



Physician Assisted Suicide

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In May this year my wife and I had the privilege of presenting day-long ethics workshops in four rural centres for Hospice and Palliative Care Manitoba. I was able to contribute my knowledge of law, policies and ethical theory. Laurie was able to bring her nine years of clinical experience as a nurse leader in cancer care and palliative care.

In order to get the workshop participants thinking about the social policy side of euthanasia and physician-assisted suicide we showed an excerpt from Bill Moyers's PBS series "On Our Own Terms." It told the story of Kitty Rayl, a 53 year old resident of Portland, Oregon, who in 1999 was dying of metastasized uterine cancer. Oregon is the one place in North America that, since 1997, has made it legal for physicians to prescribe lethal doses of drugs that will kill terminally ill patients before their disease takes them. Kitty Rayl had asked for this. The video shows Kitty talking about her reasons and Dr. Nancy Krumpacher, the compliant physician, explaining why she believed it acceptable to go along. Interestingly, Kitty's care continued to be managed by the doctor who had been her cancer specialist even after he had told her that he was resolved not to prescribe lethal drugs or do anything to intentionally shorten her life. In other words, Dr. Krumpacher was

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being consulted solely to help end Kitty's life. (Don't you find it disconcerting to think of this—Jack Kevorkian suggested calling it “obitiatry”—as a new medical specialty?)

Moyers interviewed Olson and Krumpacher together about their different positions. Dr. Olson affirmed the traditional position that there is an ethically-relevant distinction between killing patients intentionally and having patients die sooner than they would otherwise as a consequence of medications given to manage their pain.

In the field of ethics this is frequently called the principle of double effect. The principle begins with the assumption that we bear responsibility for the outcomes of our actions, but observes that actions generally have multiple effects—some of them intended by the agent, many of them not. It then says that an agent may not be morally to blame for bad things that happen even if they are foreseeable, so long as: she has intended only the good outcomes; the good outcomes are proportionately greater than the bad; and the good is not achieved by means of the bad. (The principle of double effect does not say that the good we intend necessarily absolves us of responsibility for the bad that happens too, but only that it sometimes does so.) In the case of medical care at the end of life, the principle says a physician may be not morally to blame for shortening a patient's life (a bad outcome) if the medications were prescribed purely for the purpose of reducing the patient's pain (a good outcome) and if the medications did not kill the pain by killing the patient (which is what differentiates the therapeutic use of morphine from an injection of concentrated potassium chloride).

Dr. Krumpacher explained her contrary view by saying: first, that she didn't see shortening the life of a dying person as a bad thing; and second, that she saw no important

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ethical difference between intended and unintended outcomes. Furthermore, in her words, as a competent adult it was Kitty Rayl's right to choose, and she was asking for her services.

I myself am in agreement with Olson. I am unequivocally opposed to Oregon's law, which I think is bad public policy predicated on faulty ethics. But Oregon is not the only place where people ask for "help" in dying. Disagree with this direction or not, we need to know what lies behind their requests.

To the surprise of some participants in our May workshop, Laurie shared that a number of patients have asked her about assisted suicide or active euthanasia. Mr. A. was one of them. He was a young senior with advanced incurable cancer. At the time he asked Laurie about "help," he was not actively dying but he knew his condition was terminal. Laurie told him that legally and ethically she could not end his life, but (and I think this is very important) she asked him to help her understand why he would be asking. Mr. A. explained that he had been a career military man. He liked order over unpredictable chaos, and prided himself on his personal strength and independence. He didn't want to cower in the face of pain or find himself reduced to begging for relief. His wife had died of cancer some years previously and her experience of suffering still haunted his memory. Since then he had lived on his own and he didn't want to impose on his adult children now. His son was married and in the throes of graduate school. His daughter, while single and willing to move in to care for him, had a history of depression and was thought to be already rather fragile. Knowing that dying is not simply a "medical" matter, Laurie asked Mr. A. how he was in his spirit. He described signs of clinical

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depression (not at all uncommon among people with serious physical illness). He also admitted to concern about facing death after having neglected God. Religion had been a source of dispute between himself and his wife, and so he had alienated himself from any faith community for a long time.

Why do I tell this story?

First, because Laurie had not simply deferred to some law or general ethical principle in saying “no” to Mr.A. That happens too frequently. Respect for persons, while a fundamental moral value, is awfully thin if it’s employed only in relation to those with whom we agree. People in positions of power in particular—people like physicians and nurses who can simply veto patients’ plans, and bosses who can simply order their employees to comply, for instance—should see that the measure of whether they respect others is whether they truly listen to people who disagree with them on matters of right and wrong.

Second, I tell the story of Mr. A. because it can elucidate the ethical principle of autonomy. The information I related about Mr. A begin to put flesh on him. Laurie knows more that she’s held back to preserve his privacy, but even the few details that have been shared with us help us to see why this particular man would ask about assisted suicide. I don’t want to be unfair to Dr. Krumpacher, but the impression I get from the videotape is that as soon as she learned that Kitty Rayl was a mentally alert adult who had decided on physician-assisted suicide she was willing to go along. I don’t think that’s good enough. For the same reason I think it’s not good enough when medical consent is equated with a signature on some consent form. People’s decisions do not come out of thin air (and if

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they do we should regard them more like whims than decisions). Decisions have a history. There's the biography of a unique, irreplaceable character behind them. And if we truly value individual autonomy (which could be translated, "self-determination"), we need to see the "self" that gives the decision meaning.

One reason why I believe the principle of double effect is ethically sound is that, in contrast to a utilitarian ethic, it demands that we accord value to the agency of the person who is acting and not only to the consequences of our actions. Not only *what* is decided, but *who* it is that decides, with what motives and with what intention—all this matters ethically.

The third reason I relate Mr. A.'s story is because he seemed to have a passionate aversion to being a "burden" on others, especially his children. He's not alone. Many people in our culture find the prospect of dependency not only horrible but embarrassing. Why, we should ask, is the Oregon law permitting physician-assisted suicide called the "Death with Dignity Act"? Is it supposed to imply that allowing disease and its attendant symptoms to take over is undignified? Dispelling the shame of this is one of the principal achievements of the marvellous book (and now stage play) Tuesdays with Morrie. As he slipped deeper into life with ALS, Professor Morrie Schwartz said, "The things I am supposed to be embarrassed about now—not being able to walk, not being able to wipe my ass, waking up some mornings wanting to cry—there is nothing innately embarrassing or shaming about them....In the beginning of life, when we are infants, we need others to survive, right? And at the end of life, when you get like me, you need others to survive,

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right? [His voice dropped to a whisper.] But here's the secret: in between, we need others as well."

I disagree with those teachers of Christian ethics who say that self-determination is not a Christian value, but they are right to say that something has gone seriously wrong when devotion to autonomy makes us shun interdependence. If the Christian ethic has anything to teach our culture, it is that the good life is a life in which people are covenantally bound to others in healthy community. There is an ancient tradition that says that when he was very old the writer of 1 John could not walk but had to be carried by friends and disciples wherever he went, and that the only thing he could say was "Children, love one another." It's all he could say. But in a way, that's enough, don't you think?

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