

## Euthanasia, Physician Assisted Suicide and Other Methods of Helping Along Death

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*This paper introduces a series of papers dealing with the topic of euthanasia as an introduction to a variety of attitudes by health-care professionals and philosophers interested in this issue. The lead in paper—and really the lead in idea—stresses the fact that what we are discussing concerns only a minority of people lucky enough to live in conditions of acceptable sanitation and who have access to medical care. The topic of euthanasia and PAS really has three questions: (1) is killing another ever ethically acceptable; (2) is the participation of health professionals ethically different and (3) is it wiser to permit and set criteria (being fully aware of some dangers that lurk in such a move) or to forbid (knowing that it will occur clandestinely and uncontrolled). This paper takes no definite stand although it is very troubled by useless suffering (not only pain) by many who would wish their life and with it their suffering ended.*

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**KEY WORDS:** euthanasia; physician assisted dying; emotion; rationality; terminal sedation; physician stimulated starvation.

This paper that leads into a discussion of euthanasia and physician assisted suicide (PAS) from diverse viewpoints will briefly allude to each paper but will—because the quality of the papers is exceptionally good and because the author like all authors thinks he has something to say(!)—develop some thoughts of its own.

In this paper (that introduces the discussion) I will try to suggest some crucial definitions—not, necessarily, because they are “right” but so that we all understand what we mean by certain words. Disagreements are often not really disagreements but a difference in definition of key words or concepts.

One comment: when we discuss euthanasia or informed consent or most of the other current ethical problems, we are devoting time, space and effort to problems

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which concern a minority of people on this earth and which even in the United States leaves out a large number of people. We must be aware of the fact that we are discussing problems that I have called “rich man’s ethics”—that is the problems of those of us who are adequately insured or more than well to do. The main ethical problems, it seems to me, are (1) a mal-distribution of resources so that so-called developing countries often lack simple measures which could save millions and (2) the fact that in the United States as the only developed country we lack universal access to basic medical care with close to 20% going un-insured while a vast number of people are so badly underinsured or burdened by co-payments that they often cannot see physicians until it is too late.

## DEFINITIONS

I would like to start with some definitions that hold for this particular paper and which may be defined differently in others. The important thing is not that the definition is “correct” but that when we discuss a topic we all understand what the word we use in that discussion mean in the context of that discussion. A brief note: the term “euthanasia” is used purely in the sense that it has been used and continues to be used generally (“a good death”) and never in the way that the Nazis used it to put a veneer of probity over what clearly was murder.

Euthanasia, for the sake of this particular paper, will be defined:

- As solely done in the interest of the patient being killed and in no other. The “interest of the patient”, furthermore, is defined by the patient and not by the physician, the state or anyone else (at least as long as the patient has decisional capacity—whether advance directives ought to give or reserve such power is another matter).
- As only contemplated in case of incurable and terminal illness that is beyond either cure or prolongation of a quality of life acceptable to the patient. In other words, it is a matter of optionality where the options are narrowed to only two: to live longer at the price of suffering longer or to suffer for a shorter time at the price of shortening life.
- In which a fully informed patient with decisional capacity requests this at least twice and at least a week apart and in which one of these requests is in writing and witnessed (should the patient no longer be able to write, a verbal request witnessed by two people not concerned in the treatment would suffice).

I will purposely not enter into the question of surrogate requested euthanasia for children or adults who do not have decisional capacity. That is worthy of a prolonged discussion on its own merits and is underwritten by an agreement that euthanasia or PAS is, under some very narrowly defined circumstances, ethically permissible. Nor will I enter the morass of psychiatric illness that likewise would

require a prolonged discussion—above all by someone more far more conversant with psychiatric illness than I am. Thus one can (uncharitably) say that I have made things easier for myself or (charitably) that I have purposely not bitten off more than a person can chew!

Physician Assisted Suicide will be defined, as above but in the case of PAS the physician is the necessary link in procuring the appropriate medication but not the one to directly administer it. Throughout this paper I will argue that the difference, ethically speaking, is at best trivial but that it is emotionally quite different and that emotions legitimately play a role especially when it comes to issues such as these.

At the beginning I want once again to make the, to me, crucial difference between personal morality and ethics. The difference, I believe, comes down to “authority.” An argument about an empirical matter (say the date of Napoleon’s birth) cannot be settled by discussion but can only be settled by an authority that both parties accept. That settles the matter. An argument about an ethical question can be settled by “authority” only within an enclave of persons who accept the same “authority” without further question—a religious community that determines “right” and “wrong” as derived from a book or from the head of such an organization may be an example. To believers, such a “proof” will be convincing; to the non-believer it will be irrelevant. It is this that I call personal morality—the morality valid for you and your co-believers but not a morality that other good men and women necessarily subscribe to. The difference in essence is between those of us who believe that ethics is discovered (that “somewhere out there” there is an absolute truth) and those who believe that co-equal humans within their culture craft ethics and that as conditions change ethics too may slowly evolve. We live in a multicultural world with many different religions and belief systems and it is the task of ethics to construct a framework within which ethical differences can be valid.<sup>3</sup>

A word that is constantly used in the context of sick patients is “suffering.”<sup>4</sup> That word cannot be simply equated with pain. Many people can have pain but hardly be said to suffer (Imagine dropping a book on an ingrown toenail!) and others most certainly suffer without physical pain—think of the mother who must watch while the Nazis kill her child. Furthermore statistics from many places show that patients ask for PAS because of relentless suffering while invariably pain is low on the list of reasons causing them to wish for death. Loss of autonomous action, loss of ability to be master of one’s own destiny—al these are suffering.

<sup>3</sup>Loewy EH: *Moral Strangers, Moral Acquaintance and Moral Friends: connectedness and its conditions*. Albany, NY; SUNY Press 1997.

<sup>4</sup>There is a fairly large literature about suffering—both as to suffering as a marker of moral significance and of suffering in the patient-physician relationship. See: Cassel EJ: The nature of suffering and the goals of medicine. *NEJM* 306(11): 639–45; 1982; Cassel EJ: The relief of suffering. *Archives of Int. Med.* 143(5): 22–523; 1983; Cassell E. *The Healer’s Art: A New Approach to the Patient-Physician Relationship*. Philadelphia, Pa: J.B. Lippincott, 1976.

In medicine we almost invariably equate suffering and pain but that is simply not true. While pain control is the *necessary* condition of palliation it is by no means the *sufficient* condition for good palliation that in itself plays an important role in preventing euthanasia and PAS.<sup>5</sup>

A word that almost unavoidably comes up in these discussions is the concept of “harm”—health care professionals should never intentionally “harm” their patients and should seek to “benefit” them. As comforting as this concept is it is fairly empty if we acknowledge that (1) a physician-patient encounter almost invariably causes some “harm” to the patient if only by taking away time that could be spent more pleasurably, up to the harm caused by extensive surgery in terms of pain and disability. What we, I believe, mean is that we should seek to maximize the benefit and minimize the harm. And (2) that what constitutes “harm” may be quite different when viewed from the patient’s than it is from the physician’s perspective. A patient, for example, who is riddled with metastatic cancer and pleads to be allowed to die would feel that he or she is being harmed when their urosepsis is vigorously treated whereas the physician may under some circumstances feel that he or she is benefiting their patient.

In this section I am mainly dealing with definitions but also want to correct the persistent and seemingly ineradicable misconception or myth that providing sufficient narcotic analgesia to such patients will shorten their lives. It has been shown time and again in numerous publications that, on the contrary and not always desirably, giving sufficient narcotics to render the patient pain free will, if anything, prolong life. Further, there is no maximal dosage—patients who have been on morphine for control of pain for some time will commonly if not almost invariably develop sufficient tachyphylaxis to require doses far in excess of what would be lethal to the ordinary patient.<sup>6</sup>

<sup>5</sup>As crucial as pain control is—and it remains the necessary condition of palliation—it is one of the easier and mainly technical problems. When asking for PAS patients consistently rank pain as having a much lower priority than do things like fearing the loss of self-determination, being unable to translate their willing into consequent action, etc. It is remarkable that a significant percentage of patients given a lethal prescription in Oregon fail to use it. Knowing that it is there and that they can turn to it if things become intolerably gives them the peace of mind to continue living. See: Back, AL, et al.: Physician assisted suicide in Washington State: Patient Requests and Physician Responses. JAMA 1996; 275(12): 919–923; Fishman M. *The War on Pain* New York, NY: Quill; 2001; Husebø: *Palliativmedizin* Heidelberg, Deutschland: Springer Verlag 2001; Sabatowski R, et al.: Opioids and driving ability—a problem unresolved. Deutsche Med. Wochenschrift 2003; 128: 337–341. Back, AL, et al.: Physician assisted suicide in Washington State: Patient Requests and Physician Responses. JAMA 1996; 275(12): 919–923.

<sup>6</sup>There is an old fable that the administration of enormous doses of Morphine or other opioids (which would kill patients who had not been on these for a long time) will shorten the life span. Bioethics has done its share to tacitly spread this fable by statements to the effect that a “higher dose should be used even if it were to shorten life. The point is that it does nothing of the sort. In point of fact patients whose pain is adequately controlled (by which I mean that they have little or none) will live longer (not necessarily a desired side-effect but a side-effect still). See: Thorns T: Narcotics do not shorten life. Lancet 2 . . . Bercovitch M, Adunsky A: High Dose Morphine use in the hospice setting. Cancer 1999; 86(5): 817–823; Moynihan TJ: Use of Opioid in prescriptions for severe pain in terminally ill

## BRIEF REVIEW OF THE PAPERS IN THIS ISSUE

The papers in this issue were chosen to provide a wide spectrum of attitudes and to give some facts from both physicians and philosophers. It is, quite admittedly, a different thing to sit in an armchair speaking about this matter when one has never seen a terminal patient during the last days or weeks of life in hospital and home then to philosophically analyze the question. I hasten to say that this is not an objection raised to philosophers “doing” medical ethics—in fact they have contributed the majority of papers and books dealing with diverse medical ethics questions. But it is to say that a person wishing to seriously participate in the discussion needs to have dealt with patients as well as having a sturdy background in philosophy—and that is far from being the person who ultimately feels responsible for commissions or omissions.

Drs. Gordjin and Janssens from the Netherlands have written a beautiful paper about the “state of affairs” in the Netherlands and about some of their reservations about the current law permitting euthanasia even under rigorous criteria. Dr. Faith Fitzgerald—one of the best-known academic internists, a physician who combines an almost encyclopaedic knowledge in a multitude of subjects with compassion and caring—writes of the obvious ambivalence and the agony with which conscientious physicians must face PAS and euthanasia and also shows the role which emotions play in such decisions. This is not a matter of sentimentality—as I shall later discuss the role of emotions in decision-making is crucial and decisions made by reason alone (which is impossible as long as the limbic system and its connection to the frontal lobes are intact) are invariably faulty. Dr. Pugno who has been active in practice, in administration and in education again shows the agony of decision-making, the ambivalence and the centrality of suffering. He aptly points out how attitudes change over the years and to my pleasure picks a case other than cancer to make us think. Dr. Klein writing from a German perspective (if there is such a thing—opinions are just as divided there as they are here) leaves us—as every good paper should—with many questions which we must think out for ourselves. He shows how the Nazi experience has coloured the discussion and justly emphasizes that the Nazi experience does not speak to euthanasia but to murder. This once again shows the importance place that language and precise definition have in this debate. Dr. Roberta Loewy brings up a rather fascinating issue which has really not been discussed in relation to euthanasia: that without being aware of it the health care team by “selective disclosure” may channel the patient’s choice in the direction the team seems best—be it withholding or not withholding treatment of the disease itself or of intercurrent diseases. She aptly has called this “euthanasia

patients. Mayo Clinic Proceeding 2003; 78(12): 1579; Sykes N, Thorns A.: The use of opioids and sedatives at the end of life.: Lancet Oncol. 2003; (5):312–318; Sykes, N, Thorns A: Sedative use in the last week of life and the implications for end-of-life decision making. Arch Intern Med. 2003 Feb 10;163(3):341–4 and a forthcoming book Sykes N: *Cancer Pain* New York, NY: Oxford University Press.

by deception.” This is a variation of “stacking the cards” to get the answer we want—an often almost inevitable subconscious practice of many physicians—but here it may mean further agony on the one and death on the other hand. Such practice, then, relates in important ways to this debate.

## KILLING OR LETTING DIE

The question of whether there is an ethical difference between directly causing death or deliberately refraining from treating a condition which will inevitably end fatally is often discussed.<sup>7</sup> It is a question which is quite similar to the question of starting an effective treatment and later, when it has shown promise of being effective stopping it. I am not speaking about the legal difference—albeit that the US Supreme Court in *Cruzan* ruled that treatment may be stopped at any time when the facts of the case would have caused the physician not to start it. The second instance generally differs from the first in that the medical and social facts are known in one but not in the other case who may be seen as an unknown patient in the emergency room. Vigorous treatment in an unknown or inadequately known patient may be started not as much to preserve their life as to “buy time” in which more necessary information for making a judgement can be obtained. Once it is obtained and the physician finds out that this is a patient hopelessly riddled with cancer who has expressed the wish to die stopping—at least legally—is in no way different from not having started. I will readily grant that it certainly “feels different” to the health-care team to remove a patient from a ventilator than not to start in the first place—and I will furthermore say that this emotive difference is not one that can simply be shrugged away. Emotion when controlled by and mixed with reason has been shown to be essential for “good” or “beneficial” decisions.<sup>8</sup>

I will here briefly give an example that I have stolen from Professor Rachels<sup>9</sup> (who unfortunately and as a great loss to the profession and to humanity recently

<sup>7</sup>The controversy about the ethical status of killing vs. letting die is spoken about in many papers. This question has come up in many formats some contrived and a few real. To me the question cannot be answered except in a specific case in which the options are known. To lead into a discussion see: Trammel R. Saving life and taking life. *J Phil.* 1975;72:131–137. Rachels J. Active and passive euthanasia. *N Engl J Med.* 1975;292(2):78–80.

<sup>8</sup>Recent work has shown that when the emotive area (limbic system) is ablated or separated from the frontal lobes (cognitive portion) the patient who fully recovers can continue to make logically perfectly clear judgements which, however, are almost invariably “bad” and self-destructive. Furthermore such patients are unable to learn and are apt to make the same decision leading to the same terrible outcome on subsequent occasions. See: Damasio AR: *Descartes Error: Emotion, Reason and the Human Brain* New York, NY: Avon Books; 1996, Damasio AR: *The Feeling of What Happened: body and emotion in the making of consciousness.* Fort Washington, PA: Harvest Books; 2,000, Ledoux W: *The Emotional Brain: the mysterious underpinnings of emotional life.* New York, NY: Touchstone Books, 1998; Roth G: *Dasirn und seine Wirklichkeit* Frankfurt a/M, Deutschland: Suhrkamp Taschenbuch, 2,000.

<sup>9</sup>Rachels J. *The End of Life.* New York, NY: Oxford University Press, 1986. This superb book is one of the most readable and arguably also one of the most tightly argued on the whole subject of euthanasia.

died). Let us think of a man who rooms with his brother and sister in law and their two-year-old child. The uncle wholeheartedly dislikes the child—it disturbs him when he works, dribbles food on his newly cleaned pants and wakes him at night. The one good thing is that the parents have taken out a two million dollar policy on his life with the uncle as the beneficiary. One evening the uncle comes home and finds that the parents have just stepped across the hall while the child is in the bathtub. Here is his chance! He holds the kids head under water until he has drowned. Legally and ethically this is simply murder. Let us change the situation. The uncle comes home, the parents have stepped out but the child has slipped on the soap and knocked himself unconscious on the spigot. He is floating face down and obviously drowning. The uncle with a smile on his face watches it drown and does nothing. Legally—since there are no laws which would compel you to come to the aid of one in distress—there has been no wrong committed. Ethically I believe that most of us would agree that the two actions, one active, the other passive really are not different from one another. In both cases the uncle was knowingly involved in the causal chain at the end of which there was a dead child whose life could have been easily preserved.

In medical practice the ethical difference between killing and letting die is often murky, indistinct and context bound. When we come to such a decision and our emotions scream “NO” our decision needs to be carefully re-evaluated. I am by no means saying that we should cast either our emotions or our reason aside or that either have absolute veto power but that both are necessary in arriving at a judgement that, at the very least, is ethically the least problematic.

There is one other not directly related problem but one in which the thought processes often follow very similar reasoning. It happens not rarely that a patient who has only a short time to live, who is beyond any hope of cure or meaningful prolongation of life has a long standing DNR order but now needs to go to surgery to effectively palliate a fracture, open an abscess or have some other surgical or interventional radiological procedure done. Most surgeons and anaesthetists will want the DNR order to be suspended during surgery and during the immediate post-op period. This, I believe, is very much caused by our very human (and on the whole very desirable) tendency to make good what we have caused—we feel we must pay for a dish or a car we smashed, etc. Most certainly we feel more responsibility towards a pedestrian we have struck down than we do for another who was the victim of a hit and run driver. That is not to say that we do not feel a responsibility towards anyone injured but it is to say that we feel more responsible for that which we rather than someone else has caused. The same thing may very well be at play here—the anesthetist knows full well that a minor and easily corrected mistake can cause a frail patient to suffer a cardiac arrest and the surgeon knows that a larger procedure carries much more risk and that a cardiac arrest could easily result. They feel that they must at the very least undo what they have had a part in causing. Here, I believe, honesty with the patient is not only the best but the only policy: patients should be told of the higher risks of a cardio-pulmonary

arrest and of the possibility that a trivial mistake in a basically healthy patient may very well cause a cardio-pulmonary arrest in them. It is then up to the patient (or their surrogate) to have a DNR policy suspended or continued during the operative and immediate post-operative period. If the anaesthetist or the surgeon feels that they cannot work under such conditions equally competent individuals who are willing to accept that risk can almost always be found.

## THE QUESTIONS WE MUST ASK

Discussions about euthanasia often break down when we fail to recognize that there are really three interconnected and yet separate issues we must deal with. The ethical component is exceedingly important but it is not the only issue at stake. I would suggest that there are at least three questions:<sup>10</sup>

- *The question of ethics:* Is it ever ethically permissible to kill another human being or, (which I shall argue amounts to the same thing) not prevent it from dying if that can be easily done? The contingent question, if our answer is that there are circumstances in which killing may be the least of several evils, is what constitutes a situation in which taking a life is ethically the least problematic course of action.
- *The professional question:* Is there something in the concept “health-care professional” which would prohibit members of the profession to participate in killing their patients.
- *The social, cultural and legal question:* Is it better to legalize euthanasia and PAS, set strict criteria and retro-review each case being fully aware of the dangers such a “slippery slope” may lead to or is it better to forbid euthanasia and PAS knowing full well that it will occur and is now left to the physician’s caprice.

It is clear that we countenance killing of human beings under certain circumstances: self-defense (which until Thomas Aquinas was not considered by the church as a valid reason for killing another), war (where those who kill are looked upon as heroes, capital punishment), etc. We set speed limits knowing full well that if we set them much lower fewer people would die, build high rise buildings with an often associated loss of life, mine coal and engage in other activities which may well cause the death of another. Furthermore—and hardly last of all—we know that some people in our community live in grinding poverty, that many have access to medical care only through capricious charity and that thousands of people die in the course of a week who would, had they had access to our surplus food not have perished. We are, even if we hate to admit it, not really a



life-affirming society. This question, furthermore, transcends the comfort of the armchair or lecture hall and demands that we at least become familiar with dying as it takes place over the last few months of a relentlessly downhill course. Talking about terrible suffering while sipping a glass of wine is quite a different thing when one has been familiar with the way people die than when one is not. There is no doubt that good palliative care can be effective in a large percentage of people—even in about 95% as Dr. Foley claims (and I personally doubt). But there remain these 5 or whatever percent of people in whom palliative care is ineffective—what then?

The professional question demonstrates, I believe, the difference between personal morality and ethics. A professional's morality is derived from many sources: religion, culture and, above all, their understanding of themselves as health-professionals. It is thus a question similar to abortion—for some it will not constitute a great burden (they may indeed and at the patient's request, regard it as relieving suffering) and for others it may very well be incompatible with their own understanding of what it means to be a health-care professional.

The social, cultural and legal question is for me personally the most difficult to answer and it is one which depends on the history of a particular peoples and connects readily with how a particular society or religion views itself in relation to the cosmos. On the one hand the cost consciousness about medical care in the United States raises the specter that we may find this a convenient way of ridding ourselves of the poor, the powerless, the disadvantaged, those who cannot speak for themselves or those who have become too expensive for their MCO. Many ethicists including myself have found it remarkable that ethics consultation to end life support often coincided with the patients running out of insurance. (This has, to my knowledge, not occurred at the University where I now teach). On the other hand I am frightened when I heard a physician at the end of one of my lectures about euthanasia say quite bluntly "I, as their doctor, will decide when my patient should die and do not involve either the patient or the family." Especially since I knew his Nazi background, a cold shiver ran down my spine. Personally I would argue that legalizing PAS and euthanasia is safe only where patients have universal access to health care. Where they do not the temptation for an MCO to "get rid" of a patient who has become a drain on the system will always be present. Furthermore, patients can certainly be "socialized" into a system in which they feel that they have a duty to die to relieve others of their burden. It is why I insist that laws permitting PAS and euthanasia should presuppose universal health-care and a working safety net for all residing legally within that community.

My point—which neither favours or disfavours euthanasia and PAS—is that in discussing these issues we should refrain from trying to answer them all together but rather that it behooves us to know which of the three is being discussed. Furthermore, such discussions must be underpinned by the best and most complete data available at that point in time.

## ALTERNATIVE SUGGESTIONS

It has recently been suggested that there are two perfectly legal alternatives to euthanasia or PAS. The one is termed “” and the other involves suggesting to the patient that they stop to eat and perhaps drink.<sup>11</sup>

Terminal sedation becomes a solution only “way down the road”—that is, it is applicable only at the very end when patients are already within days or a week of dying. Such patients are then placed under anaesthesia, ventilated but all other measures are stopped and the patient is then “allowed” to die of their disease. This probably leaves the physician legally safe but by no means ethically unchallengeable. Terminal sedation can come under the Doctrine of Double Effect which I will briefly discuss later.<sup>12</sup> But aside from the fact that the DDE is on itself questionable using the DDE here is by no means an easy fit.

The other suggestion which has been seriously made and in fact carried out is to suggest to a patient who asks for the means to commit suicide or euthanasia that they can stop eating and perhaps drinking and that they will receive palliative support and medication until they ultimately die of starvation. I personally consider this—and I will rarely label an act as such—ethically unacceptable. Patients who are nearing the end of life but are still willing to eat and drink are not merely consuming calories and fluid necessary to keep them alive. Eating and drinking serves a far more important emotional and social function. In every society and culture sharing food and drink is of utmost importance as a sign of shared humanity. Welcoming another with bread and salt or wine or a cup of coffee has a deep significance in all cultures—the Indian peace pipe may well have served a similar purpose. It is something shared. To tell a patient to stop eating and/or drinking when they can still share this ritual with their families and loved ones is to advise them to exclude themselves from their social nexus. It is what I have called “physician stimulated starvation.” That is not to say that there does not come a point when patients do not wish to eat or drink any more when—in a manner of speaking—they have turned their face to the wall and are ready to die or to say that this should not be respected. However it should most certainly not be suggested to the patient as an alternative because the physician out of cowardice is unwilling to prescribe medication to accomplish the same end.<sup>13</sup>

<sup>11</sup>Loewy EH. Healing and killing, harming and not harming: physician participation in euthanasia and capital punishment. *J Clin Ethics*. 1992;3(1):29–34.

<sup>12</sup>Quill TE: Palliative options of last resort: a comparison of voluntary stopping eating or drinking, terminal sedation, physician assisted suicide and voluntary active euthanasia. *JAMA*; 278(23): 2099–2105.

<sup>13</sup>Maximally sedating a patient and stopping all life sustaining therapy has been practiced since life sustaining therapy has been effective. There is much in the literature worth reading. See: Truog RD, Arnold JH, Rockoff MA: Sedation before ventilator withdrawal: medical and ethical considerations *J Clin Ethics*. 1991 Summer;2(2):127–9; Quill TE: Palliative options of last resort: a comparison of voluntary stopping eating or drinking, terminal sedation, physician assisted suicide and voluntary active euthanasia. *JAMA*; 278(23): 2099–2105, Burns JP et al.: End-of-life care in the pediatric

## THE DOCTRINE OF DOUBLE EFFECT

The doctrine of effect (DDE) is often invoked in health-care ethics and could easily be invoked in “terminal sedation or in what I have called “physician stimulated starvation.” In essence, in order to justify an act by the DDE:<sup>14</sup>

1. The act itself must be good or at least neutral
2. The intention of the actor must solely be to intend the good effect
3. If the good effect could be brought about solely without being associated with the (non-intended) bad effect that route would have to be chosen
4. The good effect is not the result of the bad action
5. There are compelling reasons to accept the bad effect

Historically the doctrine of the double effect originated with the Catholic Church in the middle ages and has been invoked ever since. It would, for example, justify the removal of a pregnant and cancerous uterus on the presumption that the death of the fetus was “not intended.” Although this doctrine is often most comforting to many members of the health-care team, we find little to justify it. Like claiming that the disease (which could easily have been treated) and not the failure to treat were responsible for the death of the patient, this doctrine is, at its roots, highly challengeable. Even in the law (in the EU as well as in the United States) persons are held culpable not merely for the intended consequences of their action but likewise for those consequences they could have readily foreseen.

We have neither time nor space to examine this doctrine at length. However, we shall summarize our objections to it briefly:<sup>15</sup>

1. It is difficult to define the action itself—almost all acting can be isolated and subdivided into its component parts. (E.g., “All I did was write—or fill, or administer—a prescription.”) But, shouldn’t the impulse to reduce an action to its more innocuous component parts raise a red flag?
2. Intentions are difficult (even for oneself) to be clear about. Rarely, if ever, does an effect have only one cause or is an effect brought about by merely one intention (something the authors have labeled as the “fallacy of unicausality or uni-intentionality”)

intensive care unit after the forgoing of life-sustaining treatment. *Critical Care Medicine* 2000; 28:3060–3066. The philosophical validity of the DDE has been debated in the literature since it was first pronounced hundreds of years ago. See: Woodward, PA: *The Doctrine of Double Effect: Philosophers Debate a Controversial Moral Principle* University of Notre Dame Press; 2003; Kamm, F.M. The doctrine of double effect: reflections on theoretical and practical issues. *Journal of Medical Philosophy* 16 (1991):571–85.; Marquis, D.B. Four versions of the double effect. *Journal of Medical Philosophy* 19 (1991):515–44 as well as numerous others.

<sup>14</sup>The best resource for the detailed statistics of the experience in Oregon can be found at: [www.chd.or.us/chs/pas.htm](http://www.chd.or.us/chs/pas.htm)

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3. What is labeled the “good effect” assumes agreement on what that “good” might be. That question may be the crux of the matter.
4. What counts as compelling reasons can invariably be questioned and is highly dependent upon the values, goals and worldviews of all involved.

Health professionals are quite relieved to invoke the DDE—it, so to speak; “lets them off the hook.” This, however, is the very danger. It permits ongoing self-delusion that, like every other self-delusion, is an ethically as well as pragmatically dangerous habit to adopt. The conviction that the health-care team never does a bad thing (even when it does the least bad available thing that it could do under the circumstances) and that, whatever else, the belief that their ethical virginity has been preserved is, like Pontius Pilate’s notorious symbolic hand washing, a dangerous delusion. Generally when we are confronted with ethical problems in the care of a patient or in the solution of problems as occur in building a health-care system or of rationing, there are no good answers but only those that are, in themselves, to various degrees unpalatable. In these circumstances it is our job to find the most palatable. But merely because an option is the least unpalatable in an array of unpalatable ones does not make it good. It is still only the least unpalatable, the least bad option. Simply not involving ourselves in such questions is, in itself, ethically problematic—part of doing the best we can for our patients is creating a health care system that allows them to become patients in the first place. Health-care ethics is not meant to be a balm for the team but is meant to search for the ethically least troublesome course of action to help the patient.

## **EUTHANASIA AND PHYSICIAN ASSISTED SUICIDE**

The Oregon law strictly prohibits euthanasia but under very restricted circumstances permits PAS. The statistics are readily available and show that the number of patient choosing PAS is extremely small and that it has not increased over the last few years. It also shows that:<sup>16</sup>

- Many patients will get their prescription, fill it but never use it. Empowering them may, in fact, act to deter suicide.
- As other studies have shown, pain is low down on the list of reasons of why patients choose PAS. Loss of capacity to care for themselves or to translate their freedom of thinking to freedom of acting is much more important to them.
- Surprisingly enough a considerable number of patients were under good hospice care when they requested PAS. Hospice has made a tremendous contribution to the care of dying patients—but it still will not be able to relieve the severe suffering of others.

The fact that the Oregon law permits PAS under restricted circumstances but forbids euthanasia under all circumstances seems peculiar, rather perverse and possibly unconstitutional to me. Patients suffering terribly from metastatic cancer of the pancreas can avail themselves of PAS. A patient suffering just as much from oesophageal cancer and unable to swallow cannot have his or her physician inject the same medication i.v. The difference seems arbitrary and appears to conflict with the equal treatment clause of the American (and most other democratic) Constitutions.

Whether PAS or euthanasia—the physician serves as a vital link at the end of which is a dead patient who could no longer stand their suffering. It is a very personal decision and one which legitimately should only come up when there are just two options: (1) to live a little longer at the price of suffering a little longer or (2) to suffer shorter at the price of also living shorter. We are a culture in which autonomy is one of the highest—if not indeed the highest—value. Many of us (myself included) think that the pendulum has swung too far and that patients are at times abandoned to their autonomy. And yet when it comes to the most basic decision an autonomous rational being makes—shall I live or shall I die?—Most states forbid PAS while not criminalizing suicide. This, of course, defies logic for it criminalizes the person helping another to perform a legal act. Two states still forbid suicide (I would suppose that the death penalty is the punishment!) and their forbidding PAS at least makes sense for it is aiding someone in carrying out an illegal act. But such a law is logically highly questionable when suicide is legal.

Holland that has recently legalized euthanasia and has for years condoned PAS if done under very strict conditions is difficult to analyze. While in Oregon both proponents and opponents of the law agree on the validity of the statistics this is not the case in Holland and it is, therefore, difficult to draw any conclusions. One chooses the statistics which support one's argument and ignores the others.

## CONCLUDING COMMENTS

This series of articles is not meant to persuade others to adopt a given point of view. Where an article takes a particular stand it is meant not so much to persuade as to provoke thought and help one reach a tentative and not fixed conclusion and perhaps to help those who eventually make the laws (as well as those who must abide by them or break them in individual cases) to think through these questions before being confronted with an actual problem which must be resolved. As societies or as individuals we learn from our experience and handle our problems after reading, thinking and talking with others about them. In ethical problems there is generally no such thing as “the right answer”—there certainly are “wrong” answers (things which are not acceptable from an ethical point of view) but there is usually an array of possible answers which than must be adjusted to the particular context of a particular case.