

Arguments Against Physician-Assisted Dying (from Gregory Pence, *Classic Cases in Medical Ethics*, 5/e, used with permission).

Cries for Help

Joanne Lynn, a physician who has cared for over 1,000 hospice patients, believes that most terminal patients who request physician-assisted death seek attention, control, dignity, relief of symptoms, or relief from depression. Sometimes the request is a plea to see “if anyone really cares whether he or she lives.”ⁱ

Physicians trained in palliative care believe aggressive treatment can ameliorate almost all unpleasant symptoms. With such specialists and good medical coverage, dying need not be undignified or painful.

It is especially important with terminal patients not just to deal with physical symptoms. Terminal patients are often bored and depressed: people avoid them. People who once had important work to do now have nothing to do. People who never watched television now are forced to watch it all day long. Good psychiatrists know how to help.

Dying at home cures some problems. It is empowering to be dying in your own home rather than a hospital, which has its own routine and hierarchy.

Allowing physician-assisted dying would be the easy way out on several fronts. First, physicians don't need to aggressively treat symptoms. Second, the system doesn't need to change to train more people in hospice and palliative care. Third, the patients may die too early and months before they need to.

In a review of the literature, bioethicist Margaret Pabst Battin, known for her decades of work on dignified death, and physician Timothy Quill conclude that physician-assisted dying should be an option of last resort after all resources are exhausted of excellent palliative care.ⁱⁱ Even

though they defend legalizing physician-assisted dying, they stress that it must be no substitute for lack of gold-standard palliative care.

So here is a recipe for physician-assisted dying gone wild: cheap care, poorly trained nurses and physicians, managed care plans that don't pay for palliative medicine, hospice or long-term nursing care, and young people impatient for their elders to "get on with it and die."ⁱⁱⁱ

The Slippery Slope

One of the most famous ideas in ethics is the slippery slope, also called the "thin edge of the wedge" -- or simply "wedge" -- argument. Claims about it figure prominently in debates about physician-assisted dying.

Slippery slope arguments assert that if a preliminary neutral or good step is accepted, a series of other changes then occur, leading to a final terrible result. It metaphorically sees society as teetering like a ball perched atop a steep slope and leaning downward, braced only by chocks or wedges on the ground, preventing it from descending. The chocks are our basic moral principles.

There are two general kinds of claims about slippery slopes: empirical and conceptual.^{iv} Claims about empirical slopes assert that once you take the first step, something bad in human nature is unleashed, which will be uncontrollable. In the article by Leo Alexander mentioned previously, he refers to an empirical slope: "The destructive principle, once unleashed, is bound to engulf the whole personality and to occupy all its relationships."^v

A conceptual slippery slope asserts that once a small change is made in a moral rule, other changes will soon follow, because of the demands of reason for consistency in treating similar cases similarly. Alexander also refers to this kind of slope:

The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude of the nonrehabilitable sick.^{vi}

Once physicians are permitted to kill one kind of patient because quality of life is so low as to make "life not worthy to be lived," they not only can, but will use the same reasoning in similar cases.

An empirical slope prediction says that once society changes a rule about protecting one class of patient, powerful forces will be unleashed that cannot be restrained and kept contained to the original class. Something like this was unleashed in Dr. Michael Swango when he started to kill: Charged and convicted in 2000 with killing three patients in New York State, Dr. Michel Swango killed at least 60 patients, possibly hundreds, starting in Zimbabwe in the early 1980's and moving around the world (when arrested, he was on his way to Saudi Arabia for a new job). His diary revealed that he killed for the thrill of the power to kill and "the sweet, husky, close smell of an indoor homicide."

It is just such malice in human nature that could be unleashed with legal, physician-assisted deaths. Law professor Yale Kamisar observes that "not all people are

kind, understanding, and loving. Yet they will be making decisions about the elderly and helpless.

Consider another example of a conceptual slope: first we will allow abortion of a fetus because of Down syndrome, then we will let a newborn with Down syndrome to die. In this kind of slope, as opposed to empirical slopes, it is always the demand of reason to treat similar cases similarly that expands the initial change.

This kind of reasoning is seen in the following claims. At the time of the Karen Quinlan case in 1976, disability advocate James Bopp said that if you "accept quality of life as the standard," then "first you withdraw the respirators, then the food and then you actively kill people. It's a straight line from one place to the others."^{vii} Bioethicist Daniel Callahan then said that the logic of the case for euthanasia will inevitably lead to its extension far beyond terminally ill competent adults. If relief of suffering is critical, Callahan said, "[W]hy should that relief be denied to the demented or the incompetent?"^{viii} In the claims of these people, what justifies one kind of case will soon justify another.

Contrasts may be made among the two kinds of slope claims. The empirical claim is a prediction about consequences if some moral change occurs, whereas the conceptual claim refers to a linkage in reasoning once particular premises are accepted. Where the empirical slope says one small change will create many others because of something bad in humans, the conceptual slope says the same kind of change can occur because of something higher in humans--reason's need to treat similar cases similarly.

Claims about slippery slopes are difficult to evaluate because the predicted, final bad event is so far away. However, critics predicted that slippery slopes would occur during the Karen Quinlan case, with Holland's changes, and

with Oregon's legalization, so we can evaluate such predictions.

In 1975, columnist Nat Hentoff predicted that the Quinlan decision would bring on an empirical slippery slope. In 1992, he felt vindicated in describing Jack Kevorkian's actions and the decriminalization of physician-assisted dying in the Netherlands, all of which he called a "reckless cheapening of life."^{ix}

What can we say about these claims? First, if the danger of an empirical slippery slope was real, we would have expected the precedent of the Quinlan case to first, make it easy for competent patients to die, and second, to generalize to other kinds of incompetent patients, such as senile, demented patients in nursing homes. Yet neither happened. It took twenty-two years after the Quinlan decision before the first terminal patient legally died with the help of a physician in Oregon in 1998, and the Schiavo case showed us how far we are from readily accepting the deaths of incompetent PVS patients. Hardly empirical slippery slopes.

What about Oregon? Physician-assisted deaths there over the first eight years averaged about 35 to 40 a year. Hardly the thousands and thousands of deaths predicted by critics.

What about Holland? Here a real expansion of cases has occurred. The 1991 Rummelink Report on physician-assisted dying by the Dutch government discovered that about 1,000 patients had died every year who were not competent and hence had not met the guidelines.^x

What about this? First, almost 99% of the patients killed had cancer or AIDS. Second, these patients had a physician who knew them intimately and who had treated them for years, such that when they became unconscious before they could make (and repeat) their request for assisted dying, these physicians knew the wishes of these patients.

But in a sense, claims about slippery slope have come true in Holland. Teenagers, psychiatric patients, and newborns who are suffering and terminal have been killed with their consent or the consent of their proxies. At present, guidelines for killing irreversibly dying infants are being considered.

Callahan's prediction has come true, but the Dutch regard it not as a downward descent but as a moral elevation: if it's justified to kill a consenting, terminal 64-year-old with cancer, why isn't it also to kill a consenting 16-year-old with cancer?

Inefficient Means

Opponents of legalization claim that physician-assisted deaths are botched 25% of the time in Holland and therefore it should be illegal.^{xi} This is a strange argument because it complains about the "how to" part of legalization, in other words, physicians at present aren't good enough to guarantee death.

Of course, death for some patients will not be easy. Some AIDS patients who were intravenous drug-users and who attempted suicide at dosages recommended by the Hemlock Society had high tolerances to central-nervous-system depressants, and did not die easily or quickly, sometimes merely ending up in vegetative comas.

To avoid this possibility, the patient needed to ask a friend to be present to possibly help at the end by attaching a large plastic bag over the patient's head and securing it with duct tape, such that the patient could suffocate to death. (This is what critic Nat Hentoff calls the "Exit Bag," sarcastically referring to the efficient, self-administered form of it with velcro straps that once could be ordered from the Hemlock Society.^{xii}) Use of Exit Bags subjects friends to charges of murder, and leaves dying patients faced with the dilemma of dying alone and botching the

attempt or asking a friend to be present, assist, and risk prosecution for assisting in suicide.

This is why Oregonian physicians often attend the deaths of terminal patients. If something goes wrong, they can adjust medications or deal with unexpected complications. In short, this argument is not an argument for no physician-assisted dying, but for more of it.

A Financial Empirical Slope?

“Money makes the world go ‘round” and some people were shocked when Oregon made it possible for a physician to not only help a patient die, but to be paid for doing so. For them, once we allow physicians to make money on assisted death, Pandora's Box is really open and great evil will occur.

In fee-for-service medicine, the more procedures a physician does on a dying patient, the more money the physician makes. New systems of managed care give the physician all his money at the beginning of the year, and if he goes over that allotment, he loses money, whereas if he is under, he gets a bonus. In the old, fee-for-service system, physicians had a financial motive to keep a dying patient alive as long as possible. In the new system, the motives are reversed.

The claim about an empirical slope here is that the cheapness of families and the avarice of physicians will conspire to speed sick patients to an early grave.

Is this claim true? The honest answer is that we don't know. Hard times have not tested American physicians this way. They are used to aggressively treating patients and being well-paid to do so, especially in oncology, cardiac surgery, and cancer surgery.

One nagging worry is that some historians think that the ultimate reason for the rise of Nazi Germany was economic. After losing World War I, the Germans were made to pay huge war reparations, which caused great harm to

the German economy and created much ill-will. Since World War II, and especially in the last two decades, North America has experienced an unparalleled economic boom. What will happen when times turn bad again and families must choose between grandma's care in a long-term nursing home and a child's college tuition?

It is odd that in formal discussions of ethical issues in medicine, money plays only a small role. One emergency room physician, Norman Paradis, raised this issue publicly in connection with the death of his own father, a surgeon, who was diagnosed with pancreatic cancer, the most lethal and swift of all cancers.^{xiii} Paradis's father told him that he had seen "physicians torture dying patients" and insisted that he wanted neither surgery nor chemotherapy. Paradis assured his father that, as a physician, he knew what to do. He was sure that his strong, direct, professional-to-professional communication with his father's physicians was unequivocal: Make my father comfortable; do no more.

As soon as he left, however, his father was taken to surgery. Why? Because, Paradis says, "consulting surgeons get paid thousands of dollars an hour when they 'decide' to operate." When the younger Paradis called to refuse his consent for further surgery, he was told that his decision was "mistaken." His father underwent further, massive surgery and died the next day. Medicare paid more than \$150,000 for these operations. When Paradis objected to Medicare officials, claiming that his father's physicians had proceeded without consent and had violated proper procedures, he was told that there were so many cases of fraud over \$1 million that they could not be bothered with his case. Paradis concludes, "Our health system is structured to meet reimbursement rather than patients' needs."

Perhaps the surgeons in this case were genuinely convinced that surgery was an acceptable risk and in the patient's best interest, but perhaps they were guilty of a

conflict of interest. If it is fair to argue against physician-assisted dying by pointing out that some families and institutions may seize the advantage to save money, it is also fair to note that some physicians and institutions make millions by maintaining the status quo. Isn't it possible that some specialists could lose enormous amounts of money if assisted dying were practiced? And if so, might they not have a conflict of interest in opposing assisted dying?

In most areas of life, we assume that people work for money, and we give them monetary incentives to work harder. When it comes to physicians, we assume that they will be moral and will not recommend treatments only to make money. Perhaps most of them don't. However, when a reasonable case can be made for denying treatment, treatment is often administered anyway--and the physician makes more money. Is this just a coincidence, or is there some connection?

In sum, this argument cuts both ways. If money motivates everything, then patients are kept alive and "tortured" so physicians can make more money. Which is worse? Such torture or early deaths?

The Roles of Physicians

Some physicians argue that "Physicians should not kill" and should always be healers. This statement assumes incorrectly that physicians can always heal. That is false. The mortality rate is 100 percent among humans. No human has ever been "healed" of death. So eventually, each human must confront death with his or her physician.

Second, to simplistically assert that, "Physicians should not kill" begs the key question of this chapter. It is like saying that, "Physicians should do not what is wrong," while assuming without argument that such-and-such is wrong.

It should be noted about roles of physicians that in Oregon where the law allowed physician-assisted dying, no

physician in the United States must assist a patient who wants to die. As with abortion, only a small percentage of physicians help terminal patients die and it is voluntary.

Lastly, the controversy about the role of physicians in assisted suicide has focused too much on Jack Kevorkian and not enough on the larger picture. Every year, over two million Americans die. Most of us will die of cancer, coronary artery disease, stroke, or one of the degenerative diseases. Despite all the newest drugs and all the medical advances, and according to the detailed descriptions of Yale surgeon Sherwin Nuland's *The Way We Die*, almost every American over age 60 will die a miserable death. Is this progress? Every day, hundreds of people are spending their last six months of life in misery. Is this progress?

Mistakes and Abuses

Physicians make mistakes. Surgeon Christiaan Barnard recalled a young woman with ovarian cancer who repeatedly begged him to kill her painlessly with morphine.^{xiv} Aware that she was terminal--and hearing her screams at night--Barnard decided to help her. When he came into her room with a syringe loaded with morphine, she was quiet, and he thought at first that she was in too much pain even to scream. Then he realized that she was semiconscious, beyond pain, and he changed his mind. The next morning, she felt better; soon she was in remission, and then lived another few months. Stories like this abound in medicine.

In Holland, some critics claim that physicians often misdiagnosis "intractable and unbearable" suffering. In Janet Adkins's case, many people were quick to say that physicians aren't infallible diagnosticians and that patients sometimes defy a dire prognosis.

Let us put this point differently. In bioethics, many discussions begin with a phrase like, "If a patient has a terminal illness" Notice the word "if". In presumably

terminal illnesses, few claims are absolute until the patient's last days. Before then, how "terminal"--how close to death--the patient is may depend on many factors that are not easy to assess: the patient's attitude, the family's attitude, the attitude of staff members, the quality and level of care, and so on. Moreover, some terminal patients were misdiagnosed and recovered. Physician-assisted dying allows a mistaken diagnosis to become a death sentence. Once physician-assisted death occurs, there is no appeal.

Israeli physician Seymour Glick also reveals a dirty little secret of medicine: every physician has some patients that he or she really hates. Some deaths are messy, some families are intolerable, and sometimes, physicians make mistakes and harm patients. In all these cases, physicians want the cases to "go away." The easiest way to make them go away is for them to die. But we should never open this door.

FURTHER READING

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ii Timothy Quill and Margaret Pabst Battin, "Excellent Palliative Care," p. 325.

iii

iv Douglas Walton, *Slippery Slope Arguments*, New York: Oxford University Press, 1992.

v Leo Alexander, "Medical Science ... ", p. 47.

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vii Michael Specter, "Suicide Device Fuels Debate," *Washington Post*, June 8, 1990.

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ix Nat Hentoff, "The Deadly Slippery Slope," *Village Voice*, September 1, 1987.

x Nat Hentoff, "Decision on Euthanasia Will Create a Slippery Slope," nationally syndicated column, *Newspaper Enterprise Association*, October 6, 1992 (see also *Washington Post* of same date).

xi Timothy Egan, "Assisted Suicide Comes"

xii Nat Hentoff, "The Coat Hanger of Assisted Suicide," *Washington Post*, December 12, 1997.

xiii Norman Paradis, "Making a Living Off the Dying," *New York Times*, April 25, 1992, p. 15.

Sherwin Nuland, *The Way We Die*,

xiv Christiaan Barnard, *One Life*, Macmillan, New York, 1965.