
Ensuring a Good Death

by David C. Thomasma

Dying in our technological society has brought with it new challenges both for patients as well as for providers. Too much emphasis on autonomy can lead to neglecting the society in which we live. Physicians as well as family members and friends must address the issue of suffering with patients before the cries for physician-assisted suicide are muted.

The terrible "problem of suffering" is regarded by the Bible not so much as a problem to be explained . . . but as an inscrutable existential fact.

(Merton 1983)

There is a duty in today's society to assist people in dying well. Perhaps there was always such a duty, given the Golden Rule of doing for others what we would have them do for us. If so, this duty may have stemmed from the common experience of dying, the knowledge that the "bell will toll" for us soon enough. As Moira Dempsey has written, "I am aware of the inevitable pull of time on my body" (Dempsey 1997). This "pull of time" may lead to an intense identification with dying persons and impel us to help them. Yet I will suggest in this essay that the way we die today has changed so dramatically that earlier assumptions about such a duty to help people to die well needs reassessment and strengthening. The problems facing the dying today require a much more specific set of actions to fulfill our duties than they did in the past.

Indeed, the United States Supreme Court seems to have recognized this shift to greater complexity in its rulings on the appeals from the Second and Ninth District Courts regarding the right to assisted suicide and euthanasia (Annas 1997). Although it rejected the arguments that persons have a right to assisted suicide and euthanasia stemming either from rights to privacy or equal protection under the Federal Constitution, the majority opinion noted that there is nothing impeding individual states from drafting such laws, and that the Court would return to the question if greater care for the dying

person is not soon worked out. It thus implied in its ruling a common sense agreement with some of the premises of the pro-euthanasia movement that people do, indeed, face unusual challenges to dying well today that they did not in the past, and that society needs to do a better job of addressing some of these challenges.

The Challenge of Dying Well Today

It is extremely difficult to die well in modern society. In olden times, people died surrounded by family and friends in familiar environments. This constituted *ars bene moriendi*. Individuals had some measure of control over their dying. Today, hospitalization and institutionalization lend themselves to alienation of the dying from familiar surroundings and from those they love. The dying patient today is often taken care of by strangers, dedicated to the patient, indeed, but unfamiliar with the patient's values and goals outside the therapeutic relationship itself (Nelson et al. 1989).

This is the price one pays for obtaining high technology care for illnesses. It is not a price people are unwilling to pay to get well. But when one is dying, this price exacts a terrible toll. Strangers caring for strangers in a strange environment depletes the dignity one deserves while dying. It contributes to the suffering of the dying process itself.

The decisions that doctors and patients can make in intimate settings, especially regarding "help in dying," are often wrested from them in institutional settings. Other interests are invoked in decisions to withhold or withdraw care (usually called passive euthanasia) or to assist someone

in dying by providing the means (called assisted suicide) or directly taking their life (called active euthanasia). Professional societies, lay groups opposed to different forms of euthanasia, the institution itself, and inevitably, the courts and legislatures become involved even in individual cases. This, too, can contribute to the suffering of the individual, dying patient, even as society's commitments and concerns are clarified through the public process.

The Current Situation

Four key elements that shape how human beings die in a technological society characterize the current situation. In some ways, each of these realities both add to and subtract from the suffering of dying.

1. Prolonging Life as a Power

The incredible power of modern medicine to prolong life would stun even the most farsighted proponent of the right to voluntary active euthanasia earlier in this century. All the arguments presented by these leaders would only be intensified by the experience of families and care givers with the real sufferings of some patients during the dying process.

2. Checking Medical Power Through Patients' Rights

Dramatic advances have occurred in underlining the rights of patients, not only to determine the treatments they desire and do not desire during the dying process, but also the development of rights to choose treatments at any time during life, not just while dying. The living will and advance directive, which includes the durable power of attorney for health care, point to eventual further clarification of these rights, even with respect to their use in long-term care settings (Rouse 1988a). The Living Will is a legally recognized instrument whereby patients detail treatments they would forgo during the dying process. Usually it only covers the last few weeks of a person's life. Advance Directives are more comprehensive. These legal instruments cover a broad range of treatment patients would either prefer or not want at any time during any illness

when they become incompetent. A Durable Power of Attorney for Health Care designates a surrogate decision maker who is empowered only during the time one is incompetent to make decisions for the patient and only with respect to that patient's health care needs.

All these instruments of patients' rights have been written about extensively. What is important to note is that the underlying motivation for the development of such instruments is the prevention of suffering (Mehling 1988; Mehling and Neitlich 1989). It would make sense to extend these rights to avoid suffering to have even greater control over the dying process.

3. The Problem of Autonomy

While families struggle to implement the preferences of their loved ones during the dying process, the emphasis upon personal autonomy in medical ethics is coming under greater scrutiny. Concerns about Libertarian assumptions implied

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by autonomy-overemphasis have led many thinkers to counter autonomy with the need for beneficence (Pellegrino and Thomasma 1988; Loewy 1989). The implications of conflicts about medical ethics and ethical theory for euthanasia include the increased role of the health provider's values in caring for the dying patient, greater attention to the relation between physician and patient, rather than exclusive focus on the needs and wants of the individual patient alone, and questions about the kind of society we ought to be. In this regard, for example, some thinkers argue that society cannot establish a general rule that third parties can end the lives of persons in permanent vegetative states (Weinstein 1989). This point of view involves an interpretation of what counts for compassionate respect for human life in our

society. Thus, respect for autonomy may not be the most important value in caring for the dying.

4. *Physicians' Duties*

Further contrast comes from physicians' concerns about either the perceptions of the community about physicians being involved in voluntary active euthanasia, (Gaylin, et al. 1988) or more profound arguments about the traditional commitments to the value of human life. Thus Leon Kass presents a thoughtful articulation of what is owed a dying patient by the physician. He argues that humanity is owed humanity, not just "humane-ness," (i.e., being merciful by killing the patient). Kass argues that the very reason we are compelled to put animals out of their misery is that they are not human and thus demand from us some measure of humaneness. By contrast, human beings demand from us our humanity itself. This thesis, in turn, rests on the relationship "between the healer and the ill" as constituted, essentially, "even if only tacitly, around the desire of both to promote the wholeness of the one who is ailing" (Kass 1989). This is still a majority view among physicians, perhaps as large as seventy-five percent.

For most physicians, then, duties towards the dying include a major concern for the traditional principles of respect for the patient's well-being (beneficence) (Pellegrino and Thomasma 1988), respect for autonomy, maintaining the integrity of the health profession, and balancing justice and equity (Rouse 1988b). Studies show that physicians do not just evaluate whether a patient is dying based on biomedical data. They also take into account important features of human interaction and the proportion between therapeutically available interventions and the possible outcome (Muller and Koenig 1988).

Such interactive concerns tend to present counter pressures to a straightforward honoring of patient wishes and autonomy with respect to end-of-life decisions.

New Challenges in Dying Today

Recently Ann Landers confessed to being

overwhelmed by responses she received about a letter from Missouri pleading for a way out of a long, lingering death through suicide. "Anonymous in Missouri" wanted a dignified exit and would commit suicide rather than live in a nursing home when she got old. As Ann Landers said:

The response to this subject has been incredible. Although I know my readers well, I never anticipated such an overwhelming avalanche of mail. One thing is for certain — the vast majority do not have a very high opinion of nursing homes and dread the thought that someday they might have to live in one. My readers have also made it clear that they hate the thought of being a burden to their children (Landers 1997).

What emerges from all the letters is, indeed, an awareness on the part of Ann Landers' readers that we die differently today than in the past. In the past, humans tended to die relatively abrupt deaths; today we die long, lingering deaths, replete with increased suffering and dependency (Battin and Lipman 1996). This new situation creates many fears about the challenges it poses.

A new study done by American Health Decisions indicates common fears across ethnic, religious, age, and cultural lines (American Health Decisions 1997). Among the findings of this survey are that Americans do not think the health care system is geared to help the dying, and they feel disconnected with their doctors and other care givers. Most Americans do not speak explicitly about their death or plan for the contingencies surrounding a long illness and decline. Instead, they seem to trust in a vague feeling that their families will know what to do. Furthermore, despite its availability, Americans misinterpret the meaning of hospice. They also confuse "living will" with the will that disposes of their property. Another worry is that advanced directives will either be too restrictive, resulting in their being withdrawn from life-support too early, or that advanced directives will do no good since they will not be followed by health care professionals and even family members.

There is no ambivalence about Americans' desire to limit the burdens, especially the economic ones, of end-of-life care on their loved ones. This is a very important consideration, borne out by the many letters to Ann Landers. Yet Americans reverse this direction when it comes to their own loved ones, whom they want to save no matter what the cost. They would "do everything" rather than give up too soon. Beverley A. Tyler, leader of the study, noted,

Americans from diverse backgrounds say they want the same thing: a humane, compassionate and trustworthy process for dying that allows them as much control as possible over what happens at the end of their lives (Tyler 1997).

Specific Duties in Caring for the Dying

As stated, the new challenges facing dying patients require greater specificity about our duties to bring about a good death in contemporary society. Some, but not all, of those more specific duties are discussed below.

1. *Coping with the Life-Prolonging Power of Medicine*

Corresponding with this power comes a duty, not only to withhold and withdraw care as the inevitable process of dying occurs, but also to anticipate the consequences for the person later down the line as earlier interventions such as chemotherapy and surgery are urged on them to stem the tide or palliate the pain. For example, after three or four shunts and antibiotic therapy are successful in helping a person live a decent life with an ever-growing tumor in her abdomen, one can anticipate that this very success will lead to intense pain near the end of life from a basketball-sized mass in her abdomen. The patient may not "sense" that she is now dying, having had the experience of successful relief in the past, but her pain and suffering are greater now than they were earlier when the mass had not spread so far. She no longer "has" pain; she is pain. Her insurance for past frequent hospitalizations may have run its course, so that she might also be beset by worries about bankrupting her family while dying.

One cannot just step back at this point and refuse to accept responsibility for her situation. With every new power comes new responsibility. Thus is born a duty to inform patients of the later consequences one may experience because of interventions to slow or arrest the course of a disease.

A second duty, therefore, is to assist in planning ahead to bring about a good death with the least amount of pain and suffering when the results of earlier interventions inevitably come to pass.

2. *Patients' Rights in Checking this Power*

In light of the new powers of medicine, the rights of patients have been underlined as a way to check that power if it is used inappropriately. A second duty, therefore, is to assist in planning ahead to bring about a good death with the least amount of pain and suffering when the results of earlier interventions inevitably come to pass.

Conflicting values create conflict at the bedside during the dying process, despite these instruments. These conflicts appear most often in post-operative cardiology in our hospital. Patients and/or families have consented to potentially life-saving therapy in an emergency situation. Most often, after the surgery, patients either get better or they die. But some of them wind up in a grey area, a kind of steady state or stable existence, in which they only marginally improve or suffer setbacks each day. When the family begins to insist on the values of the patient not to live this kind of life, dependent on machines, the physicians inevitably argue for more time, and seem to discount the prior wishes of the patient in favor of an admittedly somewhat more remote chance for life. Families begin to perceive the physician, not

as a savior of their loved one's life, but as a bull terrier who won't let go of their neck. Even in the best-prepared families, the patient's ambiguous situation creates guilt about perhaps not honoring their father's wishes as they see the very technologies applied to him that he told them earlier he would never want, such as a respirator or kidney dialysis. On the other hand, the physicians think of these interventions as temporary and suggest that their father may have only foresworn them as being permanent dependencies.

The possibility of winding up in a stable but dependent existence is an important advance warning that physicians need to help patients and families understand. Given the emergency nature of the interventions needed to save the patient's life, it seems difficult, at best, to spell out the grey area as one of the risks of surgery. However, ambiguity breeds guilt, conflict, and ruptures of trust at the bedside. An ancillary duty arises to assist families through a family care protocol in all such cases, since they are easily swayed by feelings and loyalties that may not be in the best interests of their loved one.

3. *Respect for Autonomy*

The erosion of respect for human life in contemporary, technological society has been a constant theme of humanists and religious leaders alike and will no doubt continue to be in the twenty-first century. We are aware that our approach to life through the agency of technology increases both our freedoms and our dependencies alike.

Permitting as much control over the dying process as possible meets what Americans want most of all, and can help allay fears caused by a more protracted dying process.

4. *Dispatching the Dying in a Technological Society*

The worries expressed in the American Health Decisions survey about economics seem to cut to the deepest fears we have about our society. For many today the danger of mercy killing exists in the economic sphere (Scitovsky and Capron 1986). An example occurred in the Netherlands when a physician euthanized a dying patient

whom he argued was going to die anyway, and the physician said he needed the bed (Eads 1997). Will it be easier to use a simple method of dispatching those persons whose care costs too much, or who are now considered to be a burden on society, like the aged and the poor, than to address their suffering, which sometimes is overwhelming even for the most dedicated caregivers? As the late Joseph Cardinal Bernardin noted in an address on euthanasia at the University of Chicago Hospital,

"We cannot accept a policy that would open the door to euthanasia by creating categories of patients whose lives can be considered of no value merely because they are not conscious" (Bernardin 1988).

The "technofix" solution is not only easier to conceptualize and implement than the more difficult processes of human engagement, but is also "suggested" by technology itself. The training and skills of modern health professionals are overwhelmingly nurtured within a bath of technological fixes. By instinct and proclivity, all persons in a modern civilization are tempted by technical rather than personal solutions to problems. This is the real issue for Cardinal Bernardin, for example, who poses this question:

What would we be suggesting to one another and to our society, if, seemingly with the best of motives, we were to say that those who are sick, infirm, or unconscious may be killed? How could we allege that such actions would not affect us individually and collectively? (Bernardin 1988)

Such actions are a form of "privatizing life," denying its social and communal dimensions as both a private and public good.

Therefore, the concerns of devaluing human life through technical responses to human suffering should not be dismissed as hopelessly conservative and neurotic. The overbearing experience of the twentieth century is one in which persons have been put at the mercy of technology. Caution about this reversal of the creative process, wherein persons are now subject to their own

creations, is not only justified, but important in developing any social policy and legislative process.

5. *Excessive Treatment at the End of Life*

The economic worries of dying patients are not only aimed at being "let go" too early, but also of becoming a care and economic burden on loved ones by having too much treatment. Concerns about assisting in dying should not be confined to dispatching persons too early by injections, while not meeting their physical and social needs. Another form of the "technofix" society is to prolong suffering in conditions of hopeless injury to life. "Hopeless injury," as Braithwaite and I once defined it, is:

a condition in which there is no potential for growth or repair; no observable pleasure or happiness from living . . . and a total absence of one or more of the following attributes of quality of life: cognition or recognition, motor activity, memory or awareness of time, consciousness, and language or other intelligent means of communicating thoughts or wishes (Braithwaite and Thomasma 1986).

Daily life is full of interactions with "things"—nonhuman and fundamentally incomprehensible to most persons. We sometimes get so used to technological processes that we behave as though they are substitutes for human, compassionate care. Eating, for many elderly and dying patients, has been replaced by tubes; participating in the spiritual and material values of human life has been replaced by "surviving," as a being subjugated to the very products of human imagination. As Illich observes:

Medical civilization is planned and organized to kill pain, to eliminate sickness, and to abolish the need for acts of suffering and dying . . . The experience that has replaced dignified suffering is artificially prolonged, opaque, depersonalized maintenance (Illich 1976).

Such "beings" on depersonalized maintenance

may no longer be as human as the rest of us precisely because of this subjugation. This is no way to respect the value of human life. Is a permanently unconscious "sack with organs" (Korein), without any ability to relate to its environment, a "person?" Much of earlier technological intervention was not so much life supporting, but, as Albert Jonsen suggests, organ supporting. Now, increasingly, systematic efforts are made to prolong all the vital organ systems at once, getting the essential nutrients in and wastes out. Not only have we moved from organ-specific technologies to systemic ones, but also from temporary support to permanent support. Jonsen wonders just what exactly life support supports: "We talk about the maintenance of life; we don't often talk about the maintenance of personhood. It interests me little," he says, "indeed, not at all, to be alive as an organism. In such a state I have no interests. It is enormously interesting for me to be a person . . . It is the perpetuation of my personhood that interests me; indeed, it is probably my major and perhaps my sole real interest" (Jonsen 1988).

Many technologies were developed for specific groups of patients but are now used for other patient populations where their effect has yet to be evaluated. Because the equipment makes the provider feel better, it is used. When technologies become more accessible, e.g., dialysis, cardio-pulmonary resuscitation, there is less of an imperative to justify their use. When beds in Intensive Care Units are plentiful, dying patients are tucked into them.

The effect of overuse of technology without evaluation of its efficacy and, frequently, without patient involvement in its application to them, is to increase patient and family suffering. It may prolong the suffering of dying, and it provides social suffering by wasting resources that might benefit those with potentially reversible diseases. Of those who are critically ill with chronic disease or major medical or surgical problems, the mortality rate in an ICU is 40-60% (Raffin, Shurkin, and Sinkler 1988). The weak or chronically ill will almost certainly die tethered to their machines (Raffin, Shurkin and Sinkler 1988).

6. *The Duty of Balancing Care: Controlling Pain and Addressing Suffering*

In order to protect human dignity, societies must maintain constant vigilance about protecting persons from both under treatment and abandonment and inappropriate over treatment. In both instances, we will be shepherding our technology to good human aims. This shepherding can be focused on an obligation to attempt to eliminate pain to have one's suffering addressed by other human beings.

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Pain control is not only required but possible (Angell 1982; Editorial 1988; Mohidem, et al. 1988). In this respect, the focus should turn to the obligations of the community and away from rights of patients. The patients cannot control the pain; they are entirely in the hands of caregivers. The social policy can be articulated as an obligation on the part of the community to control the pain and address the suffering of dying. This is how Liebeskind and Melzack put it on behalf of the International Pain Foundation: "We are appalled by the needless pain that plagues the people of the world — in rich and poor nations alike. By any reasonable code, freedom from pain should be a basic human right, limited only by our knowledge to achieve it" (Liebeskind and Melzack 1988). Although modern medicine offers many means for such control, it is an irony, perhaps stimulated by the overwhelming sense of responsibility for the lives of patients, that physicians are reluctant to use the means at their

disposal to control pain.(ACP 1983; Goleman 1987; Judge Urges 1988).

Although not all physical discomfort can be eradicated, there are clearly many medical means available to minimize pain and treat other symptoms than pain in terminally ill patients (Levy and Catalano 1985). When medical methods are exhausted, intensive physical and psychological comfort care must be given, using pharmacologic and interpersonal methods. These include supportive psychotherapy and spending more time with patients. Fears about depressing respirations while controlling pain should not prevent the administration of sufficient analgesia (Angell 1982). Additional suffering may be caused by a poor doctor-patient relationship, excessive truth-telling when the patient cannot bear hearing everything at once, the caregiver's avoidance mechanisms, or a hurried approach. All of these add to the broader sense of the "pain picture" that must be confronted.

The very psychodynamics of the patient-physician relationship may prevent adequate control of pain and addressing of suffering. Patients tend to be unprepared for the dying process, having always experienced medicine's ability to provide answers and cures. Physicians, on the other hand, through overwork and the technofix attitudes already noted, may be unprepared to face his or her patient's suffering. The physician may have developed an emotional aloofness that impairs the ability to sympathize with the patient's plight. Overwork itself limits the time needed to pay sufficient attention to the patient's suffering that accompanies pain.

7. *Is There a Duty to Provide Euthanasia and Assisted Suicide?*

The movement toward voluntary active euthanasia rests on the following principles:

1. Autonomy — A person has a right to do what he or she pleases with the body.
2. A person should not have to suffer unduly at the hands of a rampaging modern medical technology (Wanzer, et al. 1989). The right to control one's own destiny should be seen as a

major civil rights effort in facing the power of medicine.

3. When a person decides that continued life is meaningless, that decision ought to be respected. No one else has a better sense of the value and meaning of one's own life than that individual (Angell 1988).

Arguably, some forms of euthanasia practiced are more acceptable than others (Thomasma 1988). But is euthanasia the best way to support suffering persons (Husebo 1988; MacKinnon 1988)? When the physician and other caregivers in society approach a dying patient, is the option for terminating that life an important part of the care to be offered (Thomasma 1996)? Patients have complications that require compassionate care that borders on killing, yet physicians especially have a traditional duty to respect the life of patients. If the physician or other caregiver is committed to preserving the life of the patient, is there an alternative to active euthanasia that will

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not neglect the suffering of that patient? Aid-in-dying is certainly one modality of addressing suffering (Wanzer 1989), but a wide range of actions for controlling pain and meeting the dying person as a person are also required.

I asked if there were some alternative to the movement for active, direct euthanasia that might accomplish its goals without violating the very substantial concerns about the rule against killing. Arguments for active, direct euthanasia can be met by a social policy that ensures, through double-effect euthanasia, that no one will suffer unduly, and that all suffering will be eliminated as far as possible. Double-effect euthanasia is an action with at least two effects, one intended and

one foreseen. The intended effect is to control pain (through massive doses of pain-control medication) and the foreseen effect is the death of the patient (a probable by-product of the effort to control the pain).

Pain control is clearly not the be-all and end-all of care for the dying. Many patients do not experience 100% reduction in pain, many experience adverse side-effects, and obtaining pain relief sometimes gives them time to dwell on the tragedy of their impending death, producing serious depression. As suggested, much more than pain control must be involved in their care.

An important distinction, therefore, must be drawn. It is the distinction between pain and suffering. Persons ought not to have to suffer pain; but all dying involves a kind of suffering that cannot entirely be taken away. As Eric Cassell has argued, suffering is distinct from physical distress. The former is undergone by persons, and the latter by the body (Cassell 1982). Since persons experience suffering, personal engagement by health providers and caregivers is essential to relieve it (Dolan 1982). Daniel Maguire points out, then, that

"Pain is not the totality of what may be unbearable suffering. Someone dying of Huntington's disease may not have pain, but he has a unique suffering that many victims cannot bear and so are driven to death by choice" (Maguire 1977).

A good example of a movement surrounding this kind of suffering is that of "Merian's Friends," a voluntary group of persons who advocate for euthanasia based on the dying process of Merian Frederick, a victim of Lou Gehrig's disease (Letter 1997).

Cassell also proposes that the primary obligation of physicians and other caregivers to the dying patient is to control the suffering and pain of that person (Cassell 1982). In all respects, Cassell also argues, confrontations about the person's right to make treatment decisions within this context are "ugly" if they do not take into account the structure of that person's life and value choices

(Cassell 1984). This obligation includes, as Dame Cicely Saunders indicates from her long association with the hospice movement, an obligation to address the spiritual suffering that patients experience (Saunders 1988a).

Furthermore, as hospice principles show, the commitment of modern medicine to engaging persons and their spirits on the level of bio-social interdependence is strongly impeded in modern society by technological barriers. Technology influences training. It makes people think that the only intervention into the lives of others must be through technological means, rather than interpersonal ones.

8. *New Physician Duties*

If the focus turns to the obligation of caregivers to control pain and address suffering, this requires a rethinking of the goals of modern medicine, especially during the dying process. The goal of medicine in this instance must be to assist persons to accomplish (however small) some life-plans (Walter 1988). One way of rethinking these goals is to introduce a duty not to prolong dying at the point when a patient:

- 1) Suffers from the effects of a terminal illness, however long that illness may take to play out its course;
- 2) The patient judges, on the basis of his or her own self-worth and attendant quality-of-life concerns, or has given advance directives in this regard, that the life he or she now lives no longer has meaning;
- 3) Or, alternatively, if the patient has left no advance directives, the condition of the patient is such that the terminal illness is now in its imminent phase, and the patient is no longer able to participate in the spiritual and material goods of human life (*The Appleton Consensus* 1989).

9. *The Human Community*

Finally, a rethinking of the nature of the human community is required in any social policy stressing the obligation to address suffering. This requires, at the very least, the kind of thinking

that informs the hospice movement itself (Saunders 1988b). Not enough formal education of health professionals about the experiences of hospice in controlling pain and addressing suffering has occurred. The community must become a community of healing, even in the presence of death. Saunders refers to this as a "friendship for each individual person in pain" (Saunders 1988b).

Another way of putting this is to note that a morally significant aspect of all beings is their capacity to suffer (Loewy 1991). But even more remarkable is the moral significance of the capacity of human beings to heal. Animals feel pain and can sympathize, but they cannot heal beyond the most elemental licking of sores. Only humans can heal. This capacity grounds a view of human society as capable of being a community of healers. Perhaps this aspect of human life is most jeopardized by a social policy permitting voluntary active euthanasia. Will human persons neglect the admittedly difficult task of addressing suffering, and their own capacity to heal, by too quickly dispatching others who are clearly suffering pain and the loss of self-worth and the meaning of life?

Conclusion

I have tried to explore the new challenges of dying today that require rethinking and refocusing our duties towards providing a good death. Some conclusions are:

- 1) Death should be seen as a kindness for some dying people. As an early report of the Working Party of the Church of England noted, "It is entirely misleading to call decisions to cease curative treatment 'negative euthanasia'; they are part of good medicine and always have been" (Working Party of the Church of England 1976).
- 2) Planning for or bringing about death is a virtuous and moral act, especially if done in conjunction with the wishes of the patient.
- 3) Planning for death would accept the explicit goal of active euthanasia: a merciful and painless death for the patient, while using

passive means to carry out this goal. Among such means would be withholding and withdrawing of technological care at the patient's request, no institution of antibiotics or fluids and nutrition, and the like.

- 4) Far greater care would be taken, than is often the case today, at controlling pain and suffering, not just physical pain, but also psychological and social suffering. The principle of double-effect would be used to make a commitment to patients that they need not suffer. Evidence exists that very few dying patients want to be dispatched early (Kotulak 1986). But they also do not want to be unduly prolonged in their suffering.
- 5) Addressing pain and suffering requires a rethinking of the goal of medicine. Medicine's aim in a technological age should be to preserve life as a conditional value, that is, a good that permits us to pursue higher values, such as love, work, contributions to society, travel, friendship, and the like. When patients themselves, or their surrogates, inform us that their lives no longer have these meanings, it is a cruelty to prolong their lives at all costs while ignoring their statements. The values such patients articulate should be part of the therapeutic plan. When these values can no longer be achieved, then preserving life loses its importance in the therapeutic plan. In its place is bringing about a kind death.

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* Dr. Stein Husebo explicitly asks himself this question, examines some of the most powerful cases with which he has been associated, and concludes: "I emphasize, however, that in a very few situations, active euthanasia will be a caring thing for doctors to do."

By contrast, Kenneth MacKinnon considers active euthanasia a cop-out.

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