Active Euthanasia: One Oncologist's Point of View

by Ronald L. Stephens

Scientific technology of the 20th century has created a wealth of challenging ethical issues for the 21st century, and it should not surprise anyone that it will be the task of those living in the 21st century to find solutions. We can probably do little more at this time than establish a fertile dialogue and hope to get the questions right, so that the answers of tomorrow will have a credible basis in reason.

In this article I've elected to examine an issue that affects all of us as human beings, but has special implications for physicians. That problem is active voluntary euthanasia, or what some call assisted euthanasia or even the more pejorative, assisted suicide. With the recent article in the *New England Journal of Medicine* by a physician panel convened by the Society for the Right to Die, we are reminded that our societal attitudes about active physician assisted euthanasia appear to be evolving. Actually, ten of the twelve physicians lent their names to the cause of physician assisted euthanasia for competent patients who are hopelessly ill and who have made it clear that they wish to end their lives. The issue of assisted euthanasia has been with us for many years, and while currently topical, I doubt the problem will be settled before the 21st century, and maybe not even then. However, from a practical point of view we need some guidelines on how to confront this problem now. In this paper I will attempt to summarize my present, still evolving beliefs about this important issue.

Before highlighting the reasons for current interest in active euthanasia, I should explain my own growing concerns. As a medical oncologist I see a significant number of hopelessly ill patients, hence I have perhaps more than the average physician's experience with the question. I share the concern of Daniel Callahan and others who believe the current tyranny of medical technology requires close examination by society. George Annas has observed that American infatuation with technology sometimes translates to the notion that new medical treatments have greater rights than the patients for whom they were designed. In this regard, several years ago I implemented the use of an enlarged Kansas living will for many of the patients admitted to our cancer ward. Let me also mention that I have no personal religious affiliation, and although I have reservations about capital punishment I'm not a pacifist and under the proper set of circumstances I could kill another human being.

Ronald L. Stephens, M.D., is Director of the Division of Clinical Oncology at the University of Kansas School of Medicine.

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Arguments For and Against Active Assisted Euthanasia

There are probably no mechanical reasons why active assisted euthanasia must be performed by a physician, but currently most advocates of assisted euthanasia assert a preference for physician administered termination of life, or physician killing. The question of who administers the lethal agent is an important problem deserving a separate analysis, but for purposes of this discussion is of secondary importance. The basic question is, in the words of Leon Kass, "May or ought one kill people who ask to be killed?"

Contemporary proponents of assisted voluntary euthanasia have tried to dissociate themselves from Nazi programs designed to eliminate "undesirables" from German society. Among the people targeted were those with epilepsy, schizophrenia, mental retardation, physical handicaps, and others judged "feebleminded" or "useless." This rush to distance themselves from the German experience has led euthanasia proponents such as Joseph Fletcher to describe any connection of the modern movement of voluntary euthanasia to the involuntary variety as a "red-herring, a false trail." It's unclear, however, that this effort to distinguish sharply voluntary and involuntary euthanasia to the involuntary variety as a "red herring, a false trail." It's unclear, however, that this effort to Holland, a country where official, albeit still illegal, policy is to exempt cases of voluntary assisted euthanasia from the written prohibition against killing. A Dutch cardiologist, Richard Fenigsen, has summarized the Dutch experience in a recent *Hasting Center Report,* and as this is the only semi-sanctioned modern use of physician assisted euthanasia, what he has to say is instructive. Basically, he details a society with historical roots in the 1920's German philosophy of Binding and Hoche, what is known as the philosophy of "life not worth living," a system of belief which clearly served as the underpinning for the involuntary euthanasia of the Nazi T_4 program. He further describes a modern Dutch society in which the same majority of its citizens which supports voluntary euthanasia also believes in the involuntary variation. Moreover, institutions such as the Board of the Royal Dutch Society of Medicine and The Royal Dutch Society of Pharmacology openly and officially support involuntary euthanasia.

One modern perception of medical technology is that it is often applied without humane restraint, or that it is capable of keeping the body alive when the human essence of the mind is irreversibly absent. We can recognize that less than optimal existences range from persistent vegetative state to varying degrees of mental impairment brought on by Alzheimers. Hence the fear of a prolonged or lingering death is a real one. Whether this perception is

sufficiently accurate to warrant a major change in our society's prohibition against taking another's life, even when one requests it, requires additional study.

What medical practice has evolved to in our country is the willingness to withhold or withdraw life support systems when it seems clear that they offer only a short and temporary prolongation of the dying process. Some refer to this as passive euthanasia, as if allowing death to occur today rather than tomorrow represents a major length of life altering act by the medical profession. I personally think we in the profession have allowed an exaggerated use of terminology when we refer to such a limited change in the length of life as passive euthanasia. But I suppose the use of such a provocative term feeds our own medical sense of importance.

Several philosophers have sparked the debate over voluntary euthanasia by (1) pointing to certain life or death attitudinal inconsistencies in our own society, and (2) raising several salient issues on the subject of killing those who wish to be killed. For example, James Rachels emphasizes that active physician assisted euthanasia is often more humane than simply letting someone starve to death. He argues that the passive doctrine often leads to medical decision making on irrelevant grounds. His case for these two important points is the circumstance where children with Down's syndrome are allowed to starve to death rather than undergo a relatively straightforward surgical correction of a gastrointestinal defect which precludes oral feeding. It is my contention that this medical/social mistake rarely (if ever) occurs today, but Rachels is correct in saying, "It is the Down's syndrome, and not the intestines, that is the issue. The matter should be decided, if at all, on that basis, and not be allowed to depend on the essentially irrelevant question of whether the intestinal tract is blocked." From this discussion I think it is fair to suggest that what we have often included under the rubric of passive euthanasia is not always an ethically preferred course of action, and that no one should suggest that the term passive euthanasia always implies the right thing to do. To classify withholding or withdrawing life support systems in the category of passive euthanasia is a mistake.

From here on I'm afraid that Rachels' arguments become a bit sophistic, as his Smith/Jones doing-in-their-cousin story has only a superficial appeal, potentially more misleading than enlightening. You will recall that Smith drowns his cousin in the bathtub for his inheritance, whereas Jones is approaching the bathroom with the very same intention when his cousin slips, hits his head and submerges; and while Mr. Jones watches, the cousin becomes just as dead as Mr. Smith's cousin who was actively held under water. From this scenario we learn that "the bare difference between killing and letting die does not, in itself, make a moral difference." Apparently, we are to conclude that my act of withholding cardiopulmonary resuscitation from a patient (with her agreement) who has advanced metastatic unresponsive breast cancer is morally no different than my giving her a lethal injection a year earlier, because even at that earlier time she had disseminated breast cancer, and when diagnosed with a recurrence requested that I kill her. To avoid any confusion with Rachels' example I'll call my breast cancer patient Ms. Johnson, and in a moment I'll return to her. It is important to note that the moral equivalence Rachels attaches to passive and active euthanasia neatly avoids any reference to intent and its importance in our society. In his analysis of Rachels' argument, Thomas Sullivan identifies this tendency to ignore agent intent. I should hasten to add that nowhere else in our society do we ignore intent. To take a simple example, notice the difference between accidently bumping into someone and purposely jumping up and down on his toes. Intent is the very reason our society recognizes a difference between manslaughter and homicide.

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Perhaps the most compelling reason for holding the line against physician assisted euthanasia at this time is the difficulty in predicting the outcome for any given patient with any given set of medical circumstances. Yale Kamisar raised this issue as long ago as 1971, and the concerns he raised then apply today. Since he said it so well let me borrow his exact words: "Evidently, the presumption is that the general practitioner is a sufficient buffer between patient and the restless spouse, or overwrought relative, as well as a depository of enough general scientific know-how and enough information about current research developments and trends, to assure a minimum of error in diagnosis and anticipation of new measures of relief." It is just possible that my Ms. Johnson will choose a second opinion from an uninformed source, and will miss one or even several years of additional life with her loved ones, because she successfully obtains active physician assisted euthanasia. Kamisar goes on to observe, in regard to the question of free choice in euthanasia, "Will we not sweep up, in the process, some who are not really tired of life but think others are tired of them; some who do not really want to die but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or a cowardly act?"

I am concerned to know what my own terminally ill patients think, and in the near future I hope to query them about euthanasia. At this moment my questionnaire has been submitted to the University's Human Subjects Committee.

Before closing, I want to share a thought which can cut both ways, one which a proponent or an opponent of voluntary euthanasia might approve. It comes from a 1936 novel of Aldous Huxley, entitled *Eyeless in Gaza.* It was a time when the author was increasingly conscious of what was happening on the European continent. One of the characters, Mark Staithes, observes: "Death. . . . It's the only thing we haven't succeeded in completely vulgarizing. Not from any lack of the desire to do so, of course. We're like dogs on an acropolis. Trotting round with inexhaustible bladders and only too anxious to lift a leg against every statue. And mostly we succeed. Art, religion, heroism, love—we've left our visiting-card on all of them. But death—death remains out of reach. We haven't been able to defile *that* statue. Not yet, at any rate. But progress is still progressing."

(References available on request from Midwest Bioethics Center.)