

The Politics of Dying:

An Argument for Nationally Legalized Physician Assisted Suicide

10/26/2011
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POLS 1100

*“Darkling, I listen; and, for many a time
I have been half in love with easeful Death,
Call’d him soft names in many a mused rhyme,
To take into the air my quiet breath;
Now more than ever seems it rich to die,
To cease upon the midnight with no pain...”*

- John Keats, 1795-1821

I was twelve years old when I witnessed my first “bad death”. My grandmother had suffered with early onset Alzheimer’s disease for more than ten years, and eventually starved to death when she forgot how to swallow. I went on to choose a career in senior care and hospice, and most recently I managed an Alzheimer’s Specialty Hospital. I have seen dozens of deaths. Some were quick, painless and peaceful. Most, unfortunately, were long, agonizing, and desperate. My experience has given me a unique acceptance of death. I have realized, through a few uncomfortable conversations, that most people are not nearly as open to the topic of death as I am. In fact, America as a whole has embraced a very naïve attitude toward death. The media is guilty of consistently portraying death as a very quick experience. When someone is shot in a movie they might make a dramatic exclamation, but almost always they immediately collapse and die. In reality, eyewitness accounts of shootings tell a very different story- victims will thrash, and heave and *survive* for minutes, or hours, before finally succumbing.¹ When a TV show depicts a death after an illness the patient is shown in a crisp and serene hospital room, with a peaceful look on their face. Sometimes death looks like that; more often the patient is discolored, their muscles twitch and spasm, they moan and cry out. It is disturbing to witness, no matter how many times I have seen it...

It is this naivety about death that has led to the unnecessary restrictions on physician’s assisted suicide that we have today. If more American’s realized the potential for a miserable, drawn-out demise, they might think differently about expanding the laws that exist in some areas. Physician Assisted Suicide- defined as: a doctor prescribing lethal drugs, which a patient consumes on their own- if legalized in the United States would lead to more “good death” experiences. I support this cause because I believe in patient autonomy, and the right of individuals to choose a “good

¹ Derek Humphry “*Final Exit*”, 2002 pg. XIV

death”; I also believe that modern medicine has created a new, modern death which requires us to reevaluate how we look at end-of-life decisions.

Assisted suicide is not a new concept. There have been accounts of doctors and others in authority helping patients to a peaceful death since ancient Greece, when there was a supply of poison kept by city magistrates for any who wished to end it all. Ancient Greeks and Romans tended to support euthanasia, and stressed the voluntary nature of dying, provided it was done for the right reasons.² As religion began to dominate civilization, tolerance for euthanasia and assisted suicide sharply declined. Christians and Jews tended to oppose assisted suicide, and developing nations enacted laws against such practices. In 1828 New York became the first state to specifically outlaw assisted suicide. In spite of the vocal outcry in opposition, there have always been those who believe in the right to a merciful end. During the eighteenth century period of Enlightenment writers began to challenge the current views and Church’s opposition to Euthanasia. An important milestone in this debate was the creation of Morphine and its widespread use as a pain reliever. In the late 1800’s a non-physician, Samuel Williams began to advocate the use of the drug not only to ease a patient’s pain, but also to potentially end their suffering, and their life. As medical science continued to flourish public interest in assisted suicide and euthanasia grew steadily. By the 1930’s Americans were discussing suicide and controlled dying more than ever before, with polls indicating that 45% of the population agreed that assisted dying, under specific circumstances, was permissible.³ In the 1970’s Euthanasia was a hot topic. Eight US states adopted “Right to Die” bills, the Living Will was created and people began to take a serious interest in end-of-life issues. There were several headline-making

² Michael Manning, MD “*Euthanasia and Physician Assisted Suicide: Killing or Caring?*”, 1998

³ Ian Dow Biggin, PhD “*A Merciful End: The Euthanasia Movement in America*”, 2003

cases with names which might ring familiar, like: Karen Ann Quinlan, the 21 year old who was removed from life support after a ruling by the New Jersey Supreme Court, and Derek Humphry, the founder of the controversial Hemlock Society. In 1990 there was a new name in the headlines: Dr. Jack Kevorkian. Dr. Kevorkian assisted the suicides of 130 patients, and reignited the simmering right-to-die debates. His openness about his practice and feverish fight for the right to assist terminal patients led to a frenzy of media coverage; by the late 1990's several states introduced varying end-of-life bill. As a result, physician assisted suicide was legalized in three US states: Oregon, Washington and Montana.

*“Modern medicine produced a modern dying: a prolonged process, rather than a distinct event, which thereby made the very definition of death ambiguous and subjective...”*⁴

There is a tragic mismatch between what many terminally ill patients want, and what they get. Patients want a quick, minimally painful death; while doctors, on the other hand, want to prolong life as long as possible. These two desires are not always compatible. With modern medical science and the ability to maintain life artificially, the priority of providing a “good death” has become lost. Traditionally this term has meant: death that is free from avoidable distress and suffering and in general accord with patients' wishes.⁵ A central concept to a 'good' death is one that allows a person to die on his or her own terms relatively pain free with dignity. Consider this: Alzheimer's disease is typically broken into 3 phases, the total of which can take 20-30 years before it is fatal. Phase 1 and 2 only take about 5 years, 10 at the most. By phase 3 an individual has lost all speech, and all comprehension of language and visual images. The individual is bowel and bladder incontinent and completely immobile. Is it still a good death if

⁴ Peter G. Filene *“In the Arms of Others: A Cultural History of the Right to Die in America”*, 2003

⁵ Definition provided by 1997 Institute of Medicine http://dying.about.com/od/glossary/g/good_death.htm

they survive for another 20 years in the mere existence that is phase 3?? I have conducted hundreds of family care plan meetings for advanced Alzheimer's patients where families and doctors have made difficult decisions regarding medications, supplements, and nutrition. I have seen families decide to discontinue medications and nutritional supplements at early phases of the disease, and I have seen families continue every possible life-preserving mechanism until the very end. Every end-of-life experience is one-of-a-kind. As such, patients and their trusted family members have a right to choose which death experience fits their unique definition of a "good death". Marcia Angell, editor of the New England Journal of Medicine, said this:

"The highest ethical imperative of doctors should be to provide care in whatever way best serves patients interests, in accord with each patient's wishes, not with a theoretical commitment to preserve life no matter what the cost in suffering... The greatest harm we can do is to consign a desperate patient to unbearable pain and suffering..."

Sometimes the most ethical, humane thing to do is to administer that prescription of lethal medication. Doctors should have the legal protection to just that.

Those who campaign against physician assisted suicide use a "Slippery Slope" argument. They warn that given the chance, doctors might try to coerce unwitting patients, or administer lethal drugs to patients who do not want them. Why is this? The medical community has dealt with many "slippery slopes" before: transplants, Do Not Resuscitate orders, withdrawal of life support, etc. The solution has never been prohibiting them, but regulating and setting strict limits. The slippery slope argument discounts the harm that is done when the pleas of real people are ignored for fear of what might possibly happen at some future time and place. Theoretical future harm can be managed and avoided by establishing appropriate criteria which

must be met before a patient could receive assistance. For example: the patient must have an incurable disease which causes unbearable suffering, the patient must have attempted all reasonable life-sustaining and palliative measures, and the patient must undergo a psychiatric consultation to establish mental soundness and absence of depression. All criteria would be required to be documented, with several professional opinions.⁶ Such guidelines have already been established and successfully put into play in Oregon, Washington and Montana.

Legalizing physician assisted suicide nationwide would ensure that patients who met required guidelines, who were sick of the agony and suffering of their terminal illness, who felt ready to choose their time to die with dignity, would be able to do so. There would be no more secret appointments with a doctor who the patient has never met, but is rumored to perform assisted suicide. There would be no more miserably ill parents pleading with their children to just “pull the plug”. There would be choice. There would be control. There would be dignity. And there would be peace.

⁶ Peter Rogatz, *“The Positive Virtues of Physician-Assisted Suicide”*, 2001