



Physician-assisted suicide

■ *To the Editor:* Physician assistance in the suicide of terminally ill, unbearably suffering patients is an issue that the American public seemingly will not let die—an ironic parallel to the tendency of physicians caring for such patients to prolong their suffering through the use of high technology (in the intensive care setting) or through experimental therapy (as with cancer patients). As Smith and associates¹ pointed out in the January-February 1992 *Cleveland Clinic Journal of Medicine*, the issue has now come to a vote twice: as initiative 119 in Washington State in 1991, and again as proposition 161 in California in 1992. Although both referendums were ultimately rejected by voters of these states, substantial support was garnered for the “yes” vote: approximately 45% of the voters favored the “death with dignity” act in Washington State, and 46% did so in California. With such an underpinning, the issue is likely to come up again soon.

Smith et al mention that a central argument in favor of assisted suicide is the physician’s duty to work towards ending human suffering, especially the suffering that results from a protracted and agonizing dying process that is arrived at only via the interposition of modern medical capabilities. Benrubi² has most recently advanced this argument by stating, in essence, that disallowing a terminally ill and unbearably suffering patient the option of assisted suicide constitutes an act of abandonment on the part of the physician. In other words, it would be professional hypocrisy for a physician to “go all out” in treating a patient and then, when the efforts have obviously failed, not to stand by to care for and comfort, *by whatever means necessary*, the very patient who embodies the treatment failure.

Generally, the physician’s and care-giver’s mastery of the administration of palliative and supportive care is all that is needed in such situations. However, in contrast to the conclusion of Smith et al, this care does

not represent the easy and complete resolution of the issue that they make it out to be.

Sometimes, despite vigorous morphine dosing with patient-controlled analgesia (PCA), a nearly obtunded patient who can no longer press the PCA button (due to extreme sedation) will yet groan repetitively in apparent pain. This was the case with one of my patients, a 35-year-old woman hospitalized with disseminated multiple myeloma refractory to chemotherapy. The patient’s mother pressed the PCA button for her, administering the upper limit of morphine allowed, but the cycle of pain did not seem to be broken. The patient was not sent to a hospice, since it was estimated she had very little time to live, and arrangements for a transfer would thus have been moot. Yet the patient then lingered for more than 3 weeks.

The pain these patients experience is real. Dr. Timothy E. Quill³ states that, “[although] I know we have measures to help control pain and lessen suffering, to think that people do not suffer in the process of dying is an illusion.” In acknowledging the reality of intractable suffering, Dr. Quill offered an account of how he assisted in bringing about the suicide of one of his terminally ill cancer patients.³ The patient, whom he had known for 8 years, was quite independent-minded. She wished to avoid a situation such as the one described above by having a peaceful suicide as an option.³ Along these lines, she requested a prescription for barbiturates. In response to the patient’s request, after ensuring that she did not have a depressive disorder and after much reflection on his part, Dr. Quill agreed to provide her with enough barbiturates to commit suicide—on the condition that she meet with him regularly “to ensure that all other avenues had been exhausted.”³ Eventually, as a painful death became imminent, she did commit suicide, in an affirmation of the dignity of her life.

The point here is that palliative care is not fully effective, even when optimally administered. I suggest that the comment of Smith and associates, that “there is no reason why all terminal pain cannot be abolished,” is much too facile a judgment in light of the clinical evidence. The pathophysiology of pain is extremely complex, and today we are only beginning to understand psychic contributions to the experience of pain. Furthermore, the realm of suffering involves far more than physical pain alone. Psychosocial support and artful communication cannot always be expected to be wonderfully effective in the resolution of hopelessly ill patients’ existential crises (although sometimes they are). Certainly, better palliative and supportive care is needed. However, I would like to refer the reader to guidelines for implementing a policy of physician-assisted suicide,⁴ and to a commentary supporting it.⁵

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1. Smith ML, Orłowski J, Radey C, Scofield G. A good death: Is euthanasia the answer? *Cleve Clin J Med* 1992; 59:99–109.
2. Benrubi GI. Euthanasia—the need for procedural safeguards. *N Engl J Med* 1992; 326:197–199.
3. Quill TE. Death and dignity—a case of individualized decision making. *N Engl J Med* 1991; 324:691–694.
4. Quill TE, Cassel CK, Meier DE. Care of the hopelessly ill—proposed clinical criteria for physician-assisted suicide. *N Engl J Med* 1992; 327:1380–1384.
5. Brody H. Assisted death—a compassionate response to a medical failure. *N Engl J Med* 1992; 327:1384–1388.

■ *In reply:* Like Dr. Sheldon, we are very aware that physician-assisted suicide and active euthanasia are ethical and legal issues that will not disappear quickly. Even as we prepare our response to Dr. Sheldon, there are media reports that Dr. Jack Kavorkian has assisted in the death of his sixth female victim.

We will address three points prompted by Dr. Sheldon’s letter: 1) the argument for assisted suicide proposed by Benrubi; 2) the situation of Dr. Sheldon’s 35-year-old patient; and 3) the dangerous misconception that assisted suicide and active euthanasia are facile means to a merciful death.

First, Benrubi¹ criticizes physicians for using their full medical armamentarium to defeat disease, often prolonging agony along with life, but then offering no help when it is clear that disease will win the battle. His solution is for physicians, under restricted condi-

tions, to be able to offer euthanasia to patients as an escape from the horrors that medicine has wrought. To us, the problem is real, but the solution is wrong.

We suggest that the following are needed: abandonment of the battlefield imagery that permeates medicine; skilled communication with patients; a consensus about realistic treatment goals and plans; and an awareness that shifting from aggressive to palliative measures may require not less but even more intense caring for suffering, dying patients. Benrubi (and Sheldon) may be highlighting a systemic problem in medicine; if this is accurate, we propose major efforts and energy to change the system of medical education and the delivery of care, rather than treat the symptoms through “medicalized” killing.

Second, in recounting the agonizing, painful dying of his 35-year-old patient, Dr. Sheldon aims to illustrate his belief that palliative care is not fully effective, even when optimally administered. We respectfully question why his patient received such inadequate pain management, and we submit that this case is an excellent example to support our assertion that adequate and appropriate pain management is not being provided to many patients.

Why was this patient receiving patient-controlled analgesia when she could not activate the pump? Why was a continuous infusion of morphine not used? What protocol established the “upper limit of morphine allowed” when, in fact, it was inadequate? The “upper limit” for us is the amount of analgesia that is within standards of pain management, that honors patient wishes (when known) for the desired level of consciousness or unconsciousness, *and* that breaks the particular patient’s cycle of pain. In our view, these criteria are not mutually exclusive; they are ethically supported and justified and do not cross over the line into active euthanasia. We reiterate our position that pain management for the dying is frequently and unnecessarily inadequate, and that this inadequacy needlessly nudges many patients into believing that their only option besides an agonizing death is euthanasia or assisted suicide.

Third, we caution against the misconception that a “happy death” can easily and always be achieved by active euthanasia and assisted suicide. We are concerned that Dr. Sheldon may promote this misconception by referencing Dr. Timothy Quill’s actions with his dying patient (“Diane”) as a paradigm for proper

response and peaceful death in a terminally ill patient who is suffering without relief. Dr. Quill's essay describes how Diane's husband and son, after she had died, "found her on the couch, lying very still and covered by her favorite shawl. There was no sign of struggle. She seemed to be at peace."²

Gomez,³ after recounting 26 cases of physician-aided euthanasia in the Netherlands, comments that the Dutch practice seems to call for particular drugs with proven efficacy (eg, barbiturate and curare), and that there are protocols which guide a physician's use and administration of those drugs. But, as Gomez also explains, the Dutch practice of euthanasia has occasionally fallen prey to uncertainty, miscalculation, and mistakes (ie, drugs were not given in sufficient quantities and were inadequate to the task). One Dutch doctor, referenced and quoted by Gomez, indicated a desire to establish medical criteria for euthanasia that would be refined by using medical protocol and experimentation with dying patients.

Through personal communication with Dutch physicians, we learned of some cases of euthanasia that "fell prey to miscalculation" and "experimentation." One case involved a 29-year-old blind woman with diabetes mellitus for 12 years, renal failure, neuropathy, and severe pain requiring morphine. At her request, euthanasia was initiated. She was given 100 mg of morphine and 2.5 mg of atropine. She became comatose in 30 minutes, but after 3 hours she was still alive. The same drugs at the same doses were again given. Two hours later she was still breathing. She was then given 100 mEq of potassium chloride, and death finally followed.

A second case involved an 85-year-old woman with metastatic stomach cancer and severe pain who was residing in a nursing home and was refusing food. She

was given 10 mg of diazepam and 40 mg of morphine intramuscularly. Because she did not lapse fully into unconsciousness, she was given an additional 40 mg of morphine and 2.5 mg atropine intramuscularly. After she became unconscious but did not die, 12 mg of pancuronium was given intramuscularly. She died shortly thereafter.

Finally, related to our caution about misconceptions, we note a controversy raging in Germany over a case in which a suicide victim who used one of the 40 methods suggested by the German Society for Humane Dying decided to videotape his death.⁴ The film showed him writhing and retching horribly in the final minutes before he drowned in his bath. It is not clear what role, if any, a physician had in assisting this man's death.

We share Dr. Sheldon's desire that patients experience a peaceful death with dignity. We continue to assert that this can be achieved through adequate pain management and social support for the dying. Advocates of medicalized active euthanasia, whether they be physicians or patients, should know that their solution for the problem of pain and suffering may not always be gentle, efficient, and without complications.

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1. Benrubi GI. Euthanasia—the need for procedural safeguards. *N Engl J Med* 1992; 326:197–199.
2. Quill TE. Death and dignity—a case of individualized decision making. *N Engl J Med* 1991; 324:691–694.
3. Gomez CF. Regulating death, euthanasia and the case of the Netherlands. New York: The Free Press, 1991.
4. Nicholson R. Euthanasia elsewhere. *Bulletin of Medical Ethics* 1992; 81:6.