second, it does not absolutely exclude the permissibility of P.A.D. To begin, the analysis of the following case according to DDE yields faulty results. I will summarize the case below.¹³

CASE: Pregnant Ms. P.

Ms. P. stands to die if her pregnancy is not immediately terminated. In the first condition, she has invasive uterine cancer and a physician must perform a hysterectomy to prevent metastatic spread. The fetus stands to die from this hysterectomy (HD). The second condition is where the fetus is engaged in the uterus and cannot be removed but through a craniotomy death (CD) which is necessary to save Ms. P.'s life.

With respect to Ms. P.'s need to save her life at the expense of her fetus, traditional discussions of the case applying DDE allow for HD, but not for CD.¹⁴ Proponents of DDE would argue that in HD the doctor's intention is

¹² Quinn, 334.

¹³ Quinn, 336.

¹⁴ Kamm, 576.

to remove the uterus to save the mother's life whereas in CD, the doctor's intention is to remove the fetus to save the mother's life. The former according to DDE is acceptable but the latter is not based on the argument that although both may be fatal to the fetus, in HD the effect is not intended to be fatal whereas in CD it is. This distinction is nonsensical. The doctor's primary objective in both cases is to save the mother's life, not to harm the fetus.

Moreover, the fact that the medical instruments must be delivered directly to the fetus in one case (CD) and indirectly via Ms. P.'s uterus in another (HD), both of which result in the fetus's death, is nothing more than a linguistic medical, and not a moral distinction. The means by which the mother's life must be saved are dependent on what the medical predicament is. The means are not optional, but rather follow reasonable medical standards of care. There is only one way to save Ms.'s P.'s life in each case. To rest the distinction of these cases on the doctor's intent is faulty. The distinction between HD and CD is in the means. The consequences are the same. And the doctor is not intentionally choosing between means to save the woman's life but rather is following procedures dictated by good medical care appropriate for the circumstances in each case. If HD is permissible by DDE and the doctor could choose to do a c-section saving the fetus before removing the uterus and does not, he would be responsible for the fetus's death. The same would also hold for the doctor in the CD case. Thus, I do not believe that DDE makes any helpful distinction between these cases.

Beauchamp and Childress illustrate that many use the example of HD and CD to argue why DDE is not morally relevant.¹⁵ Once it is deemed

¹⁵ Beauchamp & Childress, 105.

morally permissible to save Ms. P.'s life at the expense of her fetus (HD according to DDE) then it should not matter whether the death of the fetus is by HD or CD. A further objection is offered, suppose that if Ms. P. was misdiagnosed and in fact her life was not in danger, taking the fetus's life would be equally regrettable regardless of the method used.¹⁶

Arguments supporting DDE often rest on how closely the bad effect is related to the agent's ultimate goal. This foundation is tenuous at best. In HD the doctor intends to remove the uterus to save P.'s life and in doing so the fetus indirectly dies. What makes CD impermissible under DDE is that the doctor intends to do a craniotomy which directly would kill the fetus to save Ms. P.'s life. This distinction borders on the absurd because it merely identifies the immediacy of the fetus's death not whether the fetus has any chance of surviving, while the doctor's intent is unchanged: saving Ms. P.'s life.

Having utilized the case of Ms. P., the DDE has not proven to be a convincing or helpful principle. As a second line of objection, even if DDE were a sound moral theory, it does not bar the permissibility of P.A.D. Let us attempt to apply the criteria. a) *The intended end must be good.* What if the intended final end was defined as ending suffering through a lethal injection? This of course assumes that killing is not an intrinsically moral wrong. This assumption is sound considering the exception of killing in self-defense. b) *The means must be acceptable.* Kamm argues that if the greater good becomes great enough, even a means which has something intrinsically wrong about it may come to be justified, thereby allowing lethal injections.¹⁷ Kamm's interpretation would allow for the moral

¹⁶ Rachels, 79.

¹⁷ Kamm, 579.

permissibility of P.A.D. as a last resort in cases of exceptional suffering, c) *The second bad effect must not be intended.* The beneficial act of relieving suffering is brought about only with a second effect of ending the patient's life. The physician's goal is to relieve the patient's suffering. It is not the objective of physicians to kill their intractably ill patients. For instance, physicians would not object to a miraculous event that would return the patient to his or her formerly healthy self. d) *The good end must be proportionate to the bad upshot.* Extenuating circumstances can leave physicians with no alternative but to end the patient's life in order to remove suffering. If a cure existed, the physician's action would not call for a lethal injection to meet the patient's needs. Few argue that the compassionate act of P.A.D. is morally wrong in such situations. Objection more often arises to the institution of a policy which would authorize such killings. This argument will be discussed in a later section.

In brief, the principle of DDE can be summarized by stating that it is always wrong to intentionally do a bad act for the sake of a good consequence but it may be permissible to do a good act that has a bad consequence.¹⁸ Whereas, Kamm argues that sometimes doing something with the intention of causing harm occurs in a particular structure of events which makes it permissible.¹⁹ Kamm offers a persuasive justification for P.A.D. -- review of individual circumstances. While I have demonstrated that the principle of DDE may not absolutely exclude P.A.D., strict applicationists may not go along with some of my assumptions in superimposing the criteria of DDE to P.A.D. That is okay, because they face the same problems I do with DDE.

¹⁸ Glover, 87.

¹⁹ Kamm, 571-585.

Flaws in the DDE include the impossibility of defining a list of absolute "bad acts", inability to make clear distinction with a difference that counts, failure to match intuitive conclusions in some cases, and the ambiguity associated with proving intent. For example, the lack of consensus on what defines a bad act from a good or neutral one leads me to be less than optimistic that such a list could be devised. Thus, for these sound reasons, I reject DDE and argue for a more direct and clear moral principle to judge whether P.A.D. is justifiable.

DDE clearly is employed to justify the morphine drip. Passive euthanasia is also justified under DDE because it defines the good effect as being the removal of futile medical care and the bad effect as allowing the patient to die. Active euthanasia is rejected under the DDE by opponents who argue the primary intent is to end life, and therefore not allowed under condition "c". However, the principle of DDE could apply if the primary intent is to relieve suffering. The case of euthanasia should not be judged morally permissible or impermissible under DDE because the intention of using either morphine or another medication in a lethal dose cases could both be utilized to end the patients life. I find DDE offers no morally significant distinction between active and passive euthanasia.

Let me close by stating that those who rely on DDE to support their present activity with passive euthanasia tragically misinterpret its justification and application. Involvement in a morally impermissible act should never be able to be dismissed because of a resounding claim of "I didn't mean it." My concern is that DDE will wrongly lead some down the path where all aspects of an action or inaction that do not in the strictest sense contribute to an agent's goal will be trimmed away as unintentional and therefore permissible. Is it not better to act in intentional ways, thus explaining why

actions are permissible, rather than falling back on arguments that allow actions that are unintentional and therefore seemingly morally defensible? I submit it is. In sum, DDE is nothing more than yoga for the conscience and its effect only temporary.

Holding the Line: passive euthanasia is 'letting die' not killing

Persons making a trajectory at this juncture in the continuum may find Mr. D.'s circumstances compelling but would argue that holding the line at passive euthanasia has merits that outweigh his individual situation. At this line, it would be permissible, for example, to remove Mr. D. from a respirator. But the fact is, he isn't on one. If he had a feeding tube in, it would also be alright to remove that. But, he doesn't have one of those either. What he does have is an existence that he finds intolerable, but some contend physicians must not be allowed to remove that. Arguments here place great emphasis on distinctions between acts of omission versus acts of commission. For example, it is permissible to discontinue "providing ventilation" as an act of omission. However, it is difficult to conceptualize how the same act redefined as "removing a ventilator" is a passive event.²⁰

A similar distinction is made between "letting die" and "killing." To a consequentialist, this line of reason may not rest on solid ground because the end result in both cases is the patient's death. An example involving Ms. P. will help to illustrate the problem with this kind of distinction. It will not seem intuitive to many that it would be more permissible to "allow" Ms. P. to die rather than to "kill" her fetus by performing a craniotomy,

²⁰ Harvard Law Review, 2028.

while it would be permissible to let the fetus die as the result of a hysterectomy.

Philippa Foot adequately articulates the distinction between letting die and killing. However, Glover's challenge to Foot is not about whether a distinction exists between these terms, but whether the distinction matters.²¹ Foot explains that the distinction between what we do and what we allow is the critical point.²² With respect to euthanasia, this differentiation has led to the distinction between active and passive. She elaborates by defining negative duties which include refraining from harming people versus positive duties that include helping others.²³ Although, she does not agree that these can be boiled down to simple clarification between acts and omissions. Indeed, two people can view the same act of P.A.D. differently: one as a positive duty and the other as a negative one. Because some define P.A.D. differently, the theory and application of act versus omission is too simplistic and of little help to those attempting to resolve this moral impasse.

Susan Wolf implies that we have only made progress toward a public acceptance of "passive euthanasia" because we have somehow promised to hold the line there.²⁴ I do not believe any such promise was made by the medical profession. She further argues that we would not have made this progress without such limitation, and she fears that if we move forward all will be lost.²⁵ Wolf is objecting to active euthanasia by invoking the slippery slope argument and suggests that we should hold the line at passive

²¹ Glover, 88.

²² Glover, 97.

²³ Glover, 97.

²⁴ Wolf, 13.

²⁵ Wolf, 13.

euthanasia. Not having substantiated any moral distinction between active and passive euthanasia, Wolf gives me no compelling reason to draw the line here. Moreover, it is clear from public opinion polls that the majority of persons in the U.S. believe that a patient should have the right to seek assistance in death from their physician if they are suffering greatly with a terminal illness. At the same time, it is recognized that the public has a concern about safeguards. This does not exclude the likelihood of the public's passing a death with dignity initiative that has adequate safeguards.

A further argument is that the public may not distinguish between active and passive euthanasia. Certainly for the patient and the family members, if death is the end result that is where the impact lies not simply in how it came about. Patients request P.A.D. for the same reasons they refuse life saving treatment. Many feel a patient's desire, not the type of treatment, should be the focus and this greatly, but not exclusively, has been the basis of legal distinction.²⁶ The suggestion to base treatment decisions and interventions on patients' desires at the end of life is reinforced clinically by Cassel's research. She found that patients, their friends, and families do not make a distinction between physical and nonphysical sources of suffering in the same ways doctors do.²⁷

Two recent *NEJM* articles can be evaluated for their effectiveness in distinguishing between killing and letting die. One recent article by Quill, Cassel, and Meier suggested "pushing the line" in allowing physician-assisted suicide to be defined as letting die but not killing.²⁸ This article outlined how physician-assisted suicide could be justified and put into

²⁶ Harvard Law Review, 2027.

²⁷ Cassel, 639-45.

²⁸ Quill, et al., 1381.

policy in the U.S. The authors of the first paper hold that it is permissible to move from passive euthanasia to physician-assisted suicide (prescribing only). Quill and others state that allowing the prescription, but not the administration of a lethal dose of medication provides a balance between a humane response to requests of patients, and the need to protect vulnerable persons.

Distinctions concerning P.A.D. remain murky. The practice of what some define as passive euthanasia in certain circumstances appears to cross over to more active intervention. Another *NEJM* article by Truog, Berde, Mitchell, and Grier outlined guidelines for administering barbiturates to the terminally ill.²⁹ Indeed, this second article hints at situations which lend themselves to being defined as active euthanasia via the administration of barbiturates.

Arguments for holding the line at physician-assisted suicide are unsubstantiated. These two *NEJM* articles do not satisfactorily justify why the line cannot be moved forward to active voluntary euthanasia. I object for two reasons. First, if the patient takes the prescribed medication and the suicide attempt fails, the physician's involvement certainly would not be considered humane. The patient can be left in a state worse than before the medication was taken. Second, the authors give no compelling reason why prescribing avoids abuse and administering is more susceptible to abuse.

The approval of using barbiturates during ventilator removal in the second *NEJM* article comes as no surprise. The procedure of removing a ventilator is considered to be an example of passive euthanasia and the concurrent use of barbiturates during the process passes the DDE standard because the barbiturates do not directly cause the patient's death. A further

²⁹ Truog, et al., 1678-1682.

plea to autonomy in justifying this protocol makes the case clearly justifiable to those seeking to hold the line at passive means only. However, I have already established that the DDE should not be relied upon to make a meaningful distinction between active and passive euthanasia. Moreover, a plea to autonomy can equally be made for active euthanasia. Therefore, neither article substantiates why physicians should allow passive but not active euthanasia, nor do they establish why prescribing, but not administering lethal doses of medication should be allowed.

The authors liken the request for barbiturates prior to ventilator removal to being "put to sleep" before it is removed as being similar to requests from patients who prefer general anesthesia for procedures that could be performed under regional anesthesia.³⁰ A similar argument can be made by patients and family members for allowing the patient to be "put to sleep" with assisted suicide. Thus, using barbiturates in both passive and active euthanasia can be defined as humane. Simply "drifting off" in a sleep-like state seems peaceful for all concerned. The irony is that if a patient is "fortunate" enough to find himself or herself on a ventilator with a request to be allowed to die, he or she can have the medical assistance of a barbiturate drip. However, if the same non-ventilated patient was at home, he or she would not fit this medical protocol and therefore not be permitted to receive barbiturates. Such reasoning is morally problematic.

Quill and others are to be harshly criticized for greatly underestimating the harm in allowing only the prescription of lethal medications for suicide and not their administration by a physician, if necessary. Take Mr. D. as an example. P.A.D. could fail for any of the following reasons: he may have developed tolerance to many medications leading to an

³⁰ Truog, et al., 1680.

underestimation of calculating a lethal dose, he has nausea and vomiting, he has malabsorption, he can barely swallow and when he can it is with great pain, and he may become unconscious before taking all the medication. All of these reasons and more could contribute to a failed attempt. Moreover, prescribing does not prevent family members from coercing patients to take this dose earlier than they would otherwise.

Physician-assisted suicide will never be able to avoid unsuccessful attempts as a potential complication. Even Humphry, who is not a physician, recognizes this and advocates the use of a plastic bag for suffocation as assurance in bringing about death.³¹ This is not my idea of death with dignity. Furthermore, after taking the prescribed medication, sleepy confused patients have loosened the bag because of discomfort, as did Mrs. Harper, a woman who attempted suicide this way. Mr. Harper, her husband was later brought up on murder charges for replacing the bag after Mrs. Harper drifted off again.³² This is yet another example of harmful complications to family members arising in a suicide attempt without adequate legal physician involvement.

Many recent writers for the *New England Journal of Medicine* are to be commended on their advancement of tough issues concerning P.A.D. However, the article by Quill and company is regrettably flawed. This previously mentioned article deserves particular attention. The authors state that unless the patient specifically requests it, he or she should not be left alone at the time of death.³³ It is of utmost importance not to abandon the patient at this critical moment. I could not agree more. I would ask

³¹ Humphry, 1991.

³² *New York Times*, 1991; May 11: 8.

³³ Quill, et al., 1383.

these authors what they would have the physician do if he or she was present to witness a failed attempt?

They do not address the case where the patient is comatose after taking the presumably lethal dose but obviously not doing to die, and that the physician's hands are tied. I assume, perhaps wrongly, from the authors of the second article that they would advocate prescribing barbiturates as a drug of choice. The problem with this medication is that complications such as those in the case of Mr. D. and Mrs. Harper can arise. I also assume they would not advocate a drug that is more certain and swift, curare or cyanide for example, because a death from these drugs (without a sedative as in The Netherlands) would be cruel in the final moments.³⁴ But if a sedative was given first, someone else would obviously have to later administer the curare or cyanide. This would be crossing the line from physician-assisted suicide (prescribing) to active euthanasia (administering), a line these authors are not willing to cross.

The authors are tight-wire walking between killing and letting die. Yet, the question remains; why the distinction? Thus far the moral distinction is more semantic than substantial. Let us examine the points that Truog and others attempt to make through their case examples. Both cases cited in the second article involved young women with widespread terminal cancer. These women had exceptional pain management complications. Extreme measures became necessary to bring relief. A conscious decision was made by the physician and patient/family surrogate that sedation was a reasonable intervention. Recall however, for some living in this unresponsive state is intolerable.

³⁴ Humphry, 1991.

To put these cases in perspective, a moderately high dose of morphine to manage postoperative pain is 10 mg every 4 hours as needed. These women were given equivalents of 1500 and 5000 mg of morphine per hour! This sedated them to the point that they could no longer have conscious awareness of pain or life for that matter. These doses were sufficient to suppress their respiratory rate enough to cause death within two days. In the United States, this is commonly permitted under DDE, but not defined as active euthanasia. Yet, in The Netherlands, where euthanasia is practiced, this same case would have been identified as (active) euthanasia. Moreover, both morphine and barbiturates are used to bring about euthanasia in The Netherlands.

Now imagine that Mr. D. was placed on a ventilator and continued to suffer from a feeling of lost dignity and having a life not worth living. Extraordinary doses of morphine (which has the action of dulling pain, "air hunger", and sensorium) would not cause death because the patient is being mechanically ventilated which compensates for the respiratory depressing effect of the morphine. What if the physician instead chose a barbiturate (which dulls sensorium but has no analgesic effect) to relieve Mr. D.'s suffering. Barbiturates, however, are more cardiotoxic than respiratory toxic in their mechanism of bringing about death in high doses and being on a ventilator would not deter this effect. Neither drug is really addressing Mr. D.'s suffering as he defines. The medications are merely placing him in a state where he is no longer aware of his suffering. Due to the difference in toxicity, there is a moral significance in choosing between morphine and a barbiturate. Morally speaking, it is more genuine to prescribe or administer a lethal medication intentionally to directly address and relieve Mr. D.'s suffering.

The physician must make moral choices about how to ease Mr. D.'s suffering. Recall that Mr. D.'s current suffering does not include unmanaged physical pain. Therefore the use of high dose morphine to blunt his awareness of his mental suffering under the guise of pain management is morally problematic. Proponents of P.A.D. will not find it necessary to justify the administration of specific medications by appealing to the distinction between intended and unintended effects or between killing and letting die. They justify the administration of either morphine or barbiturates to relieve suffering by ending life on other grounds such as the right of autonomous persons to make this determination for themselves. The shortcoming of these two *NEJM* articles is that the authors do not address the underlying problem of the need for direct intervention in P.A.D.

The view that there is no moral distinction between active and passive euthanasia was classically described by Rachels. I will summarize his example.³⁵ Suppose two men (Smith and Jones) stand to gain a large inheritance if their nephew dies. Smith drowns his nephew while the child was taking a bath and arranges for it to look like an accident. Jones had a similar plan but when he entered the bathroom, he found his nephew face down in the water. He stood by and did nothing. Both men shared the same motive. According to some, Smith killed the child whereas Jones merely let the child die. Rachels effectively concludes, if the difference between killing and letting die were in itself a morally important matter, one should say that Jones's behavior was less reprehensible than Smith's.³⁶ He doesn't believe that we could convincingly argue this conclusion, and

³⁵ Rachels, 79.

³⁶ Rachels, 79.

neither do I. In agreement with Rachels, I object to the argument that the distinction between killing and letting die is a compelling reason to not allow P.A.D.

Rachels identifies the importance of not attributing moral value to the pure distinction of "killing" versus "letting die" without evaluating the context of the circumstances. He explains that it is not purely correct to say that in passive euthanasia the doctor does nothing, for the doctor is acting by way of not performing certain other actions, for example not treating with antibiotics or informing the patient of all treatment options.³⁷ The decision to allow a patient to die is subject to moral review in the same way that a decision to kill him would be. Rachels provides a hypothetical to exemplify this point. If a doctor deliberately let a patient die who was suffering from a curable illness, the doctor would certainly be to blame for what he or she had done.³⁸ In sum, Rachel's point is that the bare difference between killing and letting die is not in itself a morally relevant distinction.

Critiques of Rachel's arguments are available in the literature. Beauchamp and Childress argue that his example is too extreme to draw conclusions. They believe that because the acts are despicable and the motives are bad, it follows too easily that killing and letting die are both morally compelling wrongs in this case.³⁹ They emphasize that the acceptance or rejection of the distinction does not necessarily determine conclusions about the moral justification of actions taken in particular cases.⁴⁰ Devettere supports Rachels by reiterating that even when the

³⁷ Rachels, 80.

³⁸ Rachels, 80.

³⁹ Beauchamp & Childress, 1979.

⁴⁰ Beauchamp & Childress, 1979.

distinction between killing and letting die is conceptually clear (as with Smith and Jones) it is often not morally important.⁴¹ I would agree.

The President's Commission for the Study of Ethical Problems in Medicine's stand against active euthanasia stated that the distinction between intentionally causing death and letting die is more consolatory and rhetorical than rational.⁴² So why do some desperately hang on to the distinction between killing and letting die? To answer this question, it may be helpful to unravel the historical development of this distinction.

Traditional moral reasoning utilizes a deductive approach. Starting with a set of standards and principles one would proceed from the general to the particular. In an attempt to reconcile the general rule that all acts intentionally causing death of a patient are bad, an escape was created by redefining the withdrawal of life support (which also caused the patient's death) as "letting die."⁴³ Rachels suggests that this has led to reinforcement of learning to think about killing in a much worse light than letting die.⁴⁴ Perhaps it is time to reevaluate this synthetic distinction. Killing, while actually a morally undetermined term from a semantic point of view, is so emotionally laden that it is impossible to employ in a purely neutrally descriptive manner.⁴⁵

So, this leaves us with a least two options. First, some suggest that we use the term killing when we refer to voluntary active euthanasia.

Humphry states that we should "call it like it is."⁴⁶ He goes on to say, killing doesn't necessarily mean it is always the wrong thing to do. Killing

⁴¹ Devettere, 145.

⁴² Devettere, 145.

⁴³ Devettere, 155.

⁴⁴ Rachels, 80.

⁴⁵ Devettere, 148.

⁴⁶ Kushner, 57-62.

in the legal sense is the intentional and unlawful taking of a life without justification. However, a moral distinction is being argued here not a legal one. A second option is to develop a new verb to describe a physician's action in active euthanasia. A term that falls somewhere between killing and letting die to describe P.A.D. may be more appropriate. I suggest referring to the act of physicians' participating in voluntary active euthanasia as the medical "*taking*" of life.

Transferring One's Right to Die: assisted suicide

Assuming that autonomy rules, it is fair to suggest that suicide could be acceptable in at least some circumstances. Accepting this premise now squarely presents the question of when, if ever, the right to an assisted death is acceptable? There are examples of other activities where substitutions are not permissible; one cannot get married by proxy. That is, you cannot have someone else stand in to say "I do" for you. Similarly, objectors argue that the right to die is non-transferable. That is, it is permissible for you to kill yourself but it is not permissible for you to ask someone else to do it for you. Since dying is such a final and weighty decision, some argue that having someone else do it for you makes this decision all too easy. Some fear that patients will not feel free to change their minds once assistance is requested. Hume counters this line of reasoning by stating, "I believe no man ever threw away life while it was worth keeping."⁴⁷ Although this statement seems exaggerated, for the most part, I am inclined to agree.

⁴⁷ Donnelly, 44.

That is not to say that all desperate persons who verbalize suicide ideation should receive assistance in a suicide or that sometimes suicide is not justifiable. For example, the patient may have depression that needs to be treated. Patient autonomy is not the ultimate trump or the sole factor in determining the moral permissibility of P.A.D. When a request for P.A.D. is made both the autonomy of the patient and the autonomy of the physician must be respected. For instance, despite the isolation, rejection, and hopelessness a love-sick teen might experience from a breakup, this would certainly not constitute a justifiable reason for a physician to grant a request for assistance in a suicide.

Another common argument presents this way: if patients are serious about ending their life, why do they have to ask for help? This argument goes on to point out that many terminally ill patients commonly have enough medications at any given time to commit suicide themselves. This line of argument assumes that the individual actually has a choice in who will carry out the deed. This is not always the case. Some patients may not have the means or the physical ability to carry out the act. For a quadriplegic patient for example, the option is either that someone helps him or her or a planned death is not possible. Assuming that suicide is a permissible option, it seems cruel and discriminatory then to deny the option to those who require assistance.

Compelling arguments can be made to justify assistance. Suicide is not a victim-less crime. Most fatal suicide attempts are successful because they are brought about by "violent" means - for example, with the use of guns or jumping off a bridge or in front of a train. In these situations, a harm exists to the person finding the suicide victim. And even if the method is less "violent" such as overdoing on pills, those left behind may suffer

from feelings of guilt. Family and friends left behind wonder why suicide took place and often blame themselves for not having helped the patient make living more tolerable. Unfortunately, when self-determination is not discussed openly, the taboo of suicide persists with all its emotional baggage for survivors.

Dorothy Parker's poem that appears on the title page of this chapter strikes at the heart of identifying the less than desirable options for suicide; hardly a death with dignity. At least in this piece, she failed to explore an alternate route - getting assistance. I have previously established that suicide is not an absolute moral wrong-doing. In this section, I add that P.A.D. is also morally permissible. In fact, such assistance not only benefits the patient but also the family. Why the physician should be the one to assist is discussed later in this chapter.

The involvement of a physician via assisting in a requested suicide is an opportunity to open lines of communication on this subject. I argue that if a person making a request can illicit the help of a willing physician, that harm to others is minimized. That is, both participants are fully aware of their commitment and its consequences. There would not be involvement by persons who have not previously consented, such as those who would unexpectedly find a suicide victim. If this takes place in an environment where this can openly be discussed, significant others can try to find empathy for the dying person's decision and begin the grieving process in advance. Assistance by physicians then can provide a minimally complicated death.

Do No Harm: the doctor's golden rule

I will neither give a deadly poison to anybody if asked for it, nor will I make a suggestion to this effect. ----- Hippocrates

Thus far, it has been established that suicide is permissible in certain circumstances. Further, a case is being established for assistance with suicide in exceptional cases. In this section, I will introduce the adapted principle of "*Do No Greater Harm*", as an argument supporting the moral justification of P.A.D. This argument in combination to the previous justifications of respect for autonomy and compassion strengthen my position.

Kamm would seemingly support the justification of active euthanasia because she states that doing something with the intention of causing harm (ending life) occurs in a particular structure of events (the suffering of a terminally ill patient) which may make it permissible.⁴⁸ Yet, opponents claim that P.A.D. violates the "do no harm" oath of a physician's practice code. Whether the Hippocratic Oath can be taken literally or whether it remains appropriate for the modern day practice of medicine remains to be seen. Further, whether ending life necessarily is doing harm will require additional exploration.

Recall Mr. D. once again. Let us consider that his doctor encouraged him to take AZT early in the course of his illness. Assume also that Mr. D. is not the type to take medications. If AZT was not available and if his physician didn't offer/encourage it, perhaps Mr. D. would no longer be alive. He probably would have died an earlier, less painful, more dignified

⁴⁸ Kamm, 571-585.

death if he had not taken AZT and other prophylactic medications. It is unlikely that he would have developed such extensive thrush and MAI because he would have died from a previous episode of pneumocystis pneumonia. Let us also assume that in taking the AZT, Mr. D. experienced side effects. It is fair to say that these side effects and opportunistic infections may be the cost of advanced medical care. However heroic at times, current day medicine has its limits and Mr. D. has found them.

Isn't medicine then, in part, responsible for some of these harms? If Mr. D. willingly accepted the consequences of taking AZT to extend life, he acted as an informed consumer to the extent any lay person suffering with a devastating terminal illness can comprehend medical jargon enough to make a decision. Yet, medicine certainly had a hand in leading Mr. D. down this path. But now that Mr. D. has lengthened his life beyond a quality he finds desirable, medicine has its hands tied. It cannot or will not accompany Mr. D back to a point where he can now die. It seems tragic that somehow in accepting medical intervention Mr. D. had to forfeit his claim to a minimally complicated death.

I argue that Mr. D. now faces a greater harm; one largely brought about through the intervention of medicine. Benrubi suggests the following scenario is analogous:

A parent encourages a child to climb higher and higher up a tree, telling the child that he or she can climb forever upward without fear until the highest branch is reached. Finally, the child arrives at the top of the tree but cannot get down without the parent's help. At that point the parent says, "I got you up there, but I will not help you come down."⁴⁹

⁴⁹ Benrubi, 197.

Similar concerns of medicine acting in this harmful fashion have been voiced by others.^{50,51} Medicine is thus responsible for a greater harm, namely, the current level of Mr. D.'s suffering through the action of "*letting live.*" Thus medicine is violating the rule of do no harm. The opportunity exists in reversing the point at which medical intervention transformed from being a benefit to becoming a harm. By applying the additional principle of do no greater harm, this wrong can be corrected. It seems not only permissible but necessary that medical intervention take place to save him from this greater harm. What a true service medicine would render Mr. D. if it extended his life while worth living but, in addition, eliminated his suffering when extension of life was no longer tolerable.

Let me tie together the case of Mr. D., Benrubi's example, and the moral justification of P.A.D. through the principle of doing no greater harm. Doctors knowingly offer patients like Mr. D. advanced medical care with the awareness that such intervention will prolong life at the expense of potentially greater suffering as a result of complications such as more virulent opportunistic infections. In this regard the example of Benrubi's parent is like Mr. D.'s physician. The harm in the physician's action is that Mr. D. is not made aware that if this suffering becomes too great, he cannot return to a prior state of health where death would come easier or that his physician is not able or not willing to help him ease that passage.

With this lack of understanding, I do not see Mr. D. as a fully informed decision-maker. I would prefer that the physician inform Mr. D. that he can prolong life through AZT, but if his condition deteriorates to a point

⁵⁰ Vaux, 21.

⁵¹ Cassel, 751.

where he no longer wants to live that the physician's clearly identified his stand as one of the following:

- a. the physician will assist Mr. D. bring about death
- b. the physician cannot or will not assist Mr. D. bring about death
- c. the physician will reserve the right to later decide under which circumstances he will participate in assisting death
- d. the physician will not assist, but will refer Mr. D. to another physician who will

Thus, Mr. D. would have a reasonable claim for P.A.D. under the principle of do no greater harm if he was not fully informed about his options and his physician's response in accepting the consequences of AZT. Mr. D. should be informed and empowered in his decisions concerning the end of life since it is the physician who has control over medications which can both extend and end life. Likewise the physician would have a moral justification under the principle of do no greater harm in assisting Mr. D. in a suicide if greater suffering would have occurred as a result of medical intervention. Thus, the principle of do no greater harm is moral justification for P.A.D. This can occur in combination with the moral justification through respect for autonomy or compassionately acting to relieve suffering. This point is significant because even if Mr. D. refused medical intervention, moral justification could still be established for assistance in suicide if suffering existed through these two additional principles.

Why the doctor? Is this an appropriate role for physicians?

Some hold the position that assistance in a suicide given a situation like Mr. D.'s may be permissible, but that the participating party should not be the physician. This doesn't follow from the above line of reasoning that the medical profession and medical technology is in part responsible for this greater harm. Arguments are given as to why the physician should not take on the role of euthanist. One claim is that the time-honored objection that a physician shall neither give a deadly drug nor tell the means, should be upheld. However effective arguments have clearly shown the Hippocratic Oath to be outdated for literal interpretation in contemporary medical practice.⁵² A second concern is that the physician will be viewed as a killer rather than a healer if this role were adopted and authorized by the profession.⁵³ An argument against this claim is that physician as "abandoner" of the suffering dying patient's request is not positive in the eyes of the public either.

If assisting is morally justifiable, but some object to the physician's assistance then who should assist? In response to this question, I was once asked, "isn't that what families are for?" At first glance the answer may be yes. The family probably knows the patient better than anyone else, and the event can take place in the loving company of family members. I thought these were legitimate reasons until I heard the following actual case:

⁵² Devettere, 145-155.

⁵³ Cassel, 750.

Torn in Two: Mrs. T.'s Family

Mrs. T. was terminally ill and in the final phase of the dying process. She was ready to die...and ready to die now, at home. She discussed suicide with her husband and their children. After much contemplation and sadness in having to face saying final good-byes, all were in agreement. The family was prepared to accept and support Mrs. T.'s decision. When Mrs. T. approached her long-time family physician for help (because she could no longer take pills by mouth) he refused to assist her directly. However, he said he would be willing to prepare a lethal injection for one of her family members to administer.

One of the children (A) volunteered to administer the injection. Because Mrs. T. did not have an I.V. in place, a vein needed to be found. Mrs. T. had poor vascular access and it was difficult for A to find a vein. A was not a health care professional and therefore had no experience in this maneuver. After 30 minutes with tension mounting, this assister gave up. Another family member (B) took over. B was later able to give the injection and Mrs. T. died.

After the event, B remained angry at A for complicating the process. The event was not as smooth as B would have wanted it for Mrs. T. and the other family members. The family divided. They chose alliance with either A or B. Twenty years later, the A and B divisions are not speaking to each other. I wonder how would Mrs. T. have felt knowing this eventual outcome?

One anecdotal story does not a generalization make. However, this points to at least one very serious reason why family members or friends should not be asked to bear the burden of assisting in suicides. This is a case of greater harm being done not only to Mrs. T. but also to her family in this complicated assisted suicide which could have been avoided if the physician was adequately involved. Technical expertise is just one reason why the physician is uniquely prepared to undertake this duty. I will explain why and go on to dispute common objections to this role for the physician.

The physician is the most appropriate person to assist a dying patient for several important reasons. The physician has the medical knowledge necessary to make judgments about diagnosis, prognosis, and underlying depression. Additionally, the physician has access to the means (drugs), has technical skills (accessing venous entry), and is trained and experienced in dealing with the practical and emotional issues involved in death and dying. In addition to these reasons, if a friend or family member is assisting, the process of dying for the patient and grieving for the survivors is at higher risk of being complicated as with the case of Mrs. T. and others.⁵⁴ This is unacceptable when physicians are willing to assist.

Some argue that while the above may be true, it is not an appropriate role for the profession to undertake. Miller tells us that whether "medical taking" of a patient's life is incompatible with the vocation of medicine depends on how the profession is understood.⁵⁵ He elaborates to say physicians, in addition to preserving life and healing, are concerned with helping patients cope with incurable illness and relieving suffering. He argues that when physicians assist patients in the decision making process of withdrawing and withholding life-sustaining medical interventions, they act neither to preserve life nor to heal.⁵⁶ He asks if this is not inconsistent with medical practice why P.A.D. would be? Miller's point is well made.

In addition to the role argument, other objections to P.A.D. have to do with the public's trust and image of physicians. Weir states that some fear even willingness to discuss the possibility of P.A.D. would undermine the trust in the doctor-patient relationship.⁵⁷ However, Cassel correctly states

⁵⁴ Olszewski, A5.

⁵⁵ Miller, 131.

⁵⁶ Miller, 131.

⁵⁷ Weir, 121.

that the public is already losing faith in the medical profession, at least in part due to the sometimes cruel insistence of life at all cost.⁵⁸ Examples that support this observation of the public include living will legislation after Cruzan, the Patient Self Determination Act, and the fact that a recipe book for self deliverance (Final Exit) became a best seller.⁵⁹ Some also fear that the public image of physicians will turn from healer to killer if P.A.D. is allowed. Gillon argues that this is a nonsensical notion that imagines a doctor will be categorized in the same camp as murderers.⁶⁰ Reichel and Dyck predict that if the practice of assisting in suicides is allowed, the doctor-patient relationship could never be the same again.⁶¹ This may be true, but it could be a change for the better.

There are many reasons why the assister be a physician. However, this does not answer the question of morally justifying that assisting is part of the role a physician may choose to undertake. For this, I endorse the Dutch resolution. They invoke the principle of *overmacht*, or overriding force to both morally and legally justify euthanasia. The rationale goes like this. A physician has both a duty to preserve life and to relieve suffering. In the case of a dying patient who is suffering and requests an end to life, the physician is faced with a conflict of duties in meeting the patients needs. In this situation, a physician is morally justified in overriding his duty to preserve life in order to compassionately relieve suffering through respecting the patient's autonomous request.

58 Cassel, 751.

59 Humphry, 1991.

60 Gillon, 117.

61 Reichel & Dyck, 1322.

Splitting Hairs: prescribing versus administering

The debate on P.A.D. in this section is restricted to voluntary euthanasia. The conditional objector here distinguishes between physician-assisted suicide (prescribing) and other types of active euthanasia (administering). Some would argue that the former is permissible but the latter is not. This distinction generally rests on whether the physician prescribes the lethal dose of medication in the former case or administers it as in the latter case. Gillett identifies what doctors frequently express as the distinction for them.⁶² That is, physicians logically see little difference between prescribing and administering, but sense that a "gut instinct" tells them one exists.⁶³

We have already seen the derivation of this contradiction earlier with the development of distinguishing between killing and letting die, and do not deny its validity on an emotional level. In most cases, given the world as it is, killing is seen as worse than letting die because a number of logically independent but emotionally relevant characteristics that are frequently correlated with killing, such as evil intent. However, this does not justify a distinction with a moral significance either in the case of differentiating between killing and letting die or between prescribing and administering a lethal dose of medication.

I have argued that in order to fully justify P.A.D., complications that can arise in the process of assisting which the physician has control over must be avoided.⁶⁴ I call this the patient's right to a minimally complicated death (MCD). What a tragedy it would be for a patient who has had an

⁶² Gillett, 61.

⁶³ Gillett, 61.

⁶⁴ Ciesielski Carlucci, 18.

attempted assisted death to wake up in an I.C.U. bed on a ventilator realizing that their attempt has failed, thus, finding themselves in the very situation that they desired most to avoid. Stories of this type are not unheard of.⁶⁵ It is unrealistic of physicians to believe this possibility is unlikely when there is evidence from The Netherlands to show that no fool-proof lethal dose of prescribed medication exists for any given patient. Dutch physicians can decide with the patient to opt for prescribing a lethal dose of medication for the patient to self-administer, and Dutch physicians are prepared and willing to take further action (a lethal injection) if necessary. Hence, these physicians find it absurd to make a distinction between active and passive euthanasia or between prescribing or administering a lethal dose of medication.⁶⁶

Failed attempts are indeed a greater harm, one that would surely undermine the trust placed in physicians by their patients. Furthermore, what if the patient like Mr. D. can't swallow or absorb a pill? Alright, perhaps he can inject himself. We have seen the horror of this with Mrs. T. But still yet, what if Mr. D. has a needle phobia or is quadriplegic? If Mr. D. could swallow and absorb a pill but was a quadriplegic, would it be permissible to bring the dose to his mouth? Is there any substantial moral reason or meaningful distinction between a doctor placing a barbiturate in the patient's hand (via prescription) and his placing it in his mouth? If not, then what is this difference between the patient's mouth and his vein? I believe it would not matter. Or, would some suggest that because Mr. D. cannot effectively administer the prescribed lethal dose to himself, he therefore should be denied this option?

⁶⁵ Selzer, 32-38.

⁶⁶ Admiraal, 370.

Another contradiction exists. Given that P.A.D. is morally permissible but illegal, a doctor could prescribe barbiturates under the guise of insomnia. However, barbiturates, in medical circles, are not the drug of choice for simple insomnia. That is because there are other equally effective medications with a much greater safety profile. In prescribing barbiturates, the physician is aware that these can specifically be used for physician-assisted suicide. This action is equally subject to moral scrutiny. Otherwise, would not a physician who suspected that the patient planned to use these to commit suicide and did not want to play a part in that choose another medication? One physician told me that he can not and does not want to be a "moral watchdog." I fear this in part is his responsibility when making decisions about what medication to prescribe. For example, what morally aware doctor would choose barbiturates to treat a patient suffering from insomnia who has a concurrent diagnosis of clinical depression? None.

If a physician knowingly prescribes barbiturates for the patient to take or stockpile with the intention of committing suicide, why would the physician not be willing to give another medication if this one fails? Once the physician has already determined that it is morally permissible for him to engage in ending a patient's life via prescribing a lethal medication, why is not administering a medication also permissible? In short, I see no morally justifiable reason why if prescribing a lethal dose is permissible, administering would not be. Moreover, I have outlined how the harm can result if a physician or society is only willing to allow the prescription, but not administration of a lethal dose of medication to carry out P.A.D.

Never Say Never: evaluating individual voluntary requests

Now we turn to the non-objector position. This perspective on the continuum accepts that there are no preconceived objections to P.A.D. and each case must be justified on its own merits. Although proponents argue right to die issues based on personal autonomy, I do not think most would argue that this right is absolute. Perhaps it may be with suicide, but this could not be the case when physicians are involved. Because the patient and physician are both moral agents, in assisting the physician must in good conscience justify accepting or rejecting any given request.⁶⁷ Parker suggests a fiduciary model in this negotiation so that there is not a duty on the part of the physician to absolutely participate in assisting when requested.⁶⁸ This allows the physician an acceptable moral out when he or she feels assisting cannot be justified. Cassel argues that patients seeking aid-in-dying should not be held hostage to our inability or unwillingness to be responsible for knowing right from wrong in each specific situation.⁶⁹

Having made what I believe are effective arguments for abandoning any absolute objections to active euthanasia, I propose a case-based evaluation system to determine the moral justification of physician involvement after any given request. Devettere gives us an example which illustrates the importance of descriptive information-gathering in any evaluation which must decide the moral credibility of an act. What if we heard the following imperative statement from across the room, "Jane, cut open Karen's body with that knife."⁷⁰ We would not know if this was a bank robbery, an

⁶⁷ Reichel & Dyck, 1322.

⁶⁸ Parker, 32.

⁶⁹ Cassel & Meier, 751.

⁷⁰ Devettere, 148.

anatomy lesson, or a cesarean section. Although this exaggerated example points to the importance of case review, it does not suggest that, even after gathering information, the decision will be an easy one to make.

In fact, Roy makes that point clear. To rephrase his concern, there is no single a priori principle or standard of moral reasoning that can match the infinite variety of human situations.⁷¹ That is, in part, the reason for the difference between statutory law and jurisprudence, between law and ethics.⁷² The legal issues demand an entire exploration of their own. P.A.D. remains a question for the law to answer to as well. A recent article shows that although no court has definitively decided whether the right to die extends to P.A.D., the author believes the language in previously decided cases can and should apply.⁷³

Having argued for an individualized case-based evaluative approach, I will suggest guidelines to base those decisions upon in the chapter five. Other well thought out guidelines have been proposed.^{74,75} I would support referring to these. Each decision will remain at least as unique as the combination of individual physicians and patients given their cultural backgrounds, values, and preferences. Suffice it to say that any safeguards or absolute restrictions in policy making would also be subject to the difficulties Roy identified. From previous arguments, it would follow that I would be hard pressed to justify absolute limitations (beyond a request and a consenting physician) based on any moral grounds.

⁷¹ Roy, 4.

⁷² Roy, 4.

⁷³ Harvard Law Review, 2033.

⁷⁴ Quill, et al., 1381.

⁷⁵ Gevers, 158.

*Slippery Arguments: we won't get there from here;
involuntary euthanasia*

One of the weaknesses of the slippery slope argument is that many define the bottom of the hill at different places. Some would say it is going too far when we grant all requests. They may, for example, argue it is permissible for the terminally ill but not the chronically ill to receive assistance in a suicide. For some, the snowball effect would lead us unacceptably to non-voluntary euthanasia. This has frequently been referred to as "mercy killing." Still others fear the worst is possible, involuntary euthanasia. Rosenblum vividly describes how the slide works.⁷⁶

Once a patient is identified as one from whom nutrition and hydration could be withdrawn, a lethal injection will be recommended as a newer, quicker, more humane method of accomplishing the same desired effect. Withdrawing food and fluids will be remembered only as the old way of doing things. Once lethal injection is accepted for these people, its application will sweep as broadly as did the withdrawal of nutrition and hydration to encompass most incompetent patients.

To slippery slope concerns, there are several lines of defense. One could effectively argue we won't get there (the bottom of the slope) from here. That is, from a starting point of a competent adult's request as a condition for moral justification of P.A.D., intervention without a request will not be tolerated. Moreover, even if P.A.D. without a request was tolerated, we have not examined why that would be so morally unacceptable. It is quite clear by now that I would reject any standardized limitations on requests

⁷⁶ Rosenblum & Forsythe, 25.

and furthermore would not interpret this expansion as a slope. I leave those decisions to the patient, the individual physician, and society.

With regard to non-voluntary euthanasia, I refer to and agree with comments by Kadish and Leenen. Kadish states that if we are to argue for non-voluntary euthanasia we must do so based on what is in the best interest of the patient, not based on any claim to autonomy that the patient may have, because he obviously has not made a previous directive.⁷⁷ Leenen, Kadish, and I are in agreement that in some cases one could morally justify non-voluntary euthanasia.⁷⁸

Involuntary euthanasia in any shape or form cannot and should not ever be morally justifiable. Yet, some fear it could be an eventual outcome of accepting voluntary active euthanasia; a practice that defies the doctrine that killing of others is always wrong. Glover would caution that the social implication of widespread abandonment of the view that taking human life is intrinsically wrong are said to be so appalling that, whatever its defects, the doctrine should not be criticized.⁷⁹ Miller disagrees, stating that a single justified counter-example of euthanasia disproves the validity of an absolute general rule against killing.⁸⁰ To satisfy Miller's criteria, the case of justifiably providing P.A.D. to Mr. D. provides such an example.

Acknowledging the experience with the Nazi atrocities of WWII, society ought to approach the issue of voluntary euthanasia with sensitivity and trepidation.⁸¹ If any doctrine even hinted at developing attitudes of indifference toward human life, this would be an overwhelming reason to

⁷⁷ Kadish, 888.

⁷⁸ Leenen & Ciesielski Carlucci, 271-274.

⁷⁹ Glover, 58.

⁸⁰ Miller, 132.

⁸¹ Lifton, 1986.

reject it.⁸² I do not believe that P.A.D. upon request would fall into this category. Furthermore, the plea for allowing P.A.D. derives from suffering patients and caring health care professionals who are sincerely motivated by good intentions in the best interest of the patient to compassionately relieve suffering and respect patient autonomy.

Parker insightfully points out that slippery slope arguments preclude moral change even when the permissibility of individual acts is admitted.⁸³ A clear example of such behavior is documented by Rosenblum. He quotes others who have stated that we should "rally in defense of its (the medical profession's) fundamental moral principles."⁸⁴ Should not we check in periodically to see whether they are worthy of being upheld and not antiquated as previous fundamental principles have been? I would argue against such blind action without discussion of the issues.

Opponents like Rosenblum fear that once we get started, each act will become easier and easier until all emotion is removed from such a deeply human decision as P.A.D. There is evidence to suggest exactly the contrary is true. Dutch physicians who have been involved in cases of euthanasia point out that they are reluctant to do so again.⁸⁵ Why? Consider this. You have had a close friend since you were a child, your dog. You got him as a puppy and remember many fond memories together. Now he is very old, has difficulty eating, is in renal failure, and can no longer walk. You are faced with the decision of "putting him to sleep." You decide it is in his best interest to end his suffering, despite, perhaps for yourself selfishly preferring to keep him alive. The sharp contrast of this example is

⁸² Glover, 1977.

⁸³ Parker, 33.

⁸⁴ Rosenblum & Forsythe, 31.

⁸⁵ Van der Maas et al., (1991) 673.

captured by Gillett: isn't it a remarkable fact that whereas in the case of human beings passive euthanasia is widely regarded as a civilized and humane compromise, in the case of animals the same thing is considered an inexcusable cruelty.⁸⁶ Having to make this decision, say good-bye, and go through with the procedure is probably one of the most emotionally difficult tasks you will ever have to undertake.

I am not implying that this example is exactly analogous. Persons seeking P.A.D. must make a request on their own, but animals can neither explore their options nor communicate their preferences. However, on an emotional level, this decision is at least as difficult. Now ask yourself whether you could imagine ever wanting to go through that again? I suggest that this is how Dutch physicians feel about euthanasia.

The most moving evidence to Vaux is the testimony he has heard of ethical and humane physicians who, out of love, would give a lethal dose to their wife, parent, or other loved one if his or her dying was marked by suffering and agony.⁸⁷ Kass tells us that a physician should not engage in such activity for either love or money.⁸⁸ I argue that the morally justified act of taking the life of another human being could only occur as an act of compassion and no price could be put on the moral conviction of a physician and the emotional impact in deciding whether or not this is the right thing to do.

A physician, and member of a hospital ethics committee, made the following reply to this line of slippery slope arguments. He stated that just because "pulling the plug" is more acceptable now in the United States, it is not any easier for him. Indeed on the issue of abuse, we have not had any

⁸⁶ Gillett, 61.

⁸⁷ Vaux, 21.

⁸⁸ Kass, 25-46.

headline news broadcasting that someone has had the "plug pulled" against his will. Furthermore, given physician hesitance to end life and the litigious nature of our society, I find it difficult to believe that such widespread abuse could occur. I realistically do not deny that some abuses are possible as they already are with other medical procedures.

The slope, if it exists, may be dangerously slippery, but that does not prove that it is inherently wrong, under all circumstances, for physicians to take the lives of their patients.⁸⁹ We do not know the extent of the risks in the United States associated with allowing physicians to assist or take the lives of their patients when agreeing to a prior request. However, even when we do have data, as in the case of The Netherlands, both sides disagree in what they define as abuse. Battin argues that the burden of protection against abuse falls on both advocates and opponents.⁹⁰ I agree. Abuses in health care occur now; we need to work at minimizing them as well. Any policy authorizing P.A.D. would be gradual - for example, restricted to the terminally ill. In this way, the procedure can be monitored and physicians, patients, and society can develop trust in this option at the end of life. The fact is that the practice is occurring now.⁹¹ It is not fair to patients, physicians, or society to allow this practice to continue underground.⁹²

⁸⁹ Miller, 132.

⁹⁰ Battin, 143.

⁹¹ Ciesielski Carlucci, 39-45.

⁹² Quill, et al., 1383.

Conclusion

The attitude held by many physicians that it is permissible for them to quietly assist in a suicide but that it is not permissible for others to do the same is hypocritical at best. If this belief is true (the next chapter will support that it is true), then physicians do not consider P.A.D. an absolute moral wrong and the point of this chapter is made. Those who uphold the slippery slope argument contend that society cannot safely regulate death.⁹³ Glover rejects slippery slope arguments by stating that there is something both objectionable and absurd about trying to argue a moral view (i.e., killing is always wrong) by saying how harmful its widespread rejection would be.⁹⁴ I believe if P.A.D. is to be objected to, it should be on moral grounds not on hypothetical abuse potential. Once morally permissible, as I have shown, concerns about abuses should be handled as a matter of policy.

In sum, objections to P.A.D. do not provide sufficient evidence that such aid is always morally impermissible. In fact, I have argued that it is morally justifiable. To recapitulate, I base the justification for P.A.D. on the patient's claim to autonomy and a minimally complicated death, the principle of doing no greater harm, and the compassionate act of a physician in a situation presenting as a conflict of duty. The strength of the appeal to a minimally complicated death as a means of morally justifying P.A.D. was cited by Dutch Researchers. They found that if euthanasia was not complicated that the grieving process of families was not adversely affected.⁹⁵ Because conditional objections have not put forth any compelling

⁹³ Doerflinger, 16.

⁹⁴ Glover, 1977.

⁹⁵ Gremmen & van der Boom, 1992.

arguments to absolutely exclude the moral permissibility of P.A.D., requests must be individually justified. As a final note on making such decisions, a wise and caring veteran physician shared with me, "Saving life is a wonderful thing, but so may be allowing someone to die - how strange life and death are." I will conclude by responding that saving a life must be a wonderful thing, but so too may be taking a patient's life at his or her request when suffering through living is no longer tolerable.

NOTES

1. For the purposes of this paper the following definitions are supplied:

suicide: the intentional taking of one's own life.

physician-assisted suicide: suicide by means of drugs knowingly prescribed by a physician for the purpose of ending life.

euthanasia: the intentional taking the life of a patient by a physician at his or her request.

passive euthanasia: any act whereby the physician allows the patient to die by determining that withholding or withdrawing medical intervention is appropriate in consultation with the patient and family if possible.

active euthanasia: a physician's administering a lethal medication to intentionally bring about the death of a patient upon the patient's request.

voluntary euthanasia: euthanasia that requires a request from the patient.

non-voluntary euthanasia: euthanasia without a request because the patient is non-communicative or incompetent.

involuntary euthanasia: euthanasia against the explicit objection of a patient or euthanasia where the patient would not have necessarily asked for it.

physician aid-in-dying: a nonspecific term used to encompass any involvement by a physician in the death of a patient from holding the patient's hand at the bedside to injecting a lethal dose of medication. As used in this work, it specifically refers to both the option of prescribing and or administering a lethal dose of medication.

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III. U.S. PHYSICIANS' ATTITUDES AND PRACTICES

*I will neither give a deadly poison to anybody if asked for it,
nor will I make a suggestion to this effect. ----- Hippocrates*

III. Results of a small opinion survey of physicians' attitudes and practices concerning physician-assisted suicide.

Introduction

Acceptance of a patient's wishes regarding end of life decisions heightened with the U.S. Supreme court decision on *Cruzan* and advances in living will legislation. Significant events within the recent past have focused on perhaps the ultimate expression of patient autonomy, physician aid-in-dying (P.A.D.). For instance, the book *Final Exit* became a best seller, giving people the detailed knowledge of how to "self-deliver."⁹⁶ In *The New England Journal of Medicine*, Dr. Timothy Quill shared his touching experience of assisting his patient "Diane" to die after she chose to decline treatment options for leukemia.⁹⁷ Dr. Jack Kevorkian made use of his highly publicized "death machine" to help several people end their lives. In addition, Washington and California had voter initiatives on "death with dignity" which would have legalized P.A.D.

An appreciable amount of investigation has focused on how various groups feel about P.A.D. Various pollsters have followed public opinion on P.A.D. over time as an expression of one's right to choose the timing and circumstances of their death.⁹⁸ Results of the various opinion surveys of both the public and physicians vary considerably based on how several key

⁹⁶ Humphry, 1990.

⁹⁷ Quill, 691-694.

⁹⁸ Scott, 31-34.

variables are phrased in the survey questions. Often these variables are not always represented in the same survey making comparative results difficult. These variables and some of the responses they have generated are summarized below.

A) Does a terminally ill patient have the right to seek assistance in dying?

According to a 1991 Boston Globe report on a Harvard School of Public Health survey, 63% of persons polled supported the right of a terminally ill patient to seek physician-assistance in a suicide or euthanasia.⁹⁹

Similarly, Heilig found that 70% of physicians felt that patients should have the option of requesting active euthanasia when faced with incurable terminal illness.¹⁰⁰

B) Should physicians be the ones to carry out such requests? Or, should physicians have the right to cause death for a patient who has requested the doctor to do this?

In the Harvard study, only 37% of the public supported allowing a relative or close friend to be the person to assist a terminally ill patient whereas 63% supported a physician assisting. When asked who should be the person to assist, of the physician respondents in the Heilig study 54% thought it should be a physician. By comparison, 46.7% of the Medical Times Reader Survey physician respondents and 62% of Australian physicians surveyed felt that physicians should be given the right to perform P.A.D.^{101,102}

C) Would you support legislation that would permit physicians to assist patients to end their lives under certain circumstances?

⁹⁹ Blendon, 2659.

¹⁰⁰ Heilig, 24.

¹⁰¹ Medical Times, 49.

¹⁰² Kuhse & Singer, 624.

Of the 63% who supported legalization in the Harvard study, 17% felt that physicians should be required to administer a lethal injection if the terminally ill patient requests it. The American Society of Internal Medicine (A.S.I.M.) survey found that physicians would have voted on the Washington state initiative in the following way: 53% opposed, 30% in favor, and 17% undecided.¹⁰³ It has been rather curious that despite the consistency of about two-thirds of public support on P.A.D. and about 50% physician support that both the Washington and California initiatives failed to pass; gaining only 46% of the votes.

D) Have you had requests to administer or prescribe a lethal dose of medication to end a patients life. And, would you participate if P.A.D. were legalized? *Note 2*

Research by the A.S.I.M. and the Centre for Human Bioethics in Victoria have found that 24% physicians have received requests from patients to assist them in a suicide and 48% have received requests to hasten the patient's death respectively. The Australian study found that 29% of physicians have already taken active steps to bring about the death of a patient who had requested it. Evidence further suggests that some American physicians would assist now, and even more would assist if legalized.¹⁰⁴ Heilig found that if physician-assisted suicide were legalized, 45% of physicians would be willing to assist. Likewise, if legalized 35% of Colorado physicians surveyed said they would be willing to participate.¹⁰⁵

¹⁰³ Crosby, 10.

Note 2 Several surveys had questions that were phrased in such a way that active and passive euthanasia could not be separated. As a result, those findings are not useful as comparative data in this chapter. For instance, the Overmyer survey asked, Have you ever taken a deliberate action that would directly cause a patient's death? No discrimination can be made in these responses between removing a ventilator or administering curare as both would deliberately end life.

¹⁰⁴ Boly, 33.

¹⁰⁵ Somerville, 17.

In sum, certain generalizations can be made about both the public and physician opinions on the issue of P.A.D. There is distinct majority support for the patient's choice in self-determination. This support wanes slightly when this right necessitates a physician's involvement in bringing about death. A more significant drop occurs when the assistance is to be carried out by a person other than a physician. Through experience with initiatives, majority support of a patient's right to P.A.D. seems to lose ground when it comes to legalization. Clearly patients are already asking physicians for assistance and the degree to which those requests are being met varies. In sum, the results of this survey add to, and are in general agreement with, the current body of knowledge gathered on physicians' attitudes and practices regarding P.A.D.

Methods

This anonymous survey was approved by the University of California at Berkeley's Human Subjects Review Committee. The survey instrument was developed with the expert advise of an ethicist, a health policy analyst, a statistician, and a survey specialist. It was also reviewed by Derek Humphry. A small number of pre-tests were completed by physicians.

The sample population consisted of physicians attending the First Annual Congress of The International Bioethics Institute which took place in San Francisco in April 1991. More than 200 registrants, 88 of whom were physicians, participated in the congress. Participants came from 31 states and Washington D.C., and four physicians attended from outside the United States. The survey was distributed to all physicians as they registered at the conference. Participants had the option of placing the

completed form in a confidential drop box or returning it by mail in a self-addressed stamped envelope. Forty-five surveys were turned in, most by mail. No follow up mailing or calling was done due to budget limitations. This provided a return rate of greater than 50%.

The physicians who completed the survey were asked several questions about their background. Approximately 60% of respondents had practiced medicine for more than 20 years. Areas of practice included 36% Internal Medicine, 13% Family Practice, 13% Pediatrics, 11% Oncology, 0% Surgeons, and 27% Other. Setting practices ranged from 31% Private Practice to 26% Group Practice to 9% H.M.O. and 33% Other. Religious affiliations were specified as 27% Jewish, 27% Catholic, 22% Protestant, 13% No Affiliation, and 27% Other. Regarding gender, 80% were male and 20% were female. Members of A.M.A. accounted for 44% of the sample. And of all participants, only 22% said that they were aware of A.M.A.'s policy against P.A.D.^{Note 3}

Note 3 The policy of the American Medical Association Judicial Council in 1982 stated the following, "For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or close or omit treatment to let a terminally ill patient die, but he should not intentionally cause death." Walsh, p.11.

Measures

Several key dimensions were compared in this survey. These can be divided into four components:

- a) the extent to which physicians would be willing to assist directly or indirectly, by *prescribing* as opposed to directly *administering* a lethal dose of medication;
- b) participation based on whether or not assisting was *illegal* or hypothetically *legal*;
- c) willingness to participate in an assisted suicide by a request from a patient either in *pain* or a patient with a *terminal illness*; and
- d) the degree to which the *relation to the physician* played a role in decision-making. The levels of relationships included self, a patient, and a family member or close friend.

Data Analysis

Most of the data was analyzed by the chi squared method. When appropriate, a t-test was also done. Any results referred to as significant had a p value of 0.05. Most of the answer choices followed the Likert format of most likely, likely, rather unlikely, or never. These were weighted on a scale from 1 to 4 respectively. An answer was considered "no" if the score was greater than or equal to 2.5.

Results

Responses to the questions are shown below. In sections A and B, responses are divided into two groups, based on whether the physician's participation is legal or illegal.

In an environment where P.A.D. is hypothetically *legal*:

A. In a hypothetical situation, an alert competent adult patient who suffers from non-terminal, chronic, intolerable, and intractable pain specifically requests your assistance in obtaining a lethal dose of medication to permit him/her to die.

1. How likely would you be to *prescribe* a lethal dose of medication to this person if they were one of your patients, a close friend or family member?

	If assisting is:	
	<u>Illegal</u>	<u>Legal</u>
At least somewhat likely	10%	21%
Rather unlikely	20%	22%
Would never do this	70%	57%

2. How likely would you be to *administer* a lethal dose of medication to this person if they were one of your patients, a close friend or family member?

	If assisting is:	
	<u>Illegal</u>	<u>Legal</u>
At least somewhat likely	3%	13%
Rather unlikely	22%	26%
Would never do this	75%	61%

3. How likely would you be to **take** a lethal dose of medication yourself if you were this patient?

	If assisting is:	
	<u>Illegal</u>	<u>Legal</u>
At least somewhat likely	22%	27%
Rather unlikely	33%	29%
Would never do this	45%	44%

In an environment where P.A.D. is *illegal*:

B. In a hypothetical situation, an alert adult who is suffering from a debilitating terminal illness specifically requests your assistance as his/her primary care provider in obtaining a lethal dose of medication to end his/her life. This patient confides in you that he/she wishes to die because he/she is no longer satisfied with his/her current quality of life.

1. How likely would you be to **prescribe** a lethal dose of medication to this person if they were one of your patients, a close friend or family member?

	If assisting is:	
	<u>Illegal</u>	<u>Legal</u>
At least somewhat likely	28%	41%
Rather unlikely	27%	21%
Would never do this	45%	38%

2. How likely would you be to *administer* a lethal dose of medication to this person if they were one of your patients, a close friend or family member?

If assisting is:

	<u>Illegal</u>	<u>Legal</u>
At least somewhat likely	12%	27%
Rather unlikely	32%	28%
Would never do this	56%	45%

3. How likely would you be to *take* a lethal dose of medication yourself if you were this patient?

If assisting is:

	<u>Illegal</u>	<u>Legal</u>
At least somewhat likely	36%	36%
Rather unlikely	33%	33%
Would never do this	31%	31%

C. In addition to the hypothetical questions posed, physicians were asked about their own personal experiences on this topic. The following questions drew the responses stated below:

1. Are you directly aware of a colleague who has ever *prescribed* a lethal dose of medication for a patient?

YES 33% NO 67%

2. Are you directly aware of a colleague who has ever *administered* a lethal dose of medication for a patient?

YES 18% NO 82%

3. How often has anyone asked you to *prescribe or administer* a lethal dose of medication?

Has happened to me at least once 56%

Has never happened to me 44%

4. Approximately how many times did you agree to do this?

* (Of those who were ever asked at least once)

Agreed to do this at least once 50%

Never agreed, always refused 50%

Of the 45 physicians surveyed, 24 of them had a total of at least 50 requests. And 12 physicians assisted at least 25 persons in a suicide. In sum, of the 45 respondents, 56% had at least one request to assist in a suicide and 27% had actually assisted at least once in the past.

5. Who was the person making this request? (Respondents were asked to circle all that applied.)

Of the total number of requests those who asked included:

Patient	87.5%	Patient's Family Member	21%
Significant Other	8%	Health Care Worker	0.5%

Only one request came from a family member in the absence of a request by the patient. Two requests came from the mother of the physicians surveyed. Comments from these physicians were as follows: "(My) mother (asked); I did not refuse", and "It was my own mother (who asked in anticipation of a) 'pre-need'".

6. All physicians who had requests were asked to identify those reasons why a physician might refuse to prescribe or administer a lethal dose of medication. For each reason listed they were asked to show to what extent if any, that reason would influence their refusal to participate.

The one main reason:

a. Because it is illegal/concern for possible litigation	4%
b. Because of my religious beliefs	8%
c. Because I am morally and ethically opposed	25%
d. Because I believe that this is not a part of a physician's role	37.5%

7. Is there any other reason why you ever refused?

YES 33%

NO 67%

A third of physicians cited other reasons why they might refuse to assist if requested to do so. These comments fell into two general categories. The first seemed to reflect an attitude that rejected the premise that there should ever be a need for a patient to make such a request. Some of the comments are listed below:

- "My answers would change... if even injected opiates don't help."
- "There is always a non lethal dose of medication that would control pain, even if it means drug coma (from which) the patient (can) live a long (time)."
- "Would rather counsel to resolve anxiety"
- "Would recommend effective analgesic or sedative"

- "Most patients do not seriously entertain the notion. In most instances where it has come up, there was no need for a 'refusal'. Refuse is an adversarial term, at odds with autonomy."
- "There is a distinct difference in prescribing and allowing an individual to end his or her own life and in killing a patient directly."
- "A patient in pain has inadequate analgesia."
- An oncologist wrote that he/she always refuses because "the patient had the means and the medication in amounts to take action if desired."
- "Patients who do have medication at their disposal for lethal action rarely ever choose to use them."
- "In...supportive settings with caring health professionals, it is rare that patients ask."
- One physician wrote that he/she thought being asked to assist was not applicable because he/she had pediatric patients.

The second category of comments centered on how assisted suicide might be done. Perhaps these suggestions hint at factors that should be considered in any policy making regarding this issue. The comments follow:

- "If legal, (I would) prescribe (but) not administer."
- "It should not be the physician who administers."
- "There should be a board to review the situation prior to administration."
- (There is a) "need to evaluate each case individually from a moral and ethical perspective."
- "Insufficient relationship with the person requesting, for example, not my patient"
- (I would only consider administering) "if the patient could not do it themselves and specifically asks for my help in administering"

- "My answer absolutely depends on these points:
 1. Having tried all modalities of pain control
 2. Long term close relationship with the patient
 3. Fixed/firm decision over some amount of time
 4. Attempts have been made to increase the quality of life"
- "I have observed several reasons why patients ask to end it all:
 1. Anger at the diagnosis and fear of burdening family
 2. Pain that is poorly controlled
 3. Loss of self-esteem, feelings of unworthiness during dependency phase of illness

My care varies depending on reasons for requests."

- "Stages of death and dying bring about healing, for example, final accomplishments, saying good-bye, and beginning the grieving process."
- "I have always been willing to discuss these issues with patients but discourage them (from) acting."

Discussion

Regarding the data collected in sections A and B, several points can be made. Respondents were significantly more apt to prescribe a lethal dose of medication rather than to administer the same dose if asked to assist. Willingness to prescribe changed from 18% to 31% if prescribing was legalized. Similarly, willingness to administer moved from 7% to 20% if administering a lethal dose were legal.

In addition, respondents were more likely to assist (defined as prescribing or administering) a patient who is suffering from a terminal illness than one who is in chronic pain. Further, this trend would remain

the same if medically-assisted suicide was made legal. However, physicians would be more likely to assist under both conditions if assisting was legal. For example, 11% would assist someone in pain if assisting were illegal but this would change to 20% if legalized. The same observation is true with terminal illness as the condition. Willingness to assist changes from 18% to 36% if legalized.

Whether or not physicians would likely take a lethal dose of medication themselves if they were suffering from pain (25%) or a terminal illness (36%) was not significantly influenced by the legal status of assisted suicide. For both pain and terminal illness, there was no difference in willingness to assist when the person requesting assistance was either a close friend or a family member rather than a patient. Physicians are more likely to take a lethal dose themselves than help others if the condition was terminal illness in an environment where assisting was illegal. However, if made legal, they would help others equally as much as themselves. However, there was no significant difference in assisting oneself versus others if the condition was pain.

A special case arose with the internists. Thirty six percent of the physicians completing the survey identified themselves as practicing internal medicine. Of the physicians who reported actually having assisted others in a suicide, 50% were internists. However, only 22% of the internists surveyed reported that they would be willing to assist in the hypothetical situations where assisting was legal. Two possible reasons could account for this discrepancy. First, these physicians may not be willing to assist someone again. Second, they may not be able to imagine

themselves assisting in the hypothetical cases posed. This curious finding has been recognized in another survey.¹⁰⁶

Several other factors were examined. There was no correlation between those who have assisted and those who have knowledge of others who have assisted. Further, none of the demographic information was correlated to those most willing to assist. Whether or not someone was a member of A.M.A. or had knowledge of A.M.A.'s policy had no predictive value as to who would assist.

Conclusion

Several unique aspects of this survey are worth mentioning here. By virtue of their self-selected interest in bioethics, this group has probably given more thought to ethical dilemmas such as P.A.D. Also of note, the survey only included one open-ended question, however many physicians wrote comments in almost all sections of the instrument in the margins.

Because of the relatively small sample size (n=45), the findings are not readily generalizable to other physicians. Further, because of the sample size, it was impossible to do any multivariate analysis. Despite these shortcomings, this survey produced results consistent with those previously cited in other P.A.D. surveys. More importantly, it reinforces the evidence that patients are asking for assistance and that Dr. Kevorkian is not alone in granting requests. This evidence points to the antiquated nature of not only the Hippocratic Oath, but also the current A.M.A. policy on P.A.D.

¹⁰⁶ Medical Times, 49.

For future work, specific issues might be addressed. When asking physicians if they have assisted, it would be valuable to know specifically if they have done this by administering or by prescribing (referred to as the "Quill Method") a lethal dose of medication. Also, those who were never asked to assist should also be asked their reason for refusing a request, if any. This survey asked physicians if they would take a lethal dose themselves in certain circumstances. I suggest that they also be asked if they would want to be able to seek and obtain assistance from their physician if they did not have the capacity to assist themselves. And, finally, it would be helpful to know if physicians would like to be free to discuss whether or not to participate in an assisted suicide with a fellow physician. This freedom and safety in disclosing this information is significant in that Slome found that 1% of physicians would report a colleague if they found out that they had assisted in a suicide.¹⁰⁷

The only confidential method of gathering data regarding physician attitudes and practices concerning P.A.D. to date has been through anonymous surveys. Perhaps with information and exposure of the issues, society will come to make a decision about whether our society will tolerate this practice out in the open. In the next chapter, we will have the opportunity to view how these factors are being played out in Holland by examining the practice of euthanasia there.

¹⁰⁷ Slome, 1990.

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IV. LESSONS FROM THE NETHERLANDS

Everybody in Holland is a Calvinist. The Protestants are Calvinists, but so are the Catholics. Even the atheists like me are Calvinists. And the Communists here, they're the worst Calvinists of all. What does this mean? We like many rules, but we do not like to be told what the rules mean.

*- William Roose**

* William Roose was the foreign secretary of the Dutch Voluntary Society for Euthanasia and made this statement in January of 1989. See Gomez, 164.

IV. Lessons from The Netherlands

Introduction

The purpose of this chapter is to outline what is known about the current practice of euthanasia in The Netherlands and to substantiate from my observations why I believe it is working well there. The subsequent chapter will address those aspects of the Dutch practice of euthanasia that could be exportable to the United States. In addition to available literature, material for this chapter is derived from two sources. The first is the Dutch Rummelink Report; the second is information obtained from an 8 week investigation of euthanasia in The Netherlands in the summer of 1992.^{Note 4}

The Dutch Definition of Euthanasia

The Dutch have carefully chosen a restricted definition of euthanasia. It is "the intentional termination of life by somebody other than the person concerned at the patient's request."¹⁰⁸ The idea that the patient must make his or her own request at the end of life is central to this definition. This restriction will have critical implications for cases, to be discussed later, in which life is actively ended when there is no request. In this chapter, I will use the term euthanasia because the Dutch do not specify a distinction

Note 4 In 1990, the Dutch government set up a commission headed by Professor Rummelink to conduct a nationwide investigation on euthanasia and other medical decisions at the end of life. Van der Maas, 1992.

¹⁰⁸ Van der Maas, et al., (1991) 669.

between prescribing and administering a lethal dose of medication when considering P.A.D. If I deviate from this usage, it will be for specific emphasis.

The Practice of Euthanasia

The current practice of euthanasia was initiated by a landmark case that occurred in 1973 whereby a physician openly disclosed that she administered euthanasia to her mother. Since this case, euthanasia has been discussed and practiced more openly in The Netherlands. Euthanasia remains illegal in The Netherlands, but is permitted within certain guidelines established by both the legal and medical authorities. An agreement now exists between the Secretary of Law and the Royal Dutch Medical Society (KNMG) that if the guidelines for euthanasia are carefully followed, prosecution is unlikely.

A physician who performs euthanasia is obligated to report that the death was attributed to an "unnatural" cause and to directly inform the coroner of the event and circumstances. The coroner in turn files a report with the local prosecutor. All cases are then referred to a central committee in The Hague, where it is determined whether or not the guidelines for euthanasia have been met. The Dutch refer to these as the "criteria for carefulness". If the guidelines were followed, prosecution will not proceed and approximately 4 months after the event, the physician will receive a letter stating that no charges will be brought against him or her

for involvement in that particular case.¹⁰⁹ If prosecution is to proceed, however, the case is returned to the original district.

It remains a serious crime to bring about death through euthanasia and claim a "natural" cause of death on the patient's death certificate. The Dutch prosecutor, A.N.A. Josephus Jitta argues that a physician who knowingly falsifies the death certificate will be prosecuted more zealously than the physician who truthfully reports but questionably meets the criteria for euthanasia.¹¹⁰ In February 1993, the agreement not to prosecute physicians who perform euthanasia according to the guidelines, was further strengthened by a law, approved by a vote of 91 to 59 in the Dutch Parliament which more formally recognized prior arrangements not to prosecute.¹¹¹ It is anticipated that this parliamentary stamp of approval will encourage open discussion of the more controversial cases involving euthanasia and increase the number of cases that are actually reported.

Guidelines

The established guidelines were originally drafted jointly by the State Commission on Euthanasia and the KNMG. These have been adopted by the courts and have thus gained legal significance. The guidelines are summarized as follows:

¹⁰⁹ Correspondence from Dr. van Delden, one of the authors of the R Emmelink Report, dated October, 1992.

¹¹⁰ Interview with Mr. Josephus Jitta, public prosecutor in Alkmaar, July 21, 1992.

¹¹¹ Correspondence from Dr. Kimsma, a Dutch physician, dated February 1993.

1. A patient's request for euthanasia must be free and voluntary.
2. The request must be explicit and persistent.
3. The patient must have unbearable suffering.
4. Euthanasia must be an action of last resort.
5. Euthanasia can only be carried out by a physician.
6. The physician must consult with at least one other colleague.

Is There A Need For Euthanasia in The Netherlands?

The Rummelink Report found that about 25,000 patients each year seek assurance from physicians that they will assist them should their suffering become unbearable.¹¹² Of those who make such inquiries only about 9,000 actually request assistance. Despite the number of these requests, only approximately 2,000 cases of euthanasia and assisted suicide occur yearly in The Netherlands. Most general practitioners equate this to performing euthanasia about once every two to three years. From these figures, it is evident that the majority of requests do not result in physician assistance in dying for several reasons. Physicians may refuse to be involved because of their personal beliefs or because they feel the circumstances in a particular case do not warrant such action. On the other hand, medical interventions and palliative care measures may relieve the unbearable suffering. And finally, in some instances the patient may die before action is taken. One fact seems clear: patients ask their physicians for assurance that death will not be more than they can bear, and in exceptional cases Dutch physicians intervene.

¹¹² Van der Maas, et al., (1991) 672.

Who Is Making Requests and Why?

The Rummelink Report revealed general characteristics of patients who had made requests for euthanasia. Men requested euthanasia slightly more often than women. The leading diagnosis of patients making requests was cancer, followed by cardiovascular disease, and then by chronic illness with neurologic and pulmonary etiologies. The largest age group making requests fell between the ages of 65 and 79.

The Rummelink investigators found that patients have complex reasons for making a request to seek assistance in ending their lives. The most commonly cited reason for patients to request euthanasia was their loss of dignity.¹¹³ Other reasons included their loss of independence and tiredness with living. Pain was cited as a reason in less than 50% of cases and in only 5% of cases was pain the only reason. These particular points would strongly dispute those who argue that if pain could be managed, there would not be reason for patients to request an ending to their lives. In sum, patients define unbearably suffering through both psychologic and physiologic processes. In fact, the most frequently cited reason for requests are the result of the former and not the latter.

The Dutch guidelines requiring the presence of unbearable suffering is an appropriate criteria. The existence of unbearable suffering is defined by the patient, not the physician. Although, the physician must give credibility to the patient's account in order to be willing to participate in such an extreme action as to bring about death. The apparent vagueness of this term, unbearable suffering, has provided flexibility in allowing the

¹¹³ Van der Maas, et al., (1991) 672.

patient to express physiologic, psychologic or a combination of both features to define their suffering. In fact, the Rummelink Report findings reinforce the importance of the various factors that contribute to each individual's suffering.

Who is Assisting and How?

Fifty-four per cent of Dutch physicians have performed euthanasia.¹¹⁴ This pool of physicians can be broken down further. For General Practitioners, 64% have participated, whereas only 12% of nursing home physicians have done the same. Thirty-four per cent of all physicians never have been involved in a case of euthanasia but would be willing to assist in certain circumstances. Another 8% would not participate themselves, but would be willing to refer to a colleague. The remaining 4% would neither perform euthanasia nor refer.

The Rummelink Report took great care in defining terms and distinguishing the various types of medical decisions made at the end of life. It reports that of the total number of deaths in The Netherlands in a one year period, the following is an accurate estimate: 1.8% euthanasia, 0.3% assisted suicide, 0.8% life-terminating acts, 17.5% alleviation of pain with medications that also shortened life, and 17.5% decisions that included withholding or withdrawing medical intervention. In all, 38% of deaths required some medical decision to be made with regard to the end of life.

The data that has generated the most attention is the 0.8% of deaths that were a result of life-terminating acts. The majority of these estimated 1,000 cases involved adults who had previously requested euthanasia, but were

¹¹⁴ Van der Maas, et al., (1991) 671.

no longer able to verbalize that request at the time euthanasia was administered.¹¹⁵ Euthanasia is not used to describe intervention by physicians in this group because there was not a persistent and explicit request at the time of death, criteria which is essential to the definition of the term.

Factors that Make the Practice of Euthanasia Tolerable in The Netherlands

The Netherlands has a national system of mandatory health insurance, which ensures that all Dutch citizens are covered at least for basic health care. This provision makes euthanasia tolerable because assistance in dying can truly be seen as a situation of last resort only if all patients making requests can receive the health care management they need first. The Dutch find repugnant the introduction of economics as a factor in the discussion of medical decisions at the end of life, particularly euthanasia.¹¹⁶ Another factor that makes euthanasia tolerable is adequate long term nursing care facilities. This provision, along with the evidence that many fewer nursing home physicians than G.P.'s have performed euthanasia quiets the slippery slope argument that the frail and elderly will become targets for indiscriminate "mercy killing" once voluntary active euthanasia is tolerated by society.

Defenders of the slippery slope argument state that once society sanctions physician aid-in-dying, then it will become dangerously easier for physicians to take the life of another. The Dutch dispute the argument

¹¹⁵ Van der Maas, et al., 1992.

¹¹⁶ Rigter, Borst-Eilers, & Leenen, 1593.

against euthanasia that states that the Nazi atrocities should remain a reminder of the risks of the slippery slope in taking lives. Instead, the Dutch came away from W.W.II vowing never again to have their freedom jeopardized. The Dutch highly value individual freedom. This is evident by their tolerance of individual choice on a number of controversial topics. The Dutch maintain a consistent approach to controversial issues: keep it in the open. In this way, the controversial activity can be quantified, evaluated, and intervention, if necessary, can take place. This approach applies to their tolerance of soft drugs such as marijuana, the availability of needle exchange and methadone maintenance programs, and prostitution.

My experience and the findings of the Rummelink Report clearly dispute the existence of a slippery slope with the practice of euthanasia in The Netherlands.¹¹⁷ My interviews with Dutch physicians reveal what a deeply emotional decision it is for them to perform euthanasia, and how serious it is to take the life of another human being. Euthanasia is hardly an action these physicians take lightly, regardless of the number of times they perform it. Indeed, it is my experience and the finding of the Rummelink Report that physicians who have assisted their patients in dying are reluctant to do so again. That is not to say that they felt they made the wrong decision in acting before. Rather, they found the experience so moving that the circumstances under which they would agree to administer euthanasia again in the future must be very compelling. I view this evidence as a safeguard rather than a slope.

There are far more G.P.'s than specialists in The Netherlands. The ratio of primary care physicians to specialists is roughly 3:1 whereas the numbers are approximately reverse in the United States. The role of

¹¹⁷ Van der Maas, et al., (1991) 673.

primary care Dutch physicians is quite important not only as gatekeepers but for providing continuity of care. For instance, it is common for a person to have a long-standing relation with his or her physician. This fosters a physician-patient relationship that is personal and built on a history of mutual understanding and trust. It is not surprising for Dutch G.P.'s to make house calls and to attend burial services when one of their patients dies. To reinforce this theme, let me cite one physician who shared his criterion for granting a request of euthanasia with me: he said that he would only assist those he considers to be close friends.¹¹⁸ It is this type of bond in the doctor-patient relationship that serves as an additional factor making euthanasia tolerable in The Netherlands.

It has been argued that the escalation of medical malpractice in the United States is at least in part a result of declining trust in the doctor-patient relationship. Medical malpractice in comparison to the United States, is virtually unheard of in The Netherlands. Further, a malpractice suit is less likely to be sought as means of sole support in the occurrence of an unfortunate adverse medical outcome whether by fault or inevitability. That is because a social security net is in place to address financial needs if the patient is unable to earn a living. Should a suit take place the recovery is capped at approximately \$1500. Consequently, Dutch doctors are less likely than their American counterparts to fear physician aid-in-dying because of anticipated lawsuits.

The location of death as a factor that makes euthanasia in The Netherlands tolerable is also noteworthy. In The Netherlands, most deaths do not occur in the hospital. Rather, approximately two-thirds occur in the

¹¹⁸ Interview with Dr. Cohen, a Dutch physician, Rotterdam, July 6, 1992.

patient's own home.¹¹⁹ Once again, these figures are generally reverse in the United States. If Dutch families choose to care for their dying family member at home, support services are available regardless of the financial resources that family has available. For example, a visiting nurse is provided who can stay over night so the family members can be relieved of their care-taking duties and get some sleep. As a result, family members are better able to cope with caring for a dying family member at home when they are being supported. This is certainly not the case, for example, in the United States for families who, more often than not, are unable to afford this support. Additionally, the fact that most Dutch patients choose to die at home creates an environment where death is accepted by both the patient and his or her family as an inevitability rather than something to ward off with heroic measures.

Working Well

The tolerance of euthanasia as an individual option at the end of life is consistent with the Dutch culture and value system. The Netherlands enjoys a majority of public support on the issue of euthanasia, which I found to be true in my daily interactions with the Dutch. Typically, family members having had a positive experience of a loved one whose life was ended by euthanasia were very grateful. Families are aware that this intervention ended the suffering of someone they cared deeply for. Many of the family members I interviewed have already sought reassurance that euthanasia would be available to them if suffering ever became unbearable.

¹¹⁹ Van der Maas, et al., (1991) 670.

A compelling reason for allowing euthanasia as an option came from a dying Dutch patient.¹²⁰ He felt freed in knowing his remaining time would not be spent being anxious about what his final days would be like, or afraid of losing control. Instead, he could spend his remaining time living, not in fear of the unknown. He knew after discussing the situation with his physician that once living became too unbearable, he would have a way out. He and his family were comforted by this. I was moved by his acceptance of the dying process and for his complete presence in the moments we shared together.

There is another feature of public support and debate regarding euthanasia which may at first glance seem obvious, but which I found fascinating. By its nature, the media covers the most sensational and controversial cases of euthanasia. Non-eventful, uncomplicated cases with positive outcomes, actually the majority of cases are not mentioned. Despite this biased exposure, euthanasia in The Netherlands has wide public support. For instance, while I was there, proposed guidelines by the Dutch Society of Pediatricians for terminating the life of severely handicapped newborns made front page coverage.¹²¹ Moreover, the following case of Mr. S. appeared in a Dutch newspaper in which he expressed his unhappiness.¹²²

One of the most convincing demonstrations that euthanasia was working well in The Netherlands occurred to me as I was speaking to Mr. S. whose mother's life was ended by a medical act that ultimately was life-terminating. She did not make a request that would have qualified as persistent and explicit, yet her life was arguably shortened with morphine

¹²⁰ Interview with Mr. H., a terminally ill patient, Arnhem, July 15, 1992.

¹²¹ de Volkskrant (a Dutch newspaper), July 29, 1992.

¹²² de Volkskrant, Dec. 7, 1991.

anyway. This man was angry that his mother's life had ended before he expected, and before all the family members had a chance to say good-bye. What was particularly telling for me was that despite his unhappiness with his own family's experience with his mother's death, he continued to believe that euthanasia is safe and an important option for the dying in The Netherlands.¹²³

I was struck by the number of times I found through casual conversation that the Dutch could not believe that their situation was so unique. They were astonished to discover that I had to come to The Netherlands to research euthanasia. They were surprised to know that euthanasia was not outwardly tolerated in the United States as well; tolerating the practice of euthanasia in society made so much sense to them.

What The Netherlands Has Learned: 20 years later

The Dutch have developed guidelines that ensures that the practice of euthanasia strikes a balance between being instructive and remaining flexible. These guidelines have served them well. For example, the condition that a request for euthanasia must be explicit as well as persistent and must voluntarily come from the patient is absolutely clear. However, what suffering is and whether or not it is unbearable to the patient is not rigidly defined, as previously discussed, allows for individual interpretation.

Another development was that the Society of Dutch Pharmacists drafted recommendations regarding methods to be used for euthanasia. Many physicians do not have this sophisticated pharmacologic knowledge in how

¹²³ Phone interview with Mr. R. S., a patient's family member, July 30, 1992.

to end life as part of their medical training. The purpose of this brochure was to establish criteria for methods that were effective and humane to the patient.¹²⁴ This printed material is available only to physicians upon request. Physicians gain the technical knowledge of bringing about euthanasia by word of mouth, prior experience, or through this brochure.

Advancements have also been made to facilitate the interactions between the legal system and physicians as well as between the legal authorities and families. Initially the police would directly investigate physicians who were involved in cases of euthanasia. Now, a coroner, who is also a physician, acts as an intermediate between the physician who performed euthanasia and the prosecuting attorney. Furthermore, prosecutors have developed standardized forms to report euthanasia.¹²⁵ This has reduced the burden of the families, physician, and coroner in meeting reporting requirements. Additionally, plain-clothed police used to take statements from family members once a case of euthanasia was reported. This sometimes occurred when the deceased was still in the family's home. Now only if the guidelines have not been followed are police visits made to family members. These changes, as expressed by both physicians and families, have reduced their feeling like criminals for their involvement when they feel euthanasia is justified.

Tough Challenges Ahead

The Dutch continue to consider the question of whether they should legalize euthanasia. The recent parliamentary vote clearly reinforced that

¹²⁴ Ciesielski Carlucci, 18.

¹²⁵ Josephus Jitta, 36-38.

if the established guidelines are met, prosecution will not likely follow in cases of euthanasia. Despite wide public support, there is still strong objection to euthanasia by religious and conservative sects in political parties. Some see keeping euthanasia illegal as a safeguard. Persons in this category argue that keeping euthanasia illegal makes physicians more hesitant to become involved.

With this recent Dutch Parliamentary decision, one could argue with considerable force that the illegality of euthanasia is a semantic distinction and not functional one. The quote on the title page of this chapter cleverly provides insight into the functional nature of ambiguity, personal choice, and flexibility in matters of Dutch politics. Euthanasia fits this model. The current illegal status of euthanasia with Parliamentary approval is ambiguous. Personal autonomy is at the center of the Dutch definition of euthanasia by establishing the criteria of an individual's request. Finally, the guidelines provide flexibility in determining under which circumstances a physician is allowed to act.

What is significant about the Parliamentary decision is that the existing guidelines will also be applied to some cases where there is no request insofar as the legal requirement for reporting is concerned, such as with severely handicapped newborns or incompetent adults with severe suffering. This comes in response to the suggestion to make this extension by the Rummelink Committee. However, since the guidelines call for a request, a case of terminating life without one when reported will surely be prosecuted.

In cases of euthanasia, I argue it is advantageous to report. My investigative experience in The Netherlands lead me to conclude that reporting benefits the patient, his or her family, the physician, and

society.¹²⁶ I have much greater reluctance in making the same recommendation to report cases of life-terminating acts where there cannot be a request (for example with a severely handicapped newborn) because of the uncertainty of the risk of prosecution and penalties.¹²⁷ I believe this should be discussed openly in society. However, for me to suggest that an individual physician bring forth a test case via reporting is asking a lot considering the consequences are uncertain. A caveat to the current legal status in The Netherlands is that a prosecutor cannot consent to a "crime" by promising not to prosecute before the action is taken. This places the physician in somewhat of a jeopardy situation. Hence, the importance of decisions-making with other physicians is made obvious. This is an area that is stirring heated debate currently in The Netherlands; one that certainly lacks consensus at the present time.

The Dutch have not worked out a perfect system to handle all decisions at the end of life. They continue to struggle with the permissibility of life-ending acts in the case of the newborn, in comatose patients, and with advance requests. With regard to euthanasia, challenging requests have presented from patients with primary diagnoses of depression and anorexia.¹²⁸ Despite the difficulty in considering these cases, the advantage for the Dutch is an environment of openness to debate and discuss possible solutions.

The Dutch are also challenged with whether to broaden the euthanasia guidelines to include prior requests or requests by proxy. They seem to have averted this question by keeping definitions separate; euthanasia (always upon request) from medical acts of terminating life when a request cannot

¹²⁶ Kimsma & Ciesielski Carlucci, 328-332.

¹²⁷ A.C.Q. Interview with Dupuis, 275-280.

¹²⁸ NRC Handelsblad (a Dutch newspaper), June 23, 1992.

be elicited, i.e., newborns. In November 1992, the Dutch Society of Pediatricians released proposed guidelines, an updated version of the 1988 report, on how to handle decisions of terminating life in severely handicapped newborn infants. This document, much like the Rummelink Report, brought mixed reviews both in The Netherlands and internationally.

Recall that a request is central to the Dutch definition of euthanasia. In the absence of such a request the same activity has frequently been referred to as "life terminating" acts. Part of the moral and social justification for euthanasia for the Dutch has rested on great respect for personal autonomy via a request and the relief of suffering. The cases of terminating life without a request raises the question, Is only the latter justification enough? I have argued elsewhere that in some cases, it can be.¹²⁹

Opponents in the euthanasia debate find the distinction between euthanasia and life-terminating acts a means for proponents to separate arguments in favor of voluntary euthanasia and to avoid addressing slippery slope arguments. Many in The Netherlands find the suggestion of using a slope analogy to describe termination of life with or without a request as foreign. Furthermore, even if a slope existed, they hardly consider making carefully thought out decisions to permit life-terminating acts a slippery process. For now, the Dutch will continue to debate this specific topic.

Returning to attempts to compare the practice of euthanasia or life terminating acts in The Netherlands to the W.W.II atrocities, other distinctions must be made clear. The activity of the Nazis was deliberately against the person's wishes or against the potentially reasonable wishes of

¹²⁹ Leenen & Ciesielski Carlucci, 275-280.

persons in cases where someone could not communicate them, for example, newborns and coma patients. I would call this *involuntary* euthanasia. With regard to life terminating events in The Netherlands, whether or not to permit intervention is determined by consideration of the patient's best interest. This is evaluated by the medical team and available relatives. I would call this *non-voluntary* euthanasia. This distinction is an important one and should not be underestimated.

The 1,000 cases of life terminating acts as cited in the Rummelink Report makes one point poignantly clear. Clinical practice is not always simple. Certainly Dutch physicians are faced with circumstances that fall outside the guidelines that also demand decisions concerning the termination of life. Even when requests seemingly meet the criteria, difficult decisions arise. How can we be sure the patient is competent? What is persistent? What is explicit? Further, determining when increasing doses of morphine changes from a "pain-relieving" to a "life-ending" intervention is also not a straight forward matter.

The Dutch have debated euthanasia (with request) openly for twenty years now. They will surely take at least that long in debating whether or not suffering is justifiable enough to end life when a request cannot be made. The tolerance of frank and open debate allows their practice of euthanasia to shape policy and their policy to shape the practice. The present Dutch analysis, by no means a consensus, seems to suggest that ending life when tremendous suffering exists and the patient cannot make his or her wishes known is a matter of good medical treatment.

Exportable to The U.S.?

The very same reasons that make euthanasia in The Netherlands tolerable to the Dutch present a major challenge to incorporate the same practice in the United States. There is still disagreement by American researchers as to whether the Dutch example is one to model or would better act as a cautionary tale.¹³⁰ I argue it is a humane system, which in order to work in the U.S. will need some modification. Lack of equitable health care access, poor nursing home placement, a shortage of primary care doctors, medical malpractice, lack of tolerance to controversial issues, a majority of deaths occurring in hospital, and limited visiting nursing services are just a few of the unique challenges to the practice of euthanasia in the U.S. These modifications at first glance may appear insurmountable. That is the very reason why further discussion in the U.S. is desperately needed regarding the how P.A.D. can be practiced in a way that meets the patient's needs and protects others. Repeatedly, the primary concern of the potential transference of this practice to the U.S. is the implementation of effective safeguards. These will be addressed in chapter five.

Why Do We Need To Talk About It In The U. S.?

P.A.D. is already occurring in the U.S., occasionally resulting in very sad failed attempts when physicians are not adequately involved. For instance in the tragic case of Mrs. T. and her family in chapter 2. Secrecy in doctor/patient negotiations is not beneficial to that relation or to society as

¹³⁰ Gomez, xvii.

a whole. We can benefit from the Dutch experience in implementing physician aid-in-dying in the United States; just how will be addressed in the next chapter. Ideally, our society would simultaneously address all the problems listed above. But in the meantime, we should not skirt this issue.

However one feels about euthanasia or physician-assisted suicide, the Dutch must be credited for their willingness to explore their differences on this topic through open debate. From my own research in The Netherlands, it is my impression that the Dutch have responded to the dying in a way that is both humane to the individual and responsible to society. Their practice of euthanasia over the past twenty years has proceeded slowly and with caution. What other countries can take from the lessons learned in The Netherlands will vary. To this end, as a health care provider, I personally believe euthanasia and physician-assisted suicide are topics that demand our careful attention in the U.S. as well.

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V. LEGAL AND POLICY
 CONSIDERATIONS

*Here is to the world that goes
 round on wheels
Death is a thing that all man feels
 If death was a thing
 that the rich could buy
 The rich would live
 and the poor would die.**

* From the William Sprague diary cited in L. Saum, "Death in Pre-Civil War America," in D. Stannard, ed., *Death in America* (Philadelphia: U. Penn. Press, 1974), 31-32.

V. From Philosophical Debate to Practical Application: Policy and the Law

Introduction

In this chapter, physician aid-in-dying (P.A.D.) is identified as a public rather than a private matter insofar as policy is concerned. Historically, society has moved from making suicide illegal to removing it from the criminal codes, from not allowing passive euthanasia to stating it as a preference, and towards legalizing P.A.D. Considering this trend, prior state initiatives that would have legalized P.A.D. can be critically evaluated with an eye for future legislation. I elaborate on the advantages and disadvantages of legalizing P.A.D. in the United States and suggest general guidelines. As a final note, I comment on what to do in the meantime.

As previously mentioned there needs to be modifications of the Dutch practice to meet the unique cultural values and differences in medical practices in the United States. However, let me plainly state that there are aspects of the Dutch experience that we can transfer directly into any future implementation of P.A.D. here. These include the construction of guidelines, reporting requirements, pharmacologic methods, the importance of a quality doctor-patient relation, and the openness and tolerance of continued debate.

Whether or not P.A.D. ought to be a private or public matter is the first question to be considered. From previous moral arguments and the fact that suicide is not illegal anywhere in the United States, it can be argued

that suicide is a private matter.¹³¹ That is, no one other than the victim is involved in the planning and execution of the suicide.

Euthanasia is an entirely different matter. The key distinction entails the involvement of a physician in bringing about the death of one of society's other members. The physician, having received licensure from the state, is accountable to society for medical actions that are only made possible through legalization. An example of this is seen with abortion. Society and the medical profession both have a role in defining the limits of the practice of abortion in a given state. For these reasons as well as the state's duty in protecting life and preventing abuse, the issue of a physician's assistance in dying should be a matter of public policy.

Current Legal Status in the U.S.

There is currently no federal legal opinion on suicide, physician-assisted suicide or euthanasia.¹³² Likewise, turning to state legislation there are no laws against suicide in the U.S. However, some states specifically prohibit physician assistance in a suicide. California is one of those states. In the late 19th century the California legislature decided to differentiate between the crime of homicide (the unlawful taking of a life) and assisting in a suicide (presumably when requested to do so).¹³³ Prior to this the charge and penalties associated with assisting in a suicide were equivalent to murder.

¹³¹ Harvard Law Review, 2024.

¹³² Harvard Law Review, 2022.

¹³³ Leonard & Simonds, 1990.

The difference between homicide and P.A.D. rests primarily upon the degree to which the offender is involved in the final death-inducing act.¹³⁴ In California, examples of assistance can include furnishing the means - the gun, the knife, or the medication with the intentional knowledge that the person will use these means to bring about death. Homicide applies when one person actually performs the lethal action on another. Examples here include administering a medication, inserting an intravenous line, or shooting the other person. Assisted suicide laws would not apply under the following circumstances. If the patient takes a medication legitimately prescribed by a physician for a medical condition in a dose that is lethal, the physician would not be charged. Similarly, withdrawing or withholding life-sustaining medical treatment would not qualify.

Several legal case histories that have been significant in determining end of life decisions have included Sakowitz, Brophy, Bussalachi, Quinlan and Cruzan to name a few. Through legal case precedence, the practice of passive euthanasia via withholding and withdrawing treatment has become generally acceptable to patients, families, physicians, and society. This took time. In the United States with exponential advances in technology, society and individuals have come to see death as the enemy. Yet, the acceptance of passive euthanasia indicates recognition of the limitations of medicine at the end of life. Active euthanasia goes one step further. It makes death a conscious desirable option for some.

Unlike the Dutch, the involvement of a physician actively bringing about death in the United States could only occur overtly if the practice were legal. It is unimaginable that it could be tolerated but not actually legal in the United States as it is in The Netherlands. The most likely way P.A.D. or

¹³⁴ Leonard & Simonds, 1990.

euthanasia would be made legal is at the state level. Having established that P.A.D. is morally justifiable and that it is a public matter, if the practice is to occur in the U.S., it ought to be legal. I advocate that the medical profession be allowed to legally provide this intervention to those patients who request it when appropriate.

Problems have occurred because P.A.D. is illegal in the U.S. I have previously cited examples where complications arose for patients and families. Another predicament due to ambiguity in the law is evident with the charges brought against Dr. Kevorkian. I am referring to his use of a "suicide-machine" in Michigan in assisting patients who requested to die. In that state there was no specific law prohibiting assistance in a suicide. Because of his involvement in the death of Janet Adkins, he was charged with murder. The court decided to drop the charges, presumably because it would have been difficult to convince a jury to give the same weight to this action and that of murder with the same penalties. Michigan has since enacted a law against physician-assisted suicide which went into effect in March of 1993 in an attempt to discourage Dr. Kevorkian's future involvement in P.A.D.

A Look Back: two state initiatives

Enough public support through gathering signatures permitted two recent state initiatives to appear on the state's ballot; one in Washington during November 1991 and another in California during November 1992. General opinion polls often cite that 63% of the public is in favor of a patient's right to choose the timing of death and supports seeking the assistance of a physician. These same public opinion poll figures were

quoted in Washington and California just a month prior to voting on the initiatives. However, both initiatives failed with 46% voting in favor. Many speculations can and have been made about why such prior support did not result in a more favorable outcome. It is my opinion that the supporters of the initiatives had very little funds remaining in the last month prior to the actual vote. Being a grassroots organization, they could not compete with the well funded opposition. Many dollars were spent on television and other media advertisement portraying the potential abuses that opponents argued would result if the initiatives past. These tactics were focused on fear. One slogan that took on quite a stronghold in California was "no real safeguards."

This turn around in public support raises several points. First, there is a need for more open public debate, better understanding of the issues, and a need to proceed slowly on this sensitive issue and to proceed with caution. The number of readily visible vulnerable persons in American society is painfully obvious. It is therefore reasonable for concerns about potential abuses of legalizing P.A.D. in the U.S. to arise. Battin states that parties on both sides of the P.A.D. issues have an obligation to avoid abuse.¹³⁵ However, if the opposition cannot substantiate that the risk versus benefit ratio is inequitable then they ought not stand in the way of the dying patient's right to choose.

¹³⁵ Battin, 134.

***A Look Ahead: establishing guidelines that are tolerable –
for patients, physicians, and society***

Having established the importance of legalization, I will outline a set of guidelines and comment on those aspects that would deem them to be either ideal or practical.¹³⁶

1. A patient requesting P.A.D. must be a terminally ill (6 months or less to live), competent adult (at least 18 years old). A consulting physician must verify the primary diagnosis and document that the patient is in the terminal phase.
2. The patient must have unbearable suffering. A request must be made by a patient who defines their emotional or physical suffering as intolerable.
3. P.A.D. must be an option of last resort. All aspects of comfort care must have been provided i.e., adequate pain management, hospice care, chaplain referral, support group referrals if appropriate. Aid in dying can only be considered after the patient has been informed of and either tried or refused other treatment options.
4. The request must be persistent (with a waiting period of at least 2 days) and explicit (in writing). The request must be of the patient's own free will without coercion. If the patient is a nursing home resident, an ombudsman must document verify this.
5. The family must be informed of the patient's request if identifiable and only with the patient's consent. However, the family can neither make a request for euthanasia nor override a patient's request.

¹³⁶ Similar guidelines in part drafted by this author have been accepted as policy by the American Medical Students' Association in March of 1993.

6. A consulting physician must agree that P.A.D. is a reasonable action given the patient's circumstances.
7. A psychiatric consult is required if either the requested physician or the consulting physician suspect the patient is clinically depressed. If the patient is determined to have clinical depression, this must be treated before any request for P.A.D. can be honored.
8. The primary physician must have a meaningful relationship with the patient.
9. Once the above conditions have been satisfied the physician may prescribe or administer the lethal dose of medication for the patient. The patient must then determine with the physician the time, place, and who will be present when the medication will be taken. The physician is informed by the patient or his or her agent about the timing of the administration. The patient and physician will discuss in advance whether or not the patient wants the physician to intervene if the self-administered dose is not effective. If death does not occur within 4-12 hours, the physician may, if previously agreed to by patient, administer a lethal dose of medication (i.e., barbiturate followed by a curare-like medication).
10. Documentation of the P.A.D. must include the patient's diagnosis, the nature of the patient's unbearable suffering, a statement by the consulting physician, a statement by the psychiatric consultant if necessary, evidence of the patient's request by a signed witnessed consent, a description of other options explored, extent of the patient-physician relation, what method(s) were used to bring about death, who was present or informed of the death i.e., family members, chaplain, how soon after the intervention took place death occurred, and what complications, if any, took place.

11. The P.A.D. must only be prescribed or administered by a physician.

I will elaborate on the rationale for the major discrepancies between these recommendations and those I would ideally advise. First the idea that the physician must be allowed to administer a lethal dose once the P.A.D. process is begun, but unlikely to be effective is not negotiable because of the possibility of complications leading to a greater harm.

Administration of a lethal dose of medication must be an option in the formulation of any future legislation.

My fundamental objection to strict guidelines is that human suffering and medical disease does not lend itself to this approach. I will briefly illustrate this by referring to two commonly debated criteria of restricting guidelines to the terminally ill and requiring a waiting period. Restricting assistance to the terminally ill excludes those with potentially equal if not greater suffering. For instance, those with cystic fibrosis, deteriorating multiple sclerosis, sickle cell disease, or Alzheimer's may not be eligible. This is made more complex as a result of the imprecise nature of determining terminal illness.

My next objection is to the so called "waiting period". A natural waiting period occurs in The Netherlands after a request is made. Perhaps at the time of the request the patient has truly thought long and hard about it, however it is the first time for the physician. It also takes time to arrange a consultation. Simply because P.A.D. is an option in The Netherlands, the advantage is that the patient can bring up the topic in advance. However, imagine the inflexibility of this waiting period restriction in the following case example.

Mr. B. hypothetically arrives via ambulance with severe burns over 90% of his body surface area from a chemical explosion at work. He is in great pain and his prognosis is that he will only live several hours despite the most heroic of medical intervention. His family was notified and were at his bedside. Only comfort measures can be provided, but they are not relieving his suffering. He asks to have a lethal dose of medication after saying good-bye to his family. Mr. B. will not survive the two day waiting period. Would you deny Mr. B. a fair and easy passage in this extreme circumstance?

I recognize that tough cases do not make good law. Yet, this illustration requires that we carefully examine and justify the restriction of a waiting period.

Battin argues that physician-assisted suicide (prescription only) rather than euthanasia (also administering) is best suited to the medicolegal climate in the United States. Yet, it would be absurd to think that a society that legalized physician-assisted suicide (prescribing only) would charge a physician with some variant of murder if he or she administered a lethal dose of medicine after the patient's attempt of taking the prescribed medication failed. I find it curious that those who are in favor of physician-assisted suicide would likely argue that there is no moral distinction between passive and active euthanasia. Yet, their distinction between prescribing and administering is not a moral one, but rather stems from policy considerations. I believe this is not an area for moral compromise.

The problem with limiting physician involvement to physician-assisted suicide and concerns about abuse related to outright approval of euthanasia can be handled in the following compromise. If a state legalized physician-assisted suicide and not euthanasia, the spirit of the law would be a result of arguments that favor the patient's initiation of the final action. This requirement could stay intact without discrimination and avoidance of failed attempts with the following caveat. The law could be drafted such

that the physician would *prescribe* what is thought to be, by current medical standards, a lethal dose of medication. The patient must be the one to self administer the dose, if this is possible. If this is impossible then and only then can the physician *administer* the dose. This eliminates the issue of discrimination if physician-assisted suicide were legally made available to some but not others. Further, the law could go on to permit the physician to *administer* a final lethal dose of a curare-like medication if the patient has already taken the prescribed medication, but death has not occurred after 4-12 hours. It is conceivable that the practicalities of carrying out this step-wise application of this suggested law could be managed.

I would prefer the acceptance of a plan that had less restrictive guidelines. Nevertheless, I am willing to go forward with a restrictive initiative recognizing its limitations rather than having no plan at all. The adoption of a strict plan does not exclude transitioning to a plan similar to one I find more ideal over time. The value of allowing P.A.D. within strict guidelines to a limited population over a period of time is to ensure public support and to evaluate the effectiveness of safeguards. Yet, there are problems with this approach. The immediate benefit in the ideal draft is that it provides the fundamental necessities and restrictions, yet allows for individual facilities to enforce stricter applications if they desire.

I am fundamentally optimistic about mankind and that is reflected in my trust of collaborating physicians to make the right choices given less restrictive guidelines. Guidelines in a strict draft with across the board restrictions could exclude certain groups with reasonable and morally justifiable claims to assistance in dying. I find this most unfortunate. Ultimately society must decide how far they are willing to go. How these guidelines and safeguards will be enforced is beyond the scope of this work,

yet I do recognize the significance and potential difficulties of implementing them.

Concerns About Regulating Death

Keeping the status quo is unpalatable for several reasons. The argument that we should address equal access to health care before giving attention to the issue of P.A.D. assumes that they are competing goods. I do not see it that way. Ideally, we would have provided equal access to care by now. With the present economic climate and the negative political attitudes about distributing wealth in the U.S., I am not optimistic that this will happen in the near future. Perhaps, with the new administration, at least some advances will occur. Therefore, I do not feel it is just to make those suffering dying patients wait for a desirable but marginally attainable goal. I believe we need to seriously work on both issues simultaneously.

Further, I believe that not allowing P.A.D. can create two injustices to the under-served. First we don't provide them with basic health care and when they develop serious disease we don't provide comfort measures or support. Secondly, we give them no out such as assistance in suicide. I am not suggesting that the initial injustice is acceptable, but rather that the latter restriction is an additional inequity. I recall one AIDS patient telling me that once her benefits ran out, she would be unable to meet her daily needs and manage her symptoms, and that she would then be forced and prepared to take her own life. She has a gun.

Finally, some argue that families will exert pressure on patients who are spending down resources to pay for terminal care. I am against this as a means of coercion for a dying patient to make a request when they would

not have otherwise. Yet, I don't believe it is necessarily wrong for others to establish that a family forfeit their option to rationally decide how they will distribute their own resources. A frequently cited example is a grandparent who feels they have lived a full life and would like to leave their resources and that of the next generation for the college education of the grandchildren.¹³⁷ I doubt that current decisions to withhold and withdraw treatment are always free of this type of factor analysis.

Even proponents of euthanasia here and in The Netherlands recognize that some P.A.D. cases fall outside the guidelines and that some limited cases of abuse may occur. One serious issue that must be addressed but is beyond the scope of this work is, what constitutes abuse? We can see from the evidence of the Rummelink Report that what one group would call good medical practice another would identify as the bottom of the slope.

The question that remains unanswered is why would physician-assisted suicide be more suspect of abuse than other current more passive means of bringing about death? I argue it is not. Passive euthanasia is subject to the same abuses as P.A.D. The difference is that passive euthanasia can occur behind closed curtains. Passive euthanasia can be more subtle, not directly identified, extend over a longer period of time, and less people may be aware of its occurrence. Moreover, it is no less significant. After all, not providing treatment options, removing a ventilator, prescribing and overdose, and injecting curare all have life-ending capability.

An additional question is if P.A.D. legalized, how could abuses be minimized? I believe this can be accomplished through peer consultation, documentation, and institutional review to name a few possibilities. P.A.D. would be more easily identifiable because of its immediate effect, the types of

¹³⁷ Bliss, 117-122.

medications used, subsequent reporting, and persons' knowledge about its occurrence. This additional disclosure with P.A.D. would provide for more checks and balances when the decision is being made and afterwards through review. In both active and passive euthanasia if a mistake is to be made, the patient will die. A benefit of P.A.D. with protocols in place such as a required physician consultation, is that the case will receive review prior to the patient's death.

Positive Aspects of Legalization

Legalizing the practice has several intrinsic benefits. A policy of openness, mediated by mandatory reporting of cases if P.A.D. were legalized, fosters acceptance, tolerance, and trust. Legalizing P.A.D. will allow physicians to collaborate and support each other, allow patients to communicate more freely with their physicians, and facilitate the grieving process of the family members in that they will have the ability to disclose the cause of death with others allowing them to have their own support network.¹³⁸ This in turn will benefit society. We have seen through the I.B.I. survey, and others like it, that patients are already making requests and that physicians are assisting them to various degrees. Secrecy of this practice in an intolerant legal system promotes fear and guilt, neither of which can serve positive outcomes for the physician, the patient, their families, or society.

¹³⁸ Schaaf & Meyboom de Jong, 1991.

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Each physician has to make a personal decision about P.A.D. in any given case. Making that decision incorporates whether or not participating is legal and whether it is felt that the request is morally justified. Therefore a physician may decide that intervention is morally appropriate despite its current illegality in the United States. This of course, may have adverse consequences.

Although the risk has been minimal for physicians who have assisted in suicides, that has not been the case for family members and does not guarantee that this will remain the same if a future case arose. There have been approximately eleven doctors brought up on charges related to euthanasia in the United States since 1935. None were sent to prison.¹³⁹ The court system has not looked so favorably upon family members who have involved themselves in euthanasia and assistance in suicides.

Making decisions about end of life is not a matter that lends itself to straightforward policy. Individual decisions within established guidelines should remain on a case-based basis. These decisions will vary practitioner to practitioner and from one culture to another. For now, I would encourage physicians to take the advise of a kind, wise, and veteran Dutch physician when confronted with a reasonable request from a patient in the current illegal environment in the United States. That is, pursue whatever decision and action you feel you would be comfortable with thirty years from now.

¹³⁹ Hemlock Society literature.

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