DOES COMPASSION INCLUDE EUTHANASIA?

Physicians' Roles in Caring for The Terminally Ill Preclude The Use of Euthanasia

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Summary As technological advances continue to allow physicians to prolong dying patients' lives, healthcare providers face many issues surrounding physician-assisted suicide and euthanasia.

When a physician performs euthanasia or assists in suicide, he or she is killing the patient. The action can in no way be interpreted as allowing an eventually inevitable death to occur earlier rather than later. The physician is culpable.

Physicians play three important roles when caring for terminally ill patients: adviser, friend, and priest. The risks inherent in each of these could create an illusion that performing euthanasia and assisting in suicide are humane and logical options.

Finally, physicians should not miss opportunities for grace when caring for dying patients. When physicians convey the diagnosis, when patients express the desire to control the timing of the death, and when patients are feeling sadness and anger, physicians must rise to the occasion to act as friend and minister and to introduce grace and healing to the dying.

Physician as killer is the antithesis to physician as healer. As a Catholic physician, I believe it is never permissible for a physician to kill another human being or to assist a person in doing so. Physicians must accept the responsibility that patients' lives are in their hands. Those who hasten patients' death spurn the principles they embraced when they took the Hippocratic oath.

Physicians who care for dying patients have many responsibilities. First, physicians must develop a clear perspective on end-of-life issues. They must also act as patients' adviser, friend, and priest. Finally, physicians must recognize opportunities for grace in their relationships with terminally ill patients.

End-of-Life Medical Decisions

As recently as 40 years ago, physicians had little ability to prolong the lives of gravely ill patients, but in the past few decades medical advances and new technologies ranging from antibiotics to mechanical ventilation have allowed physicians to delay death. Medical advances seem to give physicians a newfound power over death. New obligations and subsequently new decisions involving the timing and circumstances of a person's death have followed.

Many physicians who were just learning to cope with this new ability to control the timing of a patient's death felt confused over the options of withholding or discontinuing useless treatments. If physicians can save lives by using treatments such as artificial nutrition or invasive procedures, are they not also taking lives by stopping such treatments? And just when the profession was becoming comfortable with the notion of patient autonomy and the right to refuse treatment, doctors may be asked to end "a life not worth living"[1] at the patient's request.

Rev. Richard A. McCormick, SJ, and Daniel Callahan point out that this kind of patient autonomy is exaggerated. Callahan describes it as "self-determination run amok."[2] The concept of

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patient autonomy has nonetheless left physicians struggling with the notion that they have a spectrum of options to offer terminally ill patients, ranging from withdrawing or withholding therapy to physician-assisted suicide and euthanasia. The line between allowing patients to die from underlying terminal diseases and killing patients who have fatal diseases sometimes blurs because it appears that the motives and outcomes are similar.

I find it helpful to follow the arguments of Bernard Gert and Charles Culver.[3] They distinguish withdrawal or withholding of treatment from euthanasia on the basis of the physician-patient relationship. When a physician withholds or stops treatment at the voluntary request of a patient, he or she is abiding by a competent patient's valid refusal of life-sustaining therapy; that is, the patient, not the doctor, is the decider or the actor. The cause of death is the underlying disease (or nature taking its course, so to speak), not the physician's action to not initiate or to stop treatment.

On the other hand, physician-assisted suicide or euthanasia is something a doctor performs at a patient's request when there is no moral requirement for him or her to abide by that request. Here the physician is the decider or actor. In this situation the doctor is killing. The action can in no way be interpreted as allowing an eventually inevitable death to occur earlier rather than later. The physician is culpable.

By maintaining this distinction, one sees there is really no spectrum of choices. Euthanasia and physician-assisted suicide are not just other types of medical management. Without this distinction, we risk the situation where a doctor determines medical treatment is no longer effective in prolonging life and opts to hasten the patient's death by direct killing because it seems to be the most reasonable step, on the grounds of both humaneness and economics.

We can avoid this slippery slope, however, as long as the doctor understands who the decider is. When the patient is the decider, a physician is not morally obligated to fulill his or her request for euthanasia or assisted suicide. And a physician is not culpable when he or she decides to discontinue futile treatment. Finally, a physician cannot *morally* cross the line between stopping treatments, even if it may result in death, and doing things that kill (e.g., prescribing lethal drugs, giving lethal injections).

I believe we must look at euthanasia and assisted suicide as killing so as not to neutralize the action by using terms such as "termination of life," which helps anesthetize our feelings. Callahan calls euthanasia the worst category of killing (i.e., private self-determined killing between people to satisfy private wants and desires, not for the sake of a nation, as in just war, or for the sake of justice, as in capital punishment, or for the sake of saving a life, as in self-defense).

Physicians must accept the responsibility that patients' lives are in their hands.

John Collier

Physicians' Roles

Physicians play innumerable roles in attending to their patients. Three are especially important in the relationship with the terminally ill patient: adviser, friend, and priest. The risks inherent in each of these could create an illusion that performing euthanasia and assisting in suicide are humane and logical options.

Physician as Adviser The first role is that of adviser, the provider of medical information and skill. The doctor talks with patients and families about diagnosis, treatment options, and likely outcomes. The physician also provides the best medical management he or she can, including the intelligent use of analgesics, identification of burdensome and futile treatments and recommendations for their discontinua-

tion, and provision of the best physical comfort possible.

The risk physicians run by playing adviser invokes their humanness. Physicians have difficulty providing unbiased recommendations and predicting outcomes with certainty. They often want to do more for patients when therapies fail. Offering a quick and easy death may look appealing, and physicians may consider euthanasia.

Physician as Friend In his book *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*,[4] James F. Drane describes the virtue of friendliness or affect in the relationship between doctor and patient. The association is personalized, and the physician's obligations are derived from the patient's needs. It is therefore a dimension of benevolence, the will to help. Friendship implies a nearness, a presence to the dying patient. And when the patient experiences illness-induced isolation, the physician is the "friend who can share what he is suffering and offer some ray of hope for relief."[5] Feelings are shared, intimacies revealed, confidences exchanged.

What is the risk in friendliness? Is it possible to be too empathic? To feel the patient's pain too deeply? Dutch[6] and Australian[7] studies suggest that euthanasia is best carried out when there is an emotional bond between patient and doctor. I would argue that what is called compassion in euthanasia is a disguise for the doctor's own discomfort and feelings of inadequacy as he or she stands by watching the suffering with little more to offer.

Euthanasia is not the kindest death, but rather the final abandonment of the suffering patient. C. Everett Koop states, "It is far too easy to hasten a so-called death-with-dignity than to do the more difficult but required job of effectively managing pain during the remaining hours of life."[8] Alexander Morgan Capron finds it difficult to equate killing with healing.[9] He states that the term "physician aid in dying" is at best an evasion, when what is meant is legalizing physicians taking steps to kill patients directly, swiftly, and painlessly. Love and companionship are better ways to aid, says Capron.

Physician as Priest When physicians minister to dying patients, they take on the priestly role.[10] Because some doctors have frequent contact with death, the religious dimension of medical practice is intensified, and sensitivity to patients' needs is magnified. This puts physicians in the best position to accompany patients on their journey of dying, standing by so that patients do not die alone, and comforting them during periods of fear, doubt, and despair. Physicians aid in preserving dying patients' dignity and humanness. In the Christian tradition, physicians treat patients as Christ.[11]

This human healer, an agent of God, does not have the final authority to decide that a death is too slow or tedious. Priest does not imply judge. Koop states, "Nothing in medicine or Judeo-Christian tradition enables one person to make a true judgment about another person's quality of life."[12]

A Cry for Help An Australian survey of doctors and ministers found that two-thirds of patients' requests for euthanasia are never carried out.[13] The authors conclude two things: that the request for euthanasia is most frequently a cry for help (i.e., for assistance in living rather than in dying) and that the request is withdrawn when the patient receives good emotional support and palliative care. The kind of care implied here includes nearness, empathy, listening, and an optimal number of contacts (i.e., visiting a patient as often as necessary to help him or her through the illness and the dying process). These activities are present when the doctor has successfully carried out the roles of medical adviser, friend, and priest.

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Opportunities for Grace

In 1991 Timothy E. Quill, MD, reported on a case in which he assisted a terminally ill woman in suicide.[14] A brief look at this report reveals that Quill missed several opportunities for grace that could have led to a different outcome.

Quill had taken care of Diane for eight years. Diane could be described as a survivor, having conquered vaginal cancer and alcoholism. When diagnosed with acute myelomonocytic leukemia—a disease with a 25 percent chance of cure after extensive, costly, risky, and often painful treatments—she faced new challenges. Diane elected no treatment. Death in weeks or months was certain, and she asked Quill to help her commit suicide. After referring Diane to the Hemlock Society, Quill ultimately agreed to assist her in suicide and prescribed a lethal dose of barbiturates, which she took on her own and alone, thus ending her ordeal.

I believe Quill missed the opportunity for grace in at least three instances. The first was at the time of diagnosis. Quill, knowing Diane to be a fighter, assumed she would want aggressive treatment of her leukemia when, in fact, she refused all treatment. No matter how well physicians believe they know their patients, surprises can always occur. These are times when it is critical to listen with the "third ear" and examine not only the full range of medical options, but the

patient's spiritual and social needs as well. Quill tried to validate Diane's refusal and ultimately was convinced of her decision, but failed to relate her new needs to her refusal. Diane had now reached a new stage in her life with a new set of needs and priorities that would require a unique kind of support.

The second missed opportunity was when Diane informed Quill that she desired to control the timing of her death. A lengthy discussion ensued, with the referral being made to the Hemlock Society. But even though Quill had previously considered numerous medical possibilities, he did not seem to pursue any of Diane's spiritual needs or to introduce the "God possibility"—a discussion of her belief in God and how it related to her illness and dying.[15] Self-determination reigned supreme, and the potential cry for help was not heard.

Finally, after Quill prescribed the fatal dose of barbiturates, the months that followed held periods of intense sadness and anger for Diane. These were accepted as part of the normal dying process and not addressed as anything more. Quill missed yet another opportunity to be friend and minister, to introduce grace and healing to Diane's dying.

So Diane died alone, a quick, clean death. Quill's description makes physician-assisted suicide seem strikingly easy—painless, successful, with her so-called dignity intact. Quill lied on the death certificate, supposedly to protect the innocent. With the uncertainties out of the way, I suspect Quill will find assisted suicide easier the next time, and the next, and the next. Once the rationale is provided, many things that would have earlier been unthinkable become acceptable. Like Desert Storm, where clean high-technology kills were shown on national television, will doctors become comfortable killers, providing the "kindest" death?

But I wonder: What if Quill had said no to Diane's request and instead put on the robes of minister, the cloak of friend, and discovered her real needs, her spiritual dimension? Would there perhaps have been a miracle in her dying, when all that was left was her dignity?

I suggest that the only answer a physician can give to terminally ill patients' request for physician-assisted suicide or euthnasia is an emphatic no. The doctor should not succumb because of fear that the patients will turn to another physician or do the job unsuccessfully themselves. Rather, the physician can only practice with the limitations of God-given gifts—in this case, as adviser, friend, and priest—lest he or she risk losing patients' trust and destroy the healing sanctity of the profession.

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Dignity Remains

Each dying person for whom I care is unique. I always find some grace-filled experience (whether for the patient, family, or care giver): One human life is touched by another. Sometimes it is only found in a retrospective view of the dying process.

With each patient, there is always the unanticipated. The patient whom I would expect to cope poorly with pain has a newfound inner strength. The one who ordinarily would not tolerate dependency gives over body and spirit to the care of others. And just when it seems that it is unbearable to endure a patient's suffering any longer, when I ask why this must be dragged on, I am blessed with a smile at the moment of death, a readiness for what lies ahead.

I have taken care of more than 1,000 patients with Alzheimer's disease or other dementing illnesses and have never been asked to hasten death. Even when these patients have lost everything—speech, ambulation, continence—the single thing they had feared losing most, their dignity, is the single thing that remains. We must care for their humanness and spirit to the very end and let God call them when he is ready. □

NOTES

1. Daniel Callahan, "When Self-Determination Runs Amok," *Hastings Center Report*, March-April 1992, pp. 52-55.
2. Callahan, p. 55.
3. Bernard Gert and Charles Culver, "Distinguishing between Active and Passive Euthanasia," *Clinics in Geriatric Medicine*, vol. 2, no. 1, 1986, pp. 29-37.
4. James F. Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, Sheed & Ward, Kansas City, MO, 1988, p. 113.
5. Paul J. van der Maas et al., "Euthanasia and Other Medical Decisions Concerning the End of Life," Lancet, September 14, 1991, pp. 669-674.
6. van der Maas et al; Maurice A. M. deWachter, "Euthanasia in the Netherlands," *Hastings Center Report*, March-April 1992, pp. 23-30.
7. Helga Kuhse and Peter Singer, "Doctors' Practices and Attitudes Regarding Euthanasia," *Medical Journal of Australia*, vol. 148, no. 6, 1988, pp. 623-626.
8. C. Everett Koop, "The Challenge of Definition," *Hastings Center Report* (Suppl.), January-February 1989, pp. 2-3.
9. Alexander Morgan Capron, "Euthanasia in the Netherlands: American Observation," *Hastings Center Report*, March-April 1992, pp. 30-33.
10. Drane, pp. 113-131.
11. Drane, pp. 113-131.
12. Koop, p. 3.
13. Kuhse and Singer, p. 12.
14. Timothy E. Quill, "Death and Dignity—A Case of Individualized Decision Making," *New England Journal of Medicine*, March 7, 1991, pp. 691-694.
15. Drane, p. 130.