KILLING THE PAIN NOT THE PATIENT: PALLIATIVE CARE VS ASSISTED SUICIDE

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Some time ago an ad appeared in a medical journal promoting a new pain-killing drug. To emphasize that this new product could relieve pain without sleepiness or other side-effects, the ad began with a slogan: "Stop the pain. Not the patient."

The outcome of our society's debate on physician-assisted suicide may depend on how well we communicate—and act upon—a similar message. We are living at a time when some doctors and lawmakers think that the best solution for some patients' suffering is to give them lethal drugs for suicide. Catholics committed to the dignity of each human person must insist: "Kill the pain. Not the patient."

It is a compelling message. Some opinion polls show support for assisted suicide when it is presented as the only relief for a dying patient in unbearable pain. But when Americans are offered an alternative, they overwhelmingly say that society should concentrate on ensuring pain control and compassionate care for such patients—not on helping them take their lives. This preference is even stronger among dying patients themselves. When the medical journal The Lancet reported on interviews with cancer patients on June 29, 1996, it found that dying patients experiencing significant pain were more opposed to assisted suicide than the general public. "Patients with pain do not seem to view euthanasia or physician-assisted suicide as the appropriate response to poor pain management," wrote Dr. Ezekiel Emanuel, a director of the study. "Indeed, oncology patients in pain may be suspicious that if euthanasia or physician-assisted suicide are legalized, the medical care system may not focus sufficient resources on provision of pain relief and palliative care."

Realizing that assisted suicide is less popular than improved palliative care, euthanasia advocates have resorted to the claim that there is really not much difference between the two. Their argument goes like this:

"Let's be honest. Doctors commonly practice euthanasia now, under the guise of pain control. They give dying patients massive doses of morphine to suppress their breathing, and then call their death a mere 'side-effect.' They justify this hypocrisy by invoking an invention of Medieval theologians called 'the principle of double effect.' Sometimes they even sedate these patients into unconsciousness so they can starve them to death. This 'terminal sedation' is really slow euthanasia. It would be far more candid, as well as more humane, to practice euthanasia openly."

This argument has appeared in newspaper opinion pieces, medical journals, and briefs to the U.S. Supreme Court. In 1996 it was even endorsed to some extent by two federal appeals courts that sought to give constitutional protection to physician-assisted suicide.

Yet the American medical profession, and the Supreme Court, rejected this argument. To understand why they were right to do so, we must explore two realities: the facts about modern pain control, and the meaning of that so-called Medieval invention, the principle of double effect.

The Facts About Pain Control

Many doctors hesitate to give dying patients adequate pain relief because they fear that high doses of painkillers such as morphine will suppress the breathing reflex and cause death. Yet we now know that this fear is based on false assumptions, and on inadequate training of physicians in pain management techniques. Even among oncologists, who probably deal with more patients in severe pain, there is too little knowledge of the medically appropriate use of analgesic drugs.

In reality, a very large dose of morphine may well cause death—if given to a healthy person who is not in pain and has not received morphine before. But when administered for pain, such drugs are taken up first by the patient's pain receptors. In fact, patients regularly receiving morphine for pain quickly build up a resistance to side-effects such as respiratory suppression, so they can easily tolerate doses that would cause death in other people. Fortunately they build up a tolerance to the side-effects far more quickly than to the drugs' analgesic effects—so doctors need not hesitate to increase dosages when needed to relieve pain. The question, "What is the maximum dose of morphine for a cancer patient in pain?", has one answer: "The dose that will relieve the pain." As long as a patient is awake and in pain, the risk of hastening death by increasing the dose of narcotics is virtually zero. Unrelieved pain is itself a stimulant, which overwhelms any depressive effects of narcotics. Patients whose unrelieved pain is distorting the very fabric of their lives need adequate pain control the way a diabetic needs insulin to function properly.

Very rarely it may be necessary to induce sleep to relieve pain and other distress in the final stage of dying. Euthanasia advocates call this "terminal sedation," but it is the same kind of sedation that is sometimes needed to calm distressed or restless patients with non-terminal conditions. While some terminally ill patients may die under such sedation, this is generally because they were imminently dying already.

In competent medical hands, sedation for imminently dying patients is a humane, appropriate and medically established approach to what is often called "intractable suffering." It does not kill the patient, but it can make his or her suffering bearable. It may also allow a physician the time to re-assess a patient's pain needs: The terminally ill sedated patient may later be withdrawn from the sedatives and brought back to consciousness, with his or her pain under control.

The factual evidence supports these claims. In 1992 the Journal of the American Medical Association (JAMA) reported on 97 terminally ill patients who died after life support was withheld or withdrawn. Sixty-eight of the patients received painkilling drugs or sedatives to relieve pain and other distress while dying—and they lived longer than the patients who did not receive drugs. The study found that the dosages of these drugs were chosen to ensure relief of suffering, not to hasten death.

Only recently has the medical profession begun to appreciate that unrelieved pain can itself hasten death. It can weaken the patient, suppress his or her immune system, and induce depression and suicidal feelings. It can keep patients from living out their lives with a modicum of dignity, in the fellowship of their families and friends. So adequate pain relief can actually lengthen life. According to a JAMA news item of March 25, 1992, part of modern medicine's task may be that of "killing pain before it kills the patient." Or as the Catholic Health Association says in its 1993 guide Care of the Dying: A Catholic Perspective: "Unrelieved agony will shorten a life more surely than adequate doses of morphine."

In short, when dosages of painkilling drugs are adjusted to relieve patients' pain, there is little if any risk that they will hasten death. This fact alone should put to rest the myth that pain control is euthanasia by another name.

The Principle of Double Effect

What of the rare case when providing pain relief or sedation does risk hastening death? Is this really the same thing as deliberately killing a patient?

Centuries of Catholic moral tradition say it is not. Sometimes it is impossible to achieve some good effect without causing a bad effect as well. When an act has both a good and a bad effect, we should ask ourselves whether it meets four criteria.

First, the act itself must be good or at least morally indifferent; giving medication to relieve pain certainly meets this test. Second, the good effect must not be attained by means of the bad effect—we cannot claim, like Jack Kevorkian, that we may deliberately kill suffering people because once they are dead they can't suffer. Third, the bad effect must not be intended; we cannot give pain medication in order to end pain and cause death. Fourth, there must be a serious reason for pursuing the good effect; it would be irresponsible to risk hastening death to relieve an ordinary headache.

Taken together, these criteria have become known in Catholic moral reasoning as the principle of double effect. Euthanasia supporters like to emphasize the principle's Catholic origins so they can dismiss it as an arcane Medieval invention. Dr. Timothy Quill, for example, argues that it should not be used in our pluralistic society because it "originated in the context of a particular religious tradition" (New England Journal of Medicine, Dec. 11, 1997).

But one might as well rescind laws against robbing banks on the grounds that "Thou shalt not steal" comes from a particular religious tradition. A moment's reflection will show us that the principle of double effect is no Catholic peculiarity, but simply good common sense.

When the Ninth Circuit Court of Appeals sought to establish a "right" to assisted suicide in 1996, its opinion rejected the distinction between intended and unintended hastening of death. Judge Kleinfeld's dissenting opinion used a down-to-earth example to show how wrong the court's majority opinion was. "When General Eisenhower ordered American soldiers onto the beaches of Normandy," he wrote, "he knew that he was sending many American soldiers to certain death, despite his best efforts to minimize casualties. His purpose, though, was to ... liberate Europe from the Nazis. The majority's theory of ethics would imply that this purpose was legally and ethically indistinguishable from a purpose of killing American soldiers." Ultimately the U.S. Supreme Court reversed the appeals court's decision and upheld the principle of double effect, citing Judge Kleinfeld's historical example to illustrate its moral and legal validity.

Students of Bible history could draw the point out further. When King David was overcome by desire for the wife of Uriah the Hittite, he ordered Uriah to the front lines with the express purpose of making sure he was killed (2 Sm 11:15-17). That was an act of murder, concealed by wartime. Anyone who cannot tell the difference between King David at his most sinful and General Eisenhower's decision about D-Day should not be entrusted with life-and-death decisions!

The importance of intentions in making moral decisions should be clear to all physicians, who routinely prescribe medicines and treatments that may have unhappy or unforeseen consequences. If, despite everyone's best efforts, a patient stops breathing and dies on the operating table from anesthesia during a delicate operation, is the surgeon a killer? If so, the medical profession is filled with "unintentional murderers." A more honest appraisal would be to admit that human life is fragile, that actions can have unexpected or unintended consequences, and that human beings—including skilled and ethically responsible physicians—are fallible.

Are there borderline cases where people's intentions are not clear? Are there instances when it is irresponsible to risk hastening death even as a side-effect? Of course. The principle of double effect does not automatically clarify all questions of intent, and it does not mean that causing death is justified whenever it is not directly intended. But the distinction is a useful tool for moral decisions. In modern medicine, quite literally, we couldn't live without it.

Assisted Suicide vs. Pain Control

In important ways, assisted suicide and good palliative care are not only distinct—they are radically opposed to each other. Consider the following:

Control of pain and suffering eliminates the demand for assisted suicide. As Dr. Herbert Hendin notes in his 1997 book Seduced by Death, some terminally ill patients have suicidal thoughts, but "these patients usually respond well to treatment for depressive illness and pain medication and are then grateful to be alive." Such treatment responds to the underlying reasons why patients ask for death, instead of treating the patient himself as the problem to be eliminated. When pain control and other care improves, assisted suicide becomes largely irrelevant.

Assisted suicide undermines good pain management. During the Supreme Court's January 1997 oral arguments on its assisted suicide cases, Justice Stephen Breyer noted a remarkable fact from a report by the British parliament's House of Lords: The Netherlands, which has allowed assisted suicide and euthanasia for years, had only three hospices nationwide, while Great Britain, which bans these practices, had 185 hospices. He had placed his finger on one of the most insidious effects of legalization: Once the "quick and easy" solution of assisted suicide is accepted in a society, doctors lose the incentive to pursue more difficult but life-affirming ways of truly caring for patients close to death. The converse is also true: prohibiting assisted suicide sets a clear limit to doctors' options so they can commit themselves to the challenges of accompanying patients through their last days. As one physician said after years practicing hospice medicine: "Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying" (quoted in Leon Kass, "Why Doctors Must Not Kill," Commonweal, Sept. 1992, p. 9).

The assisted suicide movement is willing to discredit modern pain control to advance its own cause. Euthanasia advocates know that when they equate assisted suicide and modern pain management, they are not just elevating the status of assisted suicide—among people who oppose direct killing of the innocent, they are undermining good pain control. They do not seem to care that their arguments will make doctors and patients more distrustful of legitimate practices that can truly help people live with dignity in their last days.

But strong voices are being raised to make sure they do not get away with this. In an April 1997 report on constitutional arguments about assisted suicide, the prestigious New York State Task Force on Life and the Law urged people on all sides of the assisted suicide issue to keep important distinctions clear. Noting that "many physicians would sooner give up their allegiance to adequate pain control than their opposition to assisted suicide

and euthanasia," the Task Force warned that "characterizing the provision of pain relief as a form of euthanasia may well lead to an increase in needless suffering at the end of life."

This warning is even being raised by some who do not oppose physician-assisted suicide in principle. "Clinicians must believe, to some degree, in a form of the principle of double effect in order to provide optimal symptom relief at the end of life," writes Dr. Howard Brody in the April 1998 Minnesota Law Review. Dr. Brody does not oppose assisted suicide in all cases, but he knows that many doctors do—and he knows they will not practice good palliative care if it is seen as tantamount to euthanasia. "A serious assault on the logic of the principle of double effect," he writes, "could do major violence to the (already reluctant and ill-informed) commitment of most physicians to the goals of palliative care and hospice."

It is startling that a movement ostensibly dedicated to the well-being of dying patients risks undermining their care to advance its political goal. What can the Hemlock Society say in its defense? That any such adverse effects on patients are only an unintended side-effect?

Conclusion

In short, pain control and other elements of palliative care must be clearly distinguished from intentional killing of patients. In trying to blur this distinction, euthanasia advocates only show their own indifference to the goal of promoting better care for dying patients.

In logic and in practice, two very different paths lie before the medical profession and our society: What Pope John Paul II has called the "false mercy" of assisted suicide and euthanasia, and the "the way of love and true mercy" that dedicates us to compassionate care (The Gospel of Life, No. 66-67). It is literally a choice between death and life.

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