

When “Going Gentle Into That Good Night” May Be the Right Decision: The Case for Assisted Suicide

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Preface

I bring to this topic familiarity with the medical profession and professional views based on social work experience. I also bring something few avoid—personal experience with illnesses and dying. From a generalist’s perspective, I offer an overview of an issue with which we all must come to terms. As individuals and as a society, it is vital that we reach some consensus, since medical technology makes prolonged death increasingly common.

As a preface, I share with you two favorite poems, opposing and thought-provoking illuminations on the manner of our dying.

I begin with the first stanza of Dylan Thomas’ haunting villanelle, in which he addresses his father.

From “Do Not Go Gentle Into That Good Night” by Dylan Thomas (1914-1953):

Do not go gentle into that
good night,
Old age should burn and rave

at close of day;
Rage, rage against the dying
of the light.
And you, my father, there on
the sad height,
Curse, bless, me now with
your fierce tears,
I pray.
Do not go gentle into that
good night.
Rage, rage against the dying
of the light.

Many of you will be familiar with this second poem, by Alfred Lord Tennyson.

“Crossing the Bar” by Alfred Lord Tennyson (1809-1892):

Sunset and evening star,
And one clear call for me,
And may there be no
moaning of the bar,
When I put out to sea.

But such a tide as moving
seems asleep,
Too full for sound and foam,
When that which drew from
out the boundless deep
Turns again home.

Twilight and evening bell,
And after that the dark!
And may there be no sadness

of farewell,
When I embark;

For tho' from out our bourne
of time and place
The flood may bear me far,
I hope to see my Pilot face
to face
When I have crossed the bar.

I would now like to share with you three vignettes, which I hope will reverberate in your minds with the poetry and with my remarks.

THREE VIGNETTES

Helen

She was once an energetic, strongminded, loving mother, wife and grandmother. She almost never sat still, loved pretty clothes and sunshine, and was always a woman with great dignity. She was no longer that woman by the time she mercifully died at age 88. Instead, she was blind, incontinent, uncommunicative and unaware of her loved ones and her surroundings. For over a year, she moved only from bed to chair, never recognizing her devoted husband of 64 years, who cared for her tenderly. Against her will, the shell that had been Helen "raged against the dying of the light." Yet how often she had spoken of her mother's last years, after a devastating stroke; how she had feared the loss of her own mental and physical faculties. At last, she slipped out of the world she no longer knew, insensate in a nursing home; "That wasn't my mother," her son, my husband, said. "I lost my mother two years ago. I won't remember her this way; I won't."

Tippy

Years earlier, my husband cradled our still-beautiful Shetland Sheepdog, Tippy, in his arms and said "Tippy is going to die." He dealt with death and dying all the time in his profession, but tears cascaded down his face now. Tippy was our cherished "only" dog, beloved from the early days of our marriage, loving, kind and always there. But now his kidneys were failing; it was not easy for him to run to us, jump up to sit on our laps, follow us everywhere. He was a little dog with a big spirit and a big heart, who delighted all he met. Although he was endearing and charming, he was also a very self-possessed little creature, with great dignity. To surrender him to the earth seemed unthinkable at first. His continuing absence, 12 years later, still tugs at my heart. But he trusted us completely all of his life. That trust demanded that we allow him to die as he had lived, still in functioning control, before uncomprehended pain and immobility overcame him. We owed it to Tippy to let him "go gentle into that good night," and we did, whispering good-bye as he lay in our arms, his eyes on our faces. It was the hardest thing I had ever done, but to have held onto him would have been supremely selfish, motivated by our own need and weakness, not by his need and best interests. Tippy is buried in our pet cemetery, the wooden cross marking his grave painted by our then-young son, with 3 images of things Tippy had loved in life. When we think of Tippy, we see him running across the yard, silky fur brushed by the wind, happy and

loved, mind and body healthy.

Lona

Before the tumor invaded her brain, in her prime, she charted her own course, a woman who was known by her family and friends as intelligent, quick-witted, assertive, and independent. Her two daughters grown, she returned to nursing, at Chippenham Hospital in Richmond, Virginia. One winter day, Lona collapsed while caring for a patient. A tumor had invaded her brain. Surgery and chemotherapy kept her alive, but horrible drug side effects and the tumor's re-growth made this once active tennis player able to get around only with assistance. Frightening seizures felled her at unpredictable intervals. By spring of 1996, Lona and her family knew that although surgery could prolong her life, she was dying and would eventually die from her illness. And the surgery would almost certainly leave her paralyzed. Lona made her own decision about death, as she had about the rest of her life. She had "raged against the dying of the light" as long as it seemed she might defeat the disease that stalked her; now she knew the tumor would win. But she would not helplessly endure the final surrender; believing that in dying she would indeed "turn again home," she chose to die peacefully, her faculties and personhood still intact, not debilitated and supported by machines. She indeed left this world on "such a tide as moving seems asleep," thankful for the peaceful means that carried her out of this "bourne of time and place."

Doctor Death

They call him “Doctor Death”—Jack Kevorkian, M.D., with his “suicide machine.” To some, he is a murderer, taking what only God should give and take, a human life. To others, he is a hero who helps terminally and chronically ill adults, determined to have control over their quality of life, die, sparing them and their families extended pain, suffering, and debasement. From 1990 until the time of writing this, Kevorkian has “helped” 44 people to slip out of life, most by inhaling carbon monoxide gas (Adams, 1996, June 20; Wolff, 1995, May 13). Juries have yet to convict him.

On June 8, 1996, Lona Jones became Kevorkian’s “victim” or “client,” depending on your perspective. Lona Jones and her husband journeyed from Chester, Virginia to Michigan so that she could end her life with Kevorkian’s help (Adams, 1995, June 20, A7).

Last fall, in Richmond, Ralph Jones spoke to the bioethics committees of Johnston-Willis and Chippenham Hospitals. My husband chairs those committees, and I heard Lona’s husband speak, taking spellbound listeners on a remarkable odyssey, through his wife’s life before and after her illness and through the decision-making process that ended that night in Michigan. Lona Jones had investigated all possible treatments at several medical centers. Ralph Jones told us that the Kevorkian he and his wife came to know in the months before she died was not the caricatured, loose cannon we see in

the media, but a caring, sensitive physician. Kevorkian, Jones said, “made it clear that his sole purpose was to help her prolong her life as long as she felt she could exist... He never pressured her” to choose death until she was ready.

Lona Jones looked for spiritual guidance in making her decision. She had, according to her husband, “a strong faith,” and she wanted to reconcile that faith with her feelings about death. She feared ending her life helpless, without dignity, far more than she feared death. But Jones had to travel far from home to die. And her husband had to leave her at an emergency room, with a fabricated cover story about her death, and then disappear for several days until reassured that police and prosecutors would not arrest him for helping her accomplish her last wish.

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Jack Kevorkian is not the focus of this paper—I am concerned about the right of adults to make autonomous decisions about the way they will end their lives. But in 1997, in America, Kevorkian and the issue of assisted suicide

are inextricably linked. Because of his media-spotlighted crusade, state legislative responses, and the Supreme Court’s consideration, a national debate on the issue is finally burgeoning. Physician-assisted death is now legal in 12 states. Given the dilemmas and choices that medical technology has created, it is surprising that discussion about the bioethics of prolonging life (many would say prolonging dying) has remained so muted. In thinking seriously about assisted suicide, we must not think our choice vindicates or condemns Kevorkian. We may disagree with his tactics, we may be uncomfortable with the man as the media and his lawyers portray him, but we may philosophically support the individual rights he champions. At least, he has spotlighted the issue so that a national debate can begin and so that the medical profession must respond.

Don’t automatically oppose assisted suicide because your reaction to Kevorkian is negative. Perhaps terming the act of helping someone to die “assisted death” instead of “assisted suicide,” would keep our deliberations from being influenced by negative connotations of the word “suicide,” which ends a life that could be continued and implies mental irrationality that may be treated. An assisted death is one where those involved have explored all treatment options and the ramifications, physical, social, emotional, moral, ethical and spiritual, of assisted dying. Such a death “ends the life of a patient... whose hope for continued living and cure is gone and who...[faces]

suffering until inevitable death” (Jamison, 1996, p.16). I use the terms interchangeably in this paper.

Aging Population

Within 20 years, the number of persons over age 65 is expected to double to 60 million, and the oldest-old cohort are growing fastest (Osgood, 1995). America spends vastly more than any other country on intensive and chronic care, and for most people, more spent in the last year of life prolonging death, not improving quality of life, often simply warding off “the grim reaper” (ABC Nightly News, March 5, 1996). People in later years are more likely to be confronted with life-ending and debilitating diseases. People can now formulate advanced directives, the written decision not to be maintained after cognitive function ceases, and can also execute medical powers of attorney, empowering representative to make end-of-life decisions according to the patients' wishes. Still, only 1/4 of Americans presently have these documents, and according to a 1995 JAMA study, 2/3 of doctors who received the documents did not look at them (Shute, 1997). If assisted death were legal, competent, still healthy people could execute advanced directives that would allow peaceful termination of their lives by doctors' active intervention, as well as by non-action such as withholding respirators and feeding tubes, which is already being done. And the doctors would be legally bound to follow directives or find another physician who would.

Legal Considerations

In June, the Supreme Court ruled on two cases (from the Second and Ninth Circuit Courts of Appeals) involving the constitutionality of assisted death in April (Gianelli, 1995, November 13; Wilkes, 1996). The Court said that there is no constitutional guarantee to assisted suicide. In their writings, the justices made it clear that they do not expect or hope that the ruling will end attempts to meet a consensus about the issue. The Court has left it to the state legislatures to deal with the issue, an outcome that many legal commentators speculated (and some hoped) would occur. Yale Law Professor Stephen A. Carter observed this summer in *The New York Times Magazine*: “Except in emergencies, a court decision is the worst way to resolve a moral dilemma... The biggest problem is that [a Supreme Court decision] would preempt a moral debate that is, for most Americans, just beginning” (Carter, 1996, p.28). In an editorial, columnist Ellen Goodman says that America should import not the Netherlands' process of assisted suicide but “the Dutch tolerance for ambiguity; for living in the ethical gray zone, grappling with complexity instead of denying it, staying open to change” until we find “a way of dying that is both merciful and careful” (Goodman, 1997, p.A 19).

Strong and thoughtful voices on both sides present plausible arguments. Certainly, the choice to support or oppose assisted death demands reasoned debate. Even wholehearted proponents must acknowledge potential dangers to society and to individuals and

the need for firm guidelines and safeguards. Concerns touch the deepest core of our humanity. “Do our moral lives belong to us alone or do they belong to the communities or families in which we are embedded? Will this new right give the dying a greater sense of control over their circumstances, or will it weaken our respect for life?” (Carter, 1996 p.28) “To whom does a death really belong?” (Jamison, 1996, p.15)

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Judges in the Ninth Circuit Court case had ruled that “citizens have a 'fundamental' right to” make decisions about medical treatment, including physician-assisted suicide (Azevedo, 1997, p.140; “High Court Expands ... ,” 1996, p.54). Writing for the majority, Judge Stephen Reinhardt summed up eloquently the case, based on liberty and privacy issues, for autonomous end-of-life decisions: “A competent, terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incompetent” (1996, p.54).

Muted Discussion

Until we could no longer ignore it, we, as a society, have been steadfastly disinclined to consider death and dying. American aversion to discussing death is endemic. There is a reluctance to admit that we are all going to die and that there are, in fact, things worse than death. It's more reassuring to speak of "passing away," of "expiring, going to join God, embarking on the eternal sleep." The medical profession, trained to "save life," shares this reluctance, although increasing numbers of physicians are venturing into this ethical arena, as are religious leaders. Polls consistently show that about 70% of the public believes individuals should have control over their own deaths—witness the unwillingness of any jury to convict Kevorkian (Biggar, 1995; Gianelli, 1994, October 10; Girsh, 1992). In a "Quality of Life in Virginia" telephone survey last spring, 69% of those surveyed agreed that doctors should be allowed to help the terminally ill end their lives.

Patients' families should not have the burden, or opportunity, of ending another's life. The tragic story of a seventy-plus husband in Florida shows the unfairness of placing such burdens on the family: he went to jail after he shot his beloved wife, acceding to her anguished pleas for death. This husband felt he had no choice. He loved his suffering wife, so he killed her and went to jail. (After the publicity died down, he was quietly released early.) Last spring, in Virginia, a retired lawyer from Lexington shot his wheelchair-

bound wife, after repeated requests, in an apparent mercy killing, and then shot himself. The wife had severe heart disease, was paralyzed, on dialysis, and had a tracheotomy ("Man, wife shot to death," 1996).

Support for Assisted Death

Across the country, many groups lobby for and educate about assisted death. The Seattle, Washington-based group, Compassion for Dying, founded by Rev. Ralph Mero, offers counseling, emotional support, and legal advocacy to the terminally ill and their families. For patients who meet its guidelines, the organization provides someone to be present during "hastened death." The group's acts are very private; no names released, no police or media called, but Mero indicates they have many cases. There has been little public outcry or legal challenge to the low-profile group (Biggar, 1995). Oregon became the first state to legalize physician-assisted suicide for the terminally ill, passing the Death with Dignity Referendum in November 1994. While the act has not yet been instituted, its passage marks a new era in the assisted suicide debate.

What about assisted suicide in the rest of the world? A 1995 British study found that 32% of British physicians had complied with requests for active euthanasia ("British doctors," 1995). This fall in Australia, Bob Dent, a terminally ill cancer patient, punched a button on a computer keyboard, said "yes," he was ready to die—and became the first person to kill himself legally under

the world's only doctor-assisted suicide law. Dent administered to himself a lethal dose of barbituates and muscle relaxants. He used a computerized portable intravenous unit with its operation controlled by a laptop computer (American Medical News, 1996). Australia's law is again being contested in courts there.

Holland's assisted suicide climate has received great publicity for what supporters see as its "humane" approach as well as great notoriety from its detractors. (See *The Torch*, Winter 1995. The Editor). Although assisted suicide is still technically illegal in Holland, the informal system of euthanasia (in which doctors actually administer fatal injections), with fairly strict procedures and rules, operates there with impunity (Hendin, 1995). Seventy-one percent of the Dutch firmly support their system. Only 2.4% of deaths in Holland actually happen with a physician's assistance, and nine out of ten requests are turned away, according to the latest research, conducted by medical school professor Gerrit van der Wal (Goodman, 1995). Most of those patients were not nursing home residents but cancer patients in the 60s or 70s, who died in the last days or weeks of their illness, at home, treated by a family doctor they had known for an average of seven years (Goodman, 1997). The most troubling statistic is that nearly 1,000 patients die each year from "non-voluntary" euthanasia. Many see this as proof of the "slippery slope" to euthanasia to which any relaxation of strictures in this country would inevitably

lead (Hendin, 1995). Van der Wal's study found, however, that more than half of that 1,000 had earlier expressed the desire to die, although not physically able to request it again at the time of death (Goodman, 1997).

My sensitivities to such fears are deeply embedded. I understand them well. For 3 years, I lived in West Germany. I know Dachau and Mauthausen. Etched forever in my memory is Dachau's stark iron sculpture, human bodies impaled on barbed wire.

Yet, consider this: By pretending that assisted suicide never happens, we are actually opening more doors to involuntary euthanasia, Faye Girsh, a psychologist, notes in *The Western Journal of Medicine* (1992). She points out that current laws are being ignored, the police, district attorneys and grand juries are not punishing mercy killings, and in the rare cases brought to trial, juries are acquitting. She asks, "Is this better than having a law that would provide regulations about a practice that desperate people are exercising surreptitiously?" (1992, p.12) Assisted suicide proponents argue reasonably that "the best defenses against the slippery slope" are clear guidelines as to who is eligible. Restrictions like "terminally ill, mentally competent and adult are enforceable" (Azevedo, 1997, p.147).

Assisted Death Legislation Provisions

Future death with dignity legislation should be carefully crafted to allow patients and their

doctors to make a joint decision to end life, while establishing firm guidelines and penalties that would deter others (insurance companies, family members, government cost-cutters) from committing greed-motivated euthanasia (without the patient's sane-mind agreement). In addition, people must be educated about the issue and some consensus achieved. Provisions such an act should contain include oral and written requests for assistance, second opinions, psychiatric evaluations, counseling for patients and families, review by an overseeing agency.

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One safeguard would be the intense "watchdog" scrutiny of the media, which would no doubt expose excesses, as would professionals involved in the process. We would have to guard against societal, familial, and self-pressure on the elderly and disabled

to remove themselves as "burdens to society," but changing attitudes toward disabilities and the onrush of the boomers into being plus-50 give these groups increased status. I work on the psychiatric unit of a local hospital, specializing in gerontology; I have done research in adult nursing homes. I am committed to these special populations. But today, options for many elderly and disabled are limited. As social outgroups, their minimal quality of life might lead them to prefer death to a tortured existence. Instead, America must implement adequate health care for all Americans, so that no one will choose death because they can't afford health care or because no one cares about them. Currently, we are passing tacit death sentences on many, mostly poor people by neglect, lack of funding (Girsh, 1992), and cost-saving intentions by government and insurance companies.

Already, some insurance companies encourage AIDS patients to cash in their policies, thus accepting death, rather than seeking effective treatment. This is different from choosing death after exhausting possibilities of a cure. Dr. William Regelson, a Medical College of Virginia cancer researcher, exposed a study at MCV, authorized by a major insurance company, regarding cancer patients and treatment, survival, and quality of life issues. As postulated, patients who choose to forego treatment the insurance company considers "unsatisfactory" or "experimental" may receive an \$18,000 cash package (Style Weekly, 1996). That "experimental" treatment

could save lives, but foregoing it saves money for the insurers. Isn't there a need to pass assisted suicide legislation offering firm guidelines and safeguards since the intrusive insurance providers already try to save money by denying treatment? Shouldn't patients and their families make the decisions, rather than third-party payers?

As we are trying to come to a moral consensus on assisted death, we must avoid knee-jerk reactions, such as those recently introduced in many state legislatures, including the Virginia General Assembly. Currently, Virginia is one of a handful of states with no laws governing assisted suicide, but a proposed law, thrown together in light of recent focusing events, would limit debate and make future-attempts to legalize assisted death doubly hard. Under current Virginia law, arrest and prosecution are up to local police and prosecutors. Assisted suicide, remaining private between physicians and patients, certainly occurs, giving at least some people who request it respite from unbearable conditions. As a nation, we must allow laws against assisted death to become "fait accompli" before most people have made up their minds.

While the ACLU supports "the personal right of autonomy" and opposes all legislation against "humane terminations" (telephone interview, February 16, 1996), the National Society for Human Life puts opposing assisted death high on its national agenda. Virginia's executive director Dave Murphy says, "We think euthanasia advocates present a false picture

of pain management and that a lot of these people who think they want to die just need to have their depression treated" (telephone interview, February 14, 1996).

The Pain and Depression Arguments

The "if we controlled pain and depression, people wouldn't want to die" argument against suicide at first glance seems to appeal logically. However, as Dr. Timothy Quill, a plaintiff in the New York case and a strong advocate of hospice, notes, even hospice does not work 100% of the time (The Internist, 1996, p.19). Like most physicians who support assisted death, Quill is a respected, knowledgeable practitioner. He believes that "physician assisted suicide is the last resort, to be used only when good palliative or hospice care doesn't work" (p.19). He asserts that "hospice care is wonderful and good, but the notion that it can relieve 100% of the suffering of dying people is overly simplistic ... a romantic view ... people experience very hard deaths in the face of excellent palliative care ... when it does not work, we still have to work creatively with people" (p.19). MCV professor Sara Monroe agrees that "pain cannot [always] be relieved." (Kelly, 1997, p.E6). Still upset over the recent painful death of a young AIDS patient, Monroe says, "We don't allow our dogs to die such a wretched death." (p.E6).

What hospice workers do to help families and patients at difficult and meaningful times is wonderful. However, hospice and

choosing death with dignity are not mutually exclusive; in fact, hospice patients who could (and already do) opt for death with dignity when their living becomes intolerable, based on their own determination, are released to live those last weeks or months in a more rewarding, less stressful way. A social worker in a Virginia hospice recently told me about a hospice patient who planned to commit suicide when he reached his limits of living. Were assisted death an option, he could have died peacefully, rather than going into the backyard and shooting himself, as he did.

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Fear of pain, according to numerous anecdotal studies, does not cause most people to opt for death. Psychologist Faye Girsh observes that "degradation and loss of dignity ... because of incontinence, inability to swallow," lack of mobility and poor quality of life are prime motives (Girsh, 1992, p.II). High levels of pain medications often lead to heavy sedation and negative side effects; for many, existing only in a semicomatose state does not offer

an acceptable quality of life (Girsh, 1992; Jamison 1996).

Advances in medical technology have given mankind the opportunity to usurp God's will—prolonging dying rather than restoring sick people to wellness and a satisfactory quality of life. Many of people fear that a final illness might condemn them to “America's longest death row”: the prison of life support that functions simply to prolong dying (Simon, 1993, March 18, 13 A). Laws allowing assisted suicide must provide for second opinions and psychiatric evaluations to deal with the depression issue. But in fact, it is not unrealistic for people in debilitated, dying conditions to be depressed—why wouldn't they be? Being depressed doesn't necessarily mean a person is impaired to make rational decisions, but safeguards would eliminate depression as the reason for requesting suicide, as would the requirement that patients be either terminally or chronically ill, not simply emotionally or mentally ill. Patients' depression often lifts once they are reassured that they will not face lingering, demeaning deaths.

Abortion Equated with Assisted Death

As for the equation of abortion and assisted suicide, they are simply not the same thing. One can be opposed to abortion and still favor assisted suicide. Anti-abortion groups argue that abortion is the taking of another, innocent life, without that person's (the fetus's) consent. In assisted death, it is precisely the person whose

life is ending who exercises self-determination about the end of life. Increasingly, we are seeing court cases, called “wrongful life suits,” against doctors' and hospitals' refusal to carry out patients' requests not to institute respirators, feeding tubes and other death prolonging measures. Frequently, the reason behind the reluctance to avoid these measures is fear, fear that family members or government representatives will try to charge the doctors/hospitals with assisted suicide, even when the patient has requested death, even in writing. Legalized assisted death would remove fear of repercussions and permit health care providers who were ethically opposed to assisted suicide to withdraw so that professionals committed to helping patients could step in.

“Playing God?”

Those opposed to assisted death consistently charge right-to-die advocates with “playing God.” Such reasoning is sophistic. On one hand, we have allowing or helping people to die. On the other hand, we have them keeping them from dying through bio-medical technology. What distinguishes one from the other? If one action is “playing God,” isn't the other? Supporters of the right to die must not allow opponents to wrap themselves in the Bible and sanctimoniously pontificate about “God's will, redemptive suffering and thou shalt not kill.” Deep faith and belief that individuals should be allowed to die in a dignified and humane way are not opposite extremes. In a thoughtful essay in *JAMA, the Journal of the American*

Medical Association (1996, p.588), physician William Hensel states his plea for assisted suicide if “I suffer irreversible central nervous system damage to the point that I do not recognize my family.” Hensel believes that “if I am markedly neurologically impaired, I will have already ceased to exist.” To those who would object on religious grounds, Hensel responds: “... my understanding of God's will is different from theirs, ... my final request is an act of faith, based on my belief that there is a better life beyond this one” (1996, p.588).

A number of religious leaders and groups do support death with dignity. In a move to encourage national debate in the church, the Episcopal Diocese of Newark, spearheaded by high-profile Bishop John Spong, recently adopted a resolution calling suicide a “moral choice” for the terminally ill and those with persistent pain (“Episcopal Diocese deems suicide,” 1996). As for the claim of suffering and pain as “redemptive” and the position that “people come to God” and grow spiritually from adversity, I believe that we humans do grow through adversity, not that we are made to suffer by a pedantic, controlling God. Each person must resolve the “When Bad Things Happen to Good People” issue as his/her faith leads. But my rights to autonomous decision-making should not be abrogated in favor of your position. No ultimate arbiter in our human world can pronounce the final word on this as “Gospel.”

As debate on the issue opens up, it will be seen that numerous highly “religious” people—health

care professionals, clergy, families, patients—advocate death with dignity and that such a stand is completely compatible with strong faith in God and the Judeo-Christian and other religious traditions.

Doctor's Views

For years, many doctors have quietly turned off respirators, even giving a bit “too much” of pain-relieving, potentially lethal drugs such as morphine, to dying patients who request it. The AMA's 1992 Code of Ethics states that “Quality of life is a factor to be considered ... when the prolongation [of life] would be inhumane and unconscionable. Under these circumstances, withholding or removing life supporting means is ethical provided that the normal care given an individual who is ill is not discontinued” (1992 Code of Medical Ethics Current Opinions, p.13). Those opposed to assisted suicide claim that patients will not “trust” their doctor if they know he can, by law, end their lives. However, patients may trust physicians more if they know doctors will not condemn them to existences lacking an acceptable quality of life.

While the American Medical Society publicly opposes assisted death, the AMA has not recently polled members on the issue. Feelings against assisted death are far, far from unanimous among physicians across the country. In a 1994 survey, nearly 30% of New Hampshire physicians suggested they might be involved in assisted suicide if it were legal (Gianelli, October 10, 1994). The

Oregon State Medical Society's refusal to take a stand on assisted suicide helped to pass Oregon's physician-assisted suicide proposal (Gianelli, February 10, 1995); in a 1996 *New England Journal of Medicine* survey, 60% of Oregon doctors favored assisted suicide, as did 56% of 7 Michigan Doctors (Azevedo, 1997). In an informal survey by the American Society of Internal Medicine, one in five doctors reported having deliberately taken action to cause a patient's death (Knox, 1992).

Is physician aid-in-dying against tradition? Ethicist Stephen Jamison says, “There is no such thing as a linear medical 'tradition' handed down over 1,000s of years” (Jamison, 1996, p.13). Medicine's ethos moved toward prolonging life only in the 20th century, with advances in medical technology. Since then, there have been numerous court cases and rulings about keeping patients alive against their wills or in persistent vegetative states. In the last few years, “do-not-resuscitate orders are becoming commonplace, ... and doctors frequently 'allow patients to die' by withholding and withdrawing ventilators, artificial nutrition and hydration” (Jamison, 1996, p.17). Many believe the ethos should evolve alleviating suffering quickly and gently (Jamison, 1996, p.13). Doctors increasingly find their ability to exercise personal, professional judgement circumscribed by insurers. They further recognize that doctors may do more patients harm by permitting a slow, agonizing death than by doing what a patient asks and alleviating suffering quickly

and gently. A death with dignity act, allowing them to legally satisfy patients' requests, would forestall profit-oriented insurance companies insinuating their way into making end-of-life death decisions, based on economics.

Thomas Preston, a Seattle cardiologist, says that assisted suicide is not unethical: the “ethos of keeping people alive as long as possible ... is not valid anymore.” It's ethical to “keep people alive as long as doing so gives good life. It's unethical to keep terminal people alive .. if it's against their wishes” (Azevedo, 1997, p.143). Doctors supporting assisted death see it as a “last resort, to be used only when good palliative care doesn't work,” as Dr. Quill writes. Whatever their personal opinion, health care professionals have the obligation to listen to a patient who no longer wishes to live and to explore the reason behind that wish. Often, “by understanding the impetus for the request, a physician can find alternatives: better pain relief, meeting with the family, etc.” (Quill, 1996, p.19).

Conclusion

More than 50% of Americans die in the hospital, often alone, tethered to a “frightening array of high-tech equipment” (Shute, 1997, p.61). Seventeen percent more die in nursing homes. The picture of dying at home, in a “meaningful” way, alert, with loving support is simply not a reality for most people. However, there are ways to put more dying people in this picture.

Hospice care will expand now that most health care plans pay for it, thus offering it as a dying option in more areas. Doctors will learn to control patients' pain. California oncologist H. Rex Greene points to studies showing that two-thirds of physicians are incompetent at managing pain and that the "war on drugs" has led doctors and patients to "irrational fears" of addiction to morphine by a dying patient (Azevedo, 1997, p.13 7). Medical schools will continue to improve their training in pain management and in compassionate end-of-life care. Early this year, 72 organizations, including the AMA, and the AARP, formed the Last Acts Coalition, to push for sweeping reforms in the care of the dying, including the issues I have just mentioned (Shute, 1997). Some HMOs are offering hospice style home care to patients who still want aggressive treatment and may live for several years. A number of hospitals are setting up nursing and team approaches to work with patients' and families' end-of-life issues (Shute, 1997).

But there will always be people whose pain cannot be acceptably managed and whose quality of life leads them to prefer actual death to death-in-life. Death with dignity is an issue from which none of us is exempt. Society must resolve it. No one who approaches end-of-life issues with deep and sincere contemplation and study can come blithely away, opting for either side. I recognize troublesome concerns with assisted suicide even while I remain fervently convinced that we are autonomous individuals who must be allowed to make our own

end-of-life choices. I believe that each person has the right to execute a plan to choose how to enter that "good night" of death and to rely on professional support if need be. Some may choose to "rage" to the last minute. But should one hope to "go gentle into that good night," one should have that option. As human beings, we have a right to choose how we will live; we also have the right to choose how we will die.

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