

EDITORIAL VIEWS

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To Help the Dying Die—A New Duty for Anesthesiologists?

On last election day, the voters of California declined to legalize assisted suicide. The citizens of Washington State did the same 1 yr ago. In both states, the vote was close, after vigorous public debate. Without doubt, the issue will be pressed soon in other jurisdictions. An approval, if it eventually comes, will give legal protection to an act that previously has been considered criminal in every American jurisdiction. It will enhance the moral acceptability of a practice that for centuries has been proscribed to physicians by the words of the Hippocratic Oath, "I will give no deadly poison to anyone when asked to do so, nor will I suggest such a course."

The article by Truog and Berde in this issue of *Anesthesiology* proposes that anesthesiologists should be particularly concerned with the questions surrounding euthanasia.¹ They assert this for two reasons: if assisted suicide becomes legal, anesthesiologists may occupy a central role as consultants and practitioners of euthanasia; and since fear of uncontrolled pain motivates the desire for euthanasia, pain control, the province of anesthesia, will become a higher priority on the medical agenda. Anesthesiologists can play a preventative role, eliminating the desire for euthanasia by eliminating the pain that motivates such a desire. Anesthesiologists also will have to decide whether they wish to become the specialist practitioners of euthanasia. Just as obstetricians have to form their conscience about abortion, anesthesiologists will have to make a conscientious choice about euthanasia.

There is a sea of literature about euthanasia. Truog and Berde's short article, while informative, only dips into it. At the end of the 19th century and the beginning of the 20th, a flurry of debate over euthanasia stirred the medical literature. Enough public interest was aroused to lead to efforts to legalize euthanasia in Ohio and Iowa, both of which failed. The question was again debated in the 1930s, stimulated by euthanasia societies that had come into being in the United States and Great Britain. No legal changes were effected. In all of these discussions the euthanasia advocated was what

we call today "active," that is, the administration of a drug that would "make the act of dying more gentle and peaceful, even if it did involve the curtailment of life."² Only rarely was "passive euthanasia," the omission of some life-saving procedure, discussed. This is understandable, since few medical procedures held the power to prolong life. The omission of possibly life-saving surgery was sometimes considered, "where it appears that a slight chance to save a life depends on the surgical knife, should the patient undergo the hazards of a questionable operation?"³

In 1945, the revelation of the Holocaust, with its attendant medical involvement in criminal experimentation and in eugenic euthanasia programs, horrified the public and the medical profession.⁴ Historians have pointed out that the Nazi programs to eliminate the unfit had their origins in the tolerance that the German medical profession had shown toward euthanasia in the several decades before National Socialism came to power.⁵

These revelations cast a pall over discussions of euthanasia in general. The proposals for euthanasia that had surfaced occasionally during the 19th and early 20th centuries, even from the most benign proponents, took on the terrifying color of those events. So, words written in 1944, before the Nazi depredations were well known, by Dr. Frank Hinman, a benign and competent physician on the faculty at the University of California, San Francisco, where I long taught medical ethics, are now repulsive to our ears:

To end a life that is useless, helpless and hopeless seems merciful. . . They are of many kinds. . . idiots, the insane, morons, psychopaths. . . criminals, monsters, defectives, incurables and the worn out senile. . . they are of no apparent use in the world, require care, have no hope of betterment and are a great burden on society.⁶

Medical historian Stanley Reiser concludes his article "The Dilemma of Euthanasia in Modern Medical History" with the comment, "Public and professional discussion of euthanasia continued to be sparse up to the mid-1960s. Then the subject was given much attention as a consequence of the moral problems raised by the growing medical use of machines that sustained the physical functioning of dying patients but usually could not alter their grave prognosis."⁷

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It was indeed the medical use of machines that revived the euthanasia discussion, but in so doing, it markedly shifted the focus of the debate. Attention moved away from the "active euthanasia" of pre-war times to the consideration of "passive euthanasia." The reason was twofold: first, the shadow of the Holocaust lay over active euthanasia, and second, in the post-war years, the medical machines had arrived that made possible the extension of quantity of life with sometimes questionable enhancement of its quality. The support of organic life could be effected by several powerful respiratory, cardiac, and renal technologies, making it realistic to ask seriously, "Should this form of life support be initiated or continued?"

The new discipline of bioethics had come into being during the 1970s, and its attention was focused on the problems associated with death and dying. Bioethical literature has worked incessantly over these issues: determination of death, "do not resuscitate" orders, forgoing life support, advance directives, surrogacy, quality of life, and now the futility of interventions. Much has been written and many so-called "dilemmas" reduced to manageable policy and practice.

The results of this debate from the 1970s through the early '80s laid to rest the ethical doubts of many practitioners about "passive euthanasia." Even though the distinction between "active" and "passive" is logically very problematic, it seemed reasonable to accept that treatments that were no longer helpful or were no longer desired by the patient could be "forgone," a word that incorporated the two actions of withholding or withdrawing life support. Medical ethics came to accommodate this view, even though the decisions often were agonizing for doctor and family. Hospital policies upheld these decisions, when made in accord with guidelines. "Do not resuscitate" orders, once unthinkable, became routine policy. Court cases, from Quinlan to Cruzan, endorsed the idea that even life-sustaining treatment could be terminated under appropriate conditions. The President's Commission for the Study of Ethical Problems in Medicine issued its report, *Deciding to Forgo Life Sustaining Treatment*, which drew the opinions of bioethicists into clear and reasonable recommendations for policy and practice.⁸ Thus, for two decades, attention was focused on the problem created by the new technologies, and solutions were framed in terms of "passive" euthanasia, defined as refraining from the use of those technologies. It had become legally and ethically acceptable to allow a patient to die. This was, in the opinion of most commentators, genuine ethical progress.

In all of this, the older discussion about "mercy killing" remained somewhat in the background. Even in its more modern form, as "active euthanasia," it remained on the margins of the debate. It always has been present, listed in the index of death and dying issues, but it has not been, until very recently, a central issue. It was overshadowed (like so much else) by the problems posed by technology, as well as by the "night and fog" of the Holocaust. Its repudiation was axiomatic in the opinion of most physicians and bioethicists. It was, regardless of its name, killing, and killing was forbidden by morality and by medical ethics.

The literature in medical ethics demonstrates a remarkable shift in the late 1980s. The President's Commission, in 1982, had dealt with the matter rather peremptorily: while noting the arguments pro and con, its conclusion seems dictated by the axiomatic rejection. The first and second editions (1982 and 1986) of *Clinical Ethics* by Jonsen, Seigler, and Winslade, which proposes itself as a summary of ethical issues pertinent to clinical care, devoted but two pages to the question and only listed the arguments against it. The third edition, in 1992, expands the discussion to five pages and includes pro and con arguments.⁹ Thus, between the mid-1980s and the early '90s, things changed: active euthanasia, now renamed "aid-in-dying" or "assisted suicide," moved from the periphery to the center of attention.^{10,11} Perhaps the starting date for the shift was "It's All Over, Debbie," which appeared in *JAMA* in 1988.¹²

Like all starting dates in the history of ideas, it is but a particularly striking event within a broader, more vaguely defined, and somewhat unnoticed flow of ideas. The Euthanasia Society, later renamed the Society for the Right to Die, had been active in publicity and politics for many years. One of the founders of bioethics, the late Dr. Joseph Fletcher, was a member of that Society and had taken a clear position on euthanasia in his early book, *Morals and Medicine* (1954).¹³ It was a bold stand in the face of the Nazification of the issue at that time. Remarkably, to the modern reader, it completely neglects to employ the "active-passive" distinction, which is an artifact of a technologic life-support medicine yet to come. His argument rests primarily on the assertions that suicide is not evil, that killing is not always an act of malice. While relying, in Fletcherian manner, on the freedom of the individual to choose death, he allows a large role to surrogate decision-makers. He clearly favors voluntary euthanasia and repudiates what he calls purely eugenic euthanasia for all who are burdens on the community, but he does

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leave a place for the partially eugenic, namely, involuntary euthanasia for "monstrosities at birth and mental defectives."

Kohl's collection of essays, *Benevolent Euthanasia* (1976), contained arguments on both sides of the issue.¹⁴ However, the editor's purpose, expressed most clearly in his own contribution, was to further Fletcher's exploration of the possibility that killing could be beneficent in certain circumstances and thus be seen as a duty incumbent upon others, including physicians. This approach begins to draw the euthanasia issue out from under the cloud cast upon it by eugenic practice. It emphasizes the principle of beneficence as the primary justification. However, in that same volume, philosopher Baruch Brody makes a strong case in favor of active euthanasia based solely upon the competent request of the one whose life is ended, rejecting the relevance of beneficent motives. Brody's thesis anticipates a major shift in the euthanasia arguments.¹⁵

That shift clearly takes place in the late '80, in what I have called the post-Debbie discussions. The eugenic cloud has been dispelled, except, if you will pardon a mixed metaphor, at the end of a slippery slope. The "mercy" aspect of killing, which implied "doing good" for "idiots, criminals and the worn-out senile" by eliminating their suffering and our burden, has disappeared. Many physicians, having accepted both the principle of respect for patient autonomy and the ethical probity of allowing to die, began to wonder whether any relevant moral distinction could be made between passive and active euthanasia. Some leading bioethicists began to question seriously the logic of such a distinction. So, the problem of active euthanasia slowly was subsumed into bioethics' favored principle, autonomy: The person competently requesting death alone defines benefit. The language of "aid-in-dying" and "assisted suicide" reflects this shift. The moral question is now, "What reason can be given to exclude self-life ending (killing is not a politically correct word) from the repertoire of actions permitted to an autonomous person?"

This is an excellent question, and it probably will be answered by voters somewhere before it is even clearly defined by philosophers. At the same time, a plebiscite on an ethical problem can bury under a popular majority certain confusions and unclarity. If the principle of autonomy serves as the sole justification for aid-in-dying, is it possible to insist that only the presently requesting should receive it, as the California and Washington initiatives did? Must not a prior request be respected as well? What are we to do about those who

have never requested, but probably would have? Why should they, because of their incapacity, be deprived of a right others can exercise? Finally, what would justify imposing conditions, such as terminal illness or implacable pain, unless the conditions directly pertained to an assurance of competent, free consent? The powerful assertion of patient autonomy as the justification for aid-in-dying casts all these limitations and conditions into shadow.

One curious evidence of this shift from "mercy" to "autonomy" is the disappearance of "intractable pain" in the language of legislative proposals, such as those defeated in Washington and in California. No one need prove that the patient suffers from terrible, untreatable pain as a condition of legal aid-in-dying. Only a terminal illness, signifying death within 6 months, need be attested. In The Netherlands, by contrast, evidence of intractable pain is the fundamental legal rationale for tolerance of euthanasia: such evidence constitutes the "force majeure" that in European jurisprudence permits an action that would be otherwise illegal.¹⁶

Thus, although, as Truog and Berde note, "Fear of uncontrolled pain is clearly one of the major forces driving the public's desire for legalized euthanasia,"¹⁷ it is no longer a major feature of the justifying arguments. Autonomy, not pain or its merciful alleviation, is the principal and even sole justifying argument offered by modern proponents. Opponents who argue, as in the Washington and California campaigns, that modern methods of pain control can virtually eliminate the category of "intractable" pain are correct enough, but they miss the mark: the right to choose death, not the presence of pain, is now the issue. Nevertheless, Truog and Berde are right in insisting that skill in pain control and the advance of the science that underlies it should go far in relieving people's fears.

The shift to autonomy as the basic justification for active euthanasia is, in my opinion, more closely associated with the fear of loss of autonomy through mental deterioration than with intractable pain. The 19th- and early 20th-century proposals for euthanasia were stimulated by the development of the nosology of cancer, new skills in its diagnosis, and the hopeless, horrible course that such a diagnosis implied. The contemporary proposals are, I believe, prompted by wide public awareness of the threat of Alzheimer's disease and other similar dementing disorders. Ironically, the formulation of the proposals for legalization of euthanasia does not extend to this problem, because these disorders are not "terminal" and most of the proposals authorize only a competent, active request for aid-in-

dying rather than a prior directive. Still, I estimate that loss of autonomy rather than fear of pain motivates most persons to favor some form of legalized medical surcease. If my estimate is accurate (and I would hope someone would attempt to verify it empirically), the current legal formulations will not satisfy the public that votes for them. They will still find themselves facing their own loss of autonomy and that of their loved ones. Their desire is, I think, to be "put to sleep" before they become strangers to themselves and others.

In conclusion, over the past several decades, the issue of active euthanasia has moved from the periphery to the center of death and dying questions. In so doing, its proffered justification has shifted from beneficence through a mix of beneficence and autonomy and finally to pure autonomy. This is, I think, a shift that should be scrutinized, especially as public attitudes move toward favoring assisted suicide and sentiments for more tolerant law grow. Truog and Berde quite rightly summon physicians, anesthesiologists in particular, to reflection.

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