

LIFE MATTERS: DOCTOR-ASSISTED DEATH BY SUICIDE

A central facet of traditional medical ethics has been embodied in the phrase “First, do no harm.” Specifically, the original Hippocratic Oath, recited by physicians for millennia, ensured that they would give no deadly drug, even if asked. Sadly, few medical school graduates are still being asked to recite this oath. Instead, the door has been thrown open for some doctors to participate in, and even promote, giving deadly drugs with the direct intent to end human life. For such doctors, the time-honored principle of avoiding harm has been cast aside as they become willing accomplices to killing their patients.

In turn, there has been a profound shift in attitude in my state of Oregon in the fifteen years since voters narrowly embraced assisted suicide—a shift that, I believe, has been detrimental to patients, degraded the quality of medical care, and compromised the integrity of my profession.

Since assisted suicide became an option, I have had at least a dozen patients discuss this option with me in my practice. Most of the patients who have broached this issue weren’t even terminally ill.

One of my first encounters with this kind of request came from a patient with a progressive form of multiple sclerosis. “Joe” was in a wheelchair yet lived a very active life. In fact, he was a general contractor and quite productive. While I was seeing him, I asked him about how it affected his life. He acknowledged that multiple sclerosis was a major challenge and told me that if he got too much worse, he might want to “just end it.”

I responded, “It sounds like you are telling me this because you might ultimately want assistance with your own assisted suicide if things get worse.” He nodded affirmatively, and appeared relieved that I seemed to understand.

I told Joe that I could readily understand his fear and his frustration and even his belief that assisted suicide might be a good option for him. But, I added, should he become sicker or weaker, I would work to give him the best care and support available. I told him that no matter how debilitated he might become, at least to me, his life was and would always be inherently valuable. As such, I would not recommend, nor could I participate in, his assisted suicide. Joe simply said, “Thank you.”

The truth is that we are not isolated, self-sufficient individuals. Every human being is part of a huge network of interdependent relationships with others. How physicians respond to the patient’s request for lethal drugs can have a profound effect on a patient’s choices as well as on his view of himself and his inherent worth. When a patient says *I want to die*, it may simply mean *I feel useless*. When a patient says *I don’t want to be a burden*, it may really be a question, *Am I a burden?* When a patient says *I’ve lived a long life already*, she

may really be saying *I’m tired. I’m afraid I can’t keep going.* And finally, when a patient says *I might as well be dead*,

he may really be saying *No one cares about me*. Many studies show that assisted suicide requests are almost always for such psychological or social reasons.

Let’s look at experiences with legalized assisted suicide in Oregon.

There has never been any documented case of assisted suicide in Oregon because there was actual untreatable pain.

The law does not require that the patient have unbearable suffering, or *any* suffering for that matter. The actual Oregon experience has been a far cry from the televised images and advertisements that seduced the public to embrace assisted suicide. In statewide television ads, a woman named Patty Rosen claimed to have killed her daughter with an overdose of barbiturates because of intractable cancer pain. This claim was later challenged and shown to be false. Yet, even if it had been true, it would indicate inadequate medical care, not grounds for assisted suicide.

What about the potential gain to family members of the so-called “suicide” of a “loved one?” Such gain could be in the form of an inheritance, a life insurance policy or even simply freedom from previous care responsibilities. Because there is no requirement for witnesses at the time of ingestion, who is to say that the deadly drug was ingested voluntarily? Who knows whether a patient experienced a change of heart but was overruled by a “loved one?” In reality the entire paradigm of “assisted” suicide is wide open to elder abuse.

The change in attitude within the healthcare system itself is also deeply troubling. People with serious illnesses are now sometimes fearful of the motives of doctors and consultants. A few years ago, “Katherine,” a patient with bladder cancer, contacted me. She was concerned that her oncologist might be one of the “death doctors.” Katherine questioned his motives, particularly after consulting a second oncologist who was more sanguine about her prognosis and treatment options. Whether or not one or the other consultant was correct, such fears were never an issue before assisted suicide was legalized.

In Oregon, I regularly receive notices that the State’s Medicaid health plan will no longer pay for many



important services and drugs for my patients, even including some pain medications. At the same time, assisted suicide is *fully covered and sanctioned by the State of Oregon* (funded by our collective tax dollars). This “rationed” health care from the State itself—one of the largest insurers in Oregon—is putting lives at risk.

Barbara Wagner, a retired school bus driver, learned this lesson first hand. Barbara had been in remission from her lung cancer. When it recurred, her oncologist wanted her to be given a drug that (statistically) would increase the chance of her being alive in one year by 45%. The State of Oregon denied this treatment stating that her prognosis wasn’t good enough to warrant expensive medication to treat her cancer.

Yet in the same letter denying coverage for her medication, the State offered full coverage (100%) for her assisted suicide. Rather than being embarrassed about their discriminatory opinion letter, health officials (and even the governor) defended the practice. What implications does this attitude portend for national health care reform? How many older individuals with serious illnesses or disabilities could be determined “no longer worth treatment” under federal cost-saving measures?

*To concur with the intention of another person to commit suicide and to help in carrying it out through so-called “assisted suicide” means to cooperate in, and at times to be the actual perpetrator of, an injustice which can never be excused, even if it is requested. In a remarkably relevant passage Saint Augustine writes that “it is never licit to kill another: even if he should wish it, indeed if he request it because, hanging between life and death, he begs for help in freeing the soul struggling against the bonds of the body and longing to be released; nor is it licit even when a sick person is no longer able to live.”... Moreover, the act of euthanasia appears all the more perverse if it is carried out by those, like relatives, who are supposed to treat a family member with patience and love, or by those, such as doctors, who by virtue of their specific profession are supposed to care for the sick person even in the most painful terminal stages.
Pope John Paul II, *The Gospel of Life*, no. 66*

Today, promoters of assisted suicide have succeeded in spreading assisted suicide to Washington State and they continue to push for legalization in numerous other states. Using seductive euphemisms for situational killing, including *death with dignity*, *choice in dying*, and *aid-in-dying*, they deliberately distort end-of-life care and options while fanning the flames of fear of intractable suffering at death. They claim to advocate for patients and cite numerous, so-called “safeguards.” In reality, the assisted suicide laws in Oregon and Washington are severely flawed and really don’t provide protections for patients.

For example, patients accessing assisted suicide are supposed to be of sound mind. Yet fully 25% of

patients given prescriptions for lethal overdoses were found to be depressed. Many others had anxiety. The practice is supposed to be reviewed by state officials, yet the only data reported in the States of Oregon and Washington comes from second- or even third-hand reports from the doctors who wrote the prescription. Most of the doctors (about 90%) weren’t even present at the time their patients took the drug overdose, thus, they really don’t know what happened.

The reality is that the only real safeguards are those shielding the doctors. In essence, doctors in Oregon and Washington have been granted a “license to kill” with a guarantee of protection. The practice has been shrouded in secrecy. Fewer and fewer details are documented with each passing year. There is no punishment specified for failure to report. There is no peer-review—no one is allowed to evaluate cases for appropriateness, or for the complications that occur, or to even know that the case actually occurred. In fact, doctors are *prohibited* from recording assisted suicide as the cause of death on the death certificate. Instead, the law *requires* the physician to falsely list the presumed underlying terminal illness as the cause of death.

The lack of oversight and patient safeguards is consistent with the view of many who promote assisted suicide, that some individuals lack “dignity” due to their physical or mental condition and simply aren’t worth the bother or expense of having their basic needs met. They are wrong.

In contrast, Catholic teaching recognizes the inherent value of all human life. We are indeed made in the image and likeness of God. As Catholics we celebrate and defend the sanctity of life in all of its natural stages. Each of us—regardless of age, race, physical or mental ability, or economic status—is inherently valuable. There is no stage of life that is insignificant. When every life is respected, when physicians, family members and other caregivers respond generously to the needs of vulnerable persons in their care, we all benefit.

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