

## Assisted Suicide: A Shifting Tide?

Are we beginning to witness a shifting tide in attitudes toward physician-assisted suicide in this country? Recently, the American Society for Bioethics and Humanities, the professional organization for health care ethicists, held its annual meeting in Washington, DC. At least two of the presenters (and there may well have been more) openly supported physician-assisted suicide. One was a trauma surgeon who stated that he saw no difference between withdrawing life-sustaining treatment on a patient and taking measures to bring about the patient's death. In both cases, he believed he was instrumental in causing the patient's demise.

A similar note was sounded by another presenter who is co-author of a recently published book (Franklin G. Miller, Ph.D. and Robert Truog, MD, *Death, Dying, and Organ Transplantation: Reconstructing Medical Ethics at the End of Life*, Oxford University Press, 2012) challenging, in part, the traditional distinction between allowing-to-die and causing death. Miller dismissed the distinction in his remarks and endorsed physician-assisted dying as being no different than withdrawing life-sustaining treatment. In the early pages of the book, the authors write: "Accordingly, withdrawing LST has been widely regarded as allowing the patient to die and not as causing death. We contend that this stance cannot withstand critical scrutiny because withdrawing life-sustaining

treatment, when examined without moral preconceptions, is clearly seen as causing death" (p. 1). ... "[M]edicine should no longer be governed by the norm that doctors must not intentionally cause the death of their patients. In other words, medical ethics should be reconstructed so that it can accommodate the routine practice of withdrawing LST understood as legitimately causing death" (pp.1-2). (The authors' goal in rejecting the distinction is also to propose the removal of vital organs from patients prior to brain death).

Marcia Angell, MD, former editor of the *New England Journal of Medicine* and an advocate for physician assistance in dying (as it is referred to by advocates) recently published a lengthy article on assisted suicide in *The New York Review of Books* ("May Doctors Help You to Die?," Oct. 11, 2012). Angell claims that "what we are seeing is an outgrowth of a decades-long evolution in public attitudes toward how we die, which began with the 1976 case of Karen Ann Quinlan." After reviewing what has occurred in Oregon over the past 14 years, she notes that "observers looking for a slide down a slippery slope have not found it." Oregon has not produced the abuses or even the consequences that had been predicted. Ultimately, she claims that "when healing is no longer possible, when death is imminent and patients find their suffering unbearable, the physicians' role should shift from healing to relieving suffering in accord with the patient's

wishes.” She maintains as a justification for this that “most pain can be eased but other symptoms are harder to deal with—weakness, loss of control of bodily functions, shortness of breath, and nausea—and the drugs to treat those symptoms often produce side effects that are as debilitating as the problems they treat. Even worse for many dying patients is the existential suffering. They know their condition will worsen day by day until their deaths, that their course is inexorably downhill, and they find it meaningless to soldier on. Why would anyone...presume to tell someone else how much suffering they must endure as their life is ending?”

Somewhat surprising, and possibly further indicative of a shifting tide, was an article in the *New England Journal of Medicine* (Julian Prokopetz, B.A., and Lisa Soleymani Lehmann, MD, Ph.D., “Redefining Physicians’ Role in Assisted Dying,” 367, no. 2, July 12, 2012) by a physician and a student advocating for physician-assisted suicide for the terminally ill. The authors claim that the fears expressed by those who oppose physician-assisted suicide have not been borne out in Oregon and that “there is a compelling case for legalizing assisted dying” (99). However, this would not require that physicians become involved and they propose a mechanism for this to occur.

A piece in the Oct. 20, 2012 issue of *The Economist* (“Over My Dead Body: Helping the Terminally Ill to Die, Once Taboo, Is Gaining Acceptance”) and a column in the Sept. 17, 2012 issue of *The*

*Atlantic* (Wency Kaminer, “How the Catholic Church Misunderstands Death with Dignity”) also advocate for physician aid in dying.

And, of course, there is Massachusetts, a strongly Catholic state. On Nov. 6, the citizens of the state will vote on Question 2, a ballot initiative that would permit licensed physicians to prescribe life-ending medications at the request of terminally ill patients. If the initiative passes, Massachusetts would be the third state to allow assisted suicide. Recent polls suggest that anywhere from 58-68 percent of the voters of Massachusetts will support the initiative. The New Jersey legislature is currently considering legislation that would permit terminally ill patients with less than six months to live to receive and self-administer life-ending medications.

What is to be made of all of this? If the ballot initiative passes in Massachusetts, it would seem that Catholics have contributed to that victory, despite the urgings of the Archdiocese and others to oppose the initiative. What does this indicate? Second, more and more physicians seem to be supporting assisted suicide. Physicians and physician organizations have been a bulwark against this in the past. But is this opposition eroding? If it is, that means that physicians are not only not seeing the distinction between allowing to die and directly bringing death about, but also see their roles as physicians differently. Part of that role now becomes alleviating patient suffering by ending life.

What does all this suggest for Catholic health care? First, in those states where physician-assisted suicide is legal, Catholic health care institutions will have to figure out how to deal with this in a multiplicity of ways. How will they respond to patients who request assisted suicide? What will they do with requests for a referral? How will they handle physicians who assist with patients' dying outside of Catholic facilities? How will all of this be handled in hospice programs run by Catholic organizations? Or home care agencies? These are just a few of the challenging questions.

Second, it seems that the Catholic arguments against assisted suicide and the distinction between allowing to die and directly bringing death about are not sufficiently persuasive. *Ad hominem* arguments, imputing sinister motives to advocates of assistance in dying, and enumerating possible or likely consequences of legalization not based on fact have not been and are not likely to be persuasive. Statements of various types against assisted suicide are often summarily dismissed because they are deemed offensive to well-meaning people or are perceived to be factually baseless. It may be time to rethink how opposition to assisted suicide is argued and communicated. The current approach does not appear to be working either

within or outside of the Catholic community.

Third, Catholic health care organizations that do not implement the Catholic tradition's approach to end-of-life decision making need to realize that they are indirectly contributing to a push for assisted suicide. Prolonging dying beyond what is reasonable or beneficial to a patient is not the Catholic tradition. The same is true of those who fail to implement palliative care programs and hospice. Opposition to various efforts across the country to provide better end-of-life care is probably contributing to precisely what it is attempting to prevent. It is not sufficient to oppose assisted suicide. Positive alternatives need to be advanced and actively supported.

The Catholic community may well be at or coming to an important moment in its opposition to assisted suicide. It may be time to rethink the arguments and the communication of those arguments as well as take the necessary steps to ensure the best possible end-of-life care. Opposition to assisted suicide without extensive efforts to provide alternatives is hollow. Placing obstacles in the way of a "good death" flies in the face of our Christian beliefs about life, death, and resurrection.

R.H.