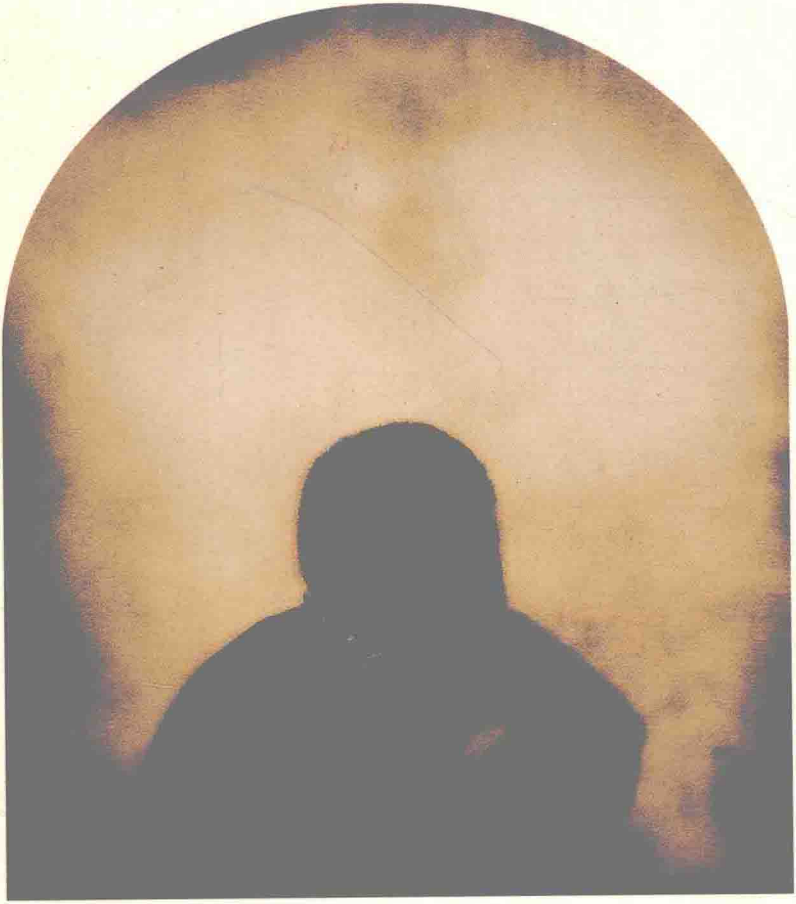
Arguing Euthanasia



HE CONTROVERSY OVER MERCY KILLING, SSISTED SUICIDE, AND THE "RIGHT TO DIE"

EDITED BY JONATHAN D. MORENO, PH.D.

provocative pieces by Timothy Quill, Nat Hentoff, Betty Rollin, Ronald Dworkin, Sidney Hook, Daniel Callahan, and others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ARGUING EUTHANASIA

The Controversy over Mercy Killing, Assisted Suicide, and the "Right to Die"

Edited by
Jonathan D. Moreno, Ph.D.

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INTRODUCTION

Jonathan D. Moreno

In 1974, several months before my twenty-second birthday, my mother and I were forced to make some agonizing decisions. My father, then in his mid-eighties, collapsed following an epidemic of the flu. During the next few weeks he became more and more disoriented, the result of a series of tiny strokes that he had suffered over a period of time but whose cumulative effects were gradually overcoming his recuperative powers. Finally, he stopped eating, and drank only enough to keep his mouth moist.

My father was a physician, and he and my mother had made a pact that, should he become seriously ill, she would not send him to the hospital to die. His wishes stemmed from fifty years of professional experience with large institutions and from his distress at the hospital death of his mother some years before. Fortunately, we were in a position to honor his preference. Early in his illness we installed a hospital bed in his room so that he would not fall while sleeping. Nursing care was available around the clock.

As my father's condition worsened, however, his discomfort grew. Barely coherent, he seemed to reverse his earlier wishes and began asking to be taken to the hospital. At that point his private physician, an old friend and colleague, determined that he was terminally ill and suggested that he be given regular morphine injections. When his doctor asked him if he wanted morphine he shook his head, but he continued to complain of discomfort. The next day, we urged his doctor to give him the injection without asking. Though conscious, this time my father acquiesced to what would be the first of many such injections. Finally he became composed and comfortable, and a few weeks later he passed away quietly.

Our own uncertainty had added to the trauma of the situation. When his pain became intense and he asked to go to the hospital, we had to decide whether this was an authentic request or rather a cry for help. Believing that she knew his true wishes, my mother tried first to relieve his pain. But his initial reluctance to be medicated raised other questions: Did he fear the further clouding of his intellect? Or, in his deluded state, did he think he was being given an overdose? Or did he perhaps simply fail to recognize his old colleague? The decision to proceed with the injection the next day was also fraught with danger: What if he physically resisted? Would we have him restrained and injected against his apparent will, on the grounds that he was confused and deluded? We were trying to help him, but would a second attempt at injection make him less trusting of us in his final days?

Although the story of my father's death seems straightforward in retrospect, at several points it could have gone very differently. If my father had been admitted to the hospital, if his doctor had expressed reluctance about pain medication, or if we had not suggested a more aggressive approach to the injection, his course would have drastically changed. Today it is less likely that a physician would be willing to take care of such a patient outside the hospital—for medical, practical, and legal reasons. But my father knew that his chances of dying peacefully would have been lessened in the hospital. Though technical interventions were limited then, as compared to twenty years later, my father did not want to spend his last days in an impersonal institutional environment. Today, routine end-of-life hospital care tends to be even more aggressive than it was then. In fact, after his suffering was under control, my father gave no indication that he wanted to leave our home or that he wanted the medication to cease. In the time that followed, a legion of old friends and former students were able to visit and say good-bye, unimpeded by hospital technology or visiting hours.

That my father's dying unfolded as it did was due to several factors: his communication of his wishes to my mother, the availability of medical and nursing care at home, the financial wherewithal to afford such services, my mother's exceptional courage and determination, and an era when institutionalized and technologically mediated death could be more easily avoided. Even as recently as the mid-1970s, physicians were less inclined to practice defensive medicine for legal reasons, and end-of-life technology could not so effectively extend the dying process. There was also a measure of luck: We knew him well enough to assess his true wishes accurately when we needed to. I have often wondered how differently things would have gone if any one of these factors had been absent.

I have wondered, too, if we made the right decision in the first place about keeping him at home. Should we have hospitalized him in spite of his previously expressed wish? In doing so we might have had him for a few more months, though in an increasingly debilitated condition. Or, if he was ready to die, would he have preferred to have his trusted medical friend end it quickly with a lethal dose? Or, as a strong-willed man, would he have elected to give himself the injection when still able to do it? As a licensed physician he had access to the medication for an overdose, but considering my father's zest for life, I am sure he never considered death by his own hand. Perhaps he would have preferred his doctor to give him a lethal injection, as in the case of his medical school lecturer Sigmund Freud. Even under the best of circumstances, dying can be a grueling and laborious affair. At one point he said to my mother, after weeks spent lying in bed, "It takes a long time to die."

Mainly I feel that we did well by my father, but doubt is a humane and noble thing when the stakes are so high.

As much as any other personal factor, the experience of my father's dying led me to a career as a teacher and scholar of medical ethics. The subject of euthanasia and assisted suicide is among the most ancient and important in this field. The Hippocratic Oath, which remains the primary touchstone of medical ethics in our culture, appears to rule out physician-assisted death. But it is reasonable to ask how a code that is over two thousand years old can apply to medical techniques that would have been beyond the wildest dreams of its author. In fact, for a few hundred years, and perhaps longer, some patients have called the strict Hippocratic prohibition into question, and it is certain that some doctors have violated it.

Of course, it is one thing to say that a moral code like the Hippocratic Oath is often violated and quite another thing to say that it is wrong. But the fact is that the oath is among the most revered and least read documents of Western civilization, even among physicians. Many medical school commencements include a ritualistic recitation of the oath by the young men and women about to become doctors of medicine, but it is usually a sanitized version that omits references to sensitive subjects like euthanasia and abortion. Ignorance of the Hippocratic Oath's actual content is perhaps best exemplified by the frequent references to the maxim *Primum non nocere*, or "First do no harm." The precept is indeed Hippocratic, but it does not appear in the oath.

One could argue that our modern technology and our complex society have left the oath's ancient wisdom far behind, that what worked twenty-three hundred years ago cannot work now. But even then the Hippocratic circle was but one of many medical cults; and dissatisfaction with its apparent prohibition of physician-assisted suicide, or active euthanasia, is nothing new. In his *Utopia* (1516), Thomas More wrote:

> They console the incurably ill by sitting and talking with them and by alleviating whatever pain they can. Should life become unbearable for these incurables the magistrates and priests do not hesitate to prescribe euthanasia. . . . When the sick have been persuaded of this, they end their lives willingly either by starvation or drugs, that dissolve their lives without any sensation of death. Still, the Utopians do not do away with anyone without his permission, nor lessen any of their duties to him.

Of course, the social conditions under which most people get sick and die are still far short of utopia, which gives rise to legitimate concerns about the implications of such a practice in the real world.

It is interesting that the modern secular state has mainly avoided the issue. Euthanasia and assisted suicide have usually been treated as forms of homicide, at least technically, and only in the Netherlands have the courts officially tolerated the practice. But all that changed dramatically on November 8, 1994, when Oregon voters became the first in the nation to approve a ballot measure that allows doctors to hasten the death of those who are terminally ill. Measure 16 was the successor to two closely defeated initiatives in Washington State in 1991 and in California (for the second time) in 1992. Importantly, those previous efforts permitted a doctor to administer lethal drugs, while the Oregon law only allows a physician to prescribe an overdose of medication. If Measure 16 survives a constitutional challenge in court, it would legalize physician-assisted suicide in Oregon, not active euthanasia, and this is thought to be less liable to abuse. In the Netherlands, allegations that some patients have been put to death without their consent are the basis for powerful criticisms of the Dutch courts' toleration of active euthanasia.

With the approval of the Oregon initiative, an epochal legal, cultural, and psychological barrier has been breached, for better or for worse. Evaluation of the actual results of the law will surely take years, but it may take far less time for other states to approve similar measures, now that the line has been crossed. It is critical to understand how we arrived at this Northwest passage.

The popular movement that led up to the Oregon referendum can be dated from at least 1988, when the *Journal of the American Medical Association* published an anonymous five-hundred-word article called "It's Over, Debbie." The author claimed to be a physician in graduate training who had granted the apparent wish of a seemingly dying young woman to be put out of her misery.

The brief entry unleashed a firestorm of criticism from some of the country's leading medical ethicists, perhaps especially those who were physicians. Their outrage was directed primarily at the reported conduct of the doctor. According to the article, he or she had met this patient only minutes before the event, and in the middle of the night, without even a modicum of standard assessment and consultation. In the critics' judgment, the act described was without the slightest shred of professionalism—a thoughtless murder perpetrated against a vulnerable person in a hospital bed, in wholesale violation of the most elementary standards of medical ethics. The ethicists unleashed a secondary volley at the editor of the prestigious journal for even having published such a document.

A backlash ensued among professionals and members of the general public who were unimpressed by the alleged wisdom of these ethicists; they upbraided the ethics experts for failing to take adequate account of the suffering of the dying. During the 1980s, many people had become sensitized to the contemporary problems of dying. Indeed, stories about dying people had almost become a literary genre. Among them was journalist Betty Rollin's powerful description, in her book *Last Wish*, of her mother's struggle with terminal cancer, and of her decision to assist in her moth-