

August 1998

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Recommended Citation

Watson, Richard A. (1998) "Doctor, Thou Shalt Not Kill," *The Linacre Quarterly*: Vol. 65: No. 3, Article 3.
Available at: <http://publications.marquette.edu/lnq/vol65/iss3/3>

Doctor, Thou Shalt Not Kill

by

Richard A. Watson, M.D., F.A.C.S.

The author is Associate Professor of Clinical Surgery (Urology), at the UMDNJ/New Jersey Medical School, Newark, NJ and President-Elect of the Catholic Medical Association.

Apart from the question of whether or not our society should legalize suicide, or whether people suffering terminal illness, intractable pain, and/or permanently impaired mentation have an inherent "right" to self-destruction, there arises the question: "If so, who would be the most appropriate person to kill them or to assist them in killing themselves?"

Implicit in the strategies of those who have framed the argument, thus far, has been the assumption that doctors will be expected to do the killing – or, at the very least that a physician should be on hand to "assist" at the suicide. This assumption has been, in part, historically based, since the justification for legalized euthanasia has been first (and most effectively) introduced in the emotionally-charged setting of painful, terminal illness. The physician, already responsible for providing comforting analgesia, might logically be expected to administer the final antidote that ends all earthly pain and suffering.

Beyond this historical relationship, however, there seems to lie a more diabolical stratagem. By thrusting the poison into the hand of the healer, euthanasia proponents are successfully convincing many, even among our fellow physicians, that suicide is not only a rational, but also an intrinsically medical option. Choosing death, like choosing therapy, is purportedly a health care decision, to be made conjointly by the patient and his or her own personal physician.

Front-Alley Euthanasia

Should active euthanasia (that is, homicide after birth) become, like abortion (that is, homicide before birth), legally in America today, a matter of free and unfettered choice – strictly a private decision between the patient (or his heirs) and the doctor? Euthanasia advocates hope that, by legitimizing the practice of mercy killing within medicine, they will be able to elevate euthanasia to the high level of esteem that our medical profession has achieved. Unfortunately, we are more likely to find that instead just the reverse will happen. The prestige of our profession will be mortally compromised by this unhappy association. Nevertheless, mercy killing will remain discredited. In much the same way, proponents of legalized abortion once predicted that, by virtue of the Supreme Court decision, abortion would be elevated to the high rank of a respected medical procedure. In fact, “back alley” abortionists merely moved to the front of the same, now legalized alley. The full-time, mill-run abortionist is, to this day, still seen as scraping the bottom of the professional barrel. He is held in low esteem both by his medical colleagues and by the public-at-large.

“Take Two Cyanides and Call Me in the Mourning”

While perhaps losing popular support on a superficial level, the notorious Doctor Kevorkian is nonetheless achieving major tactical inroads by convincing the lay public (and not a few physicians) that suicide involves therapeutic and technologic decision-making so complex as to require the expertise of a skilled physician. His bizarre intravenous contraption, the “Mercitron”¹, and his “noble” insistence on being personally present at the site of suicides, have led many to conclude (often without consciously examining their assumptions) that the presence and professional consultation of a physician is an appropriate, if not an absolute requirement. The fact is, of course, that no physician is needed in order for a person to kill another person or to kill himself. Annually, across America, tens of thousands of suicides and homicides are successfully effected without the benefit of close monitoring on the part of the medical profession. Yet, Kevorkian, in his determination to fabricate a medical

prerequisite for assisted suicide, has entitled his own book, *Prescription Medicine*.¹

Abuse Only as Directed

Much of the justification for involving a physician in assisted suicide has been based upon current legal requirements for a medical prescription in order to authorize the sale of potentially lethal compounds. However, if the purpose of the drug is self-destruction, why should there be any need for a prescription?² Our prescription system is, to a large extent, a peculiarly Anglo-American phenomenon. Even as close as in neighboring Mexico, one might have found (at least until recently) that many drugs were readily available – antibiotics, steroids, even chemotherapy – without need for a prescription.

What, then, is the point of America's elaborate, cumbersome, and costly system of prescription controls? – to insure, through the oversight of a licensed physician that a patient does not inadvertently harm himself.

"But Doctor, you don't understand!" exclaims a distraught patient intent on suicide, "I want to harm myself – FATALLY harm myself!" Why, then, is there need for a prescription from a physician? Clearly, one does not require a doctor's approval to consider one's death wish options. Derek Humphry, in his best-selling *Final Exit*,³ arrays a smorgasbord of lethal alternatives which even now are readily and legally available. For computer-literate travelers on the information highway, graphic details on how to kill oneself are now on sale through the Internet⁴ and a quick visit to the local public library can provide supplementary information, free-of-charge, for anyone who is "dying to learn more"!

If then, this society should ever see fit to endorse suicide as a rational option, shouldn't it, at the least, allow "consumers" (not "patients") to circumvent costly and needless interference on the part of a physician? Why not let those who are interested in poisoning themselves consult directly with their local pharmacist? ("Say, 'Doc', what's good for euthanasia?") Or, better still, they might turn to the local veterinarian, who, after all, has had considerably more experience in putting patients "to sleep." Resorting to tongue-in-

cheek satire in order to make their point, the authors of a recent article in *National Review*⁵ speculate: "Certainly physicians possess a comprehensive knowledge of the vulnerabilities of human bodies. But one does not need all the training of an engineer to be a saboteur or the skill of an anatomist to be a butcher. Indeed, there is something more than faintly unsettling about asking the preservers of life to play so prominent a role in destroying it, much as if a government bent on iconoclasm insisted that painters and sculptors take the lead in smashing images on which they had labored. If society decides to recognize a right of assisted suicide, the simplest way of implementing it might be to expand the duties of the mortician. He is already adept at using the syringe to withdraw and inject fluids. With a modicum of additional training he could administer a fatal injection and then have the body right at hand for his customary ministrations. The efficiencies of such a scheme are obvious, and even the title of 'mortician' seems singularly apt."

Serious recommendations have already been put forward that physicians' assistants or nurse-practitioners receive specialized training and licensure, specifically to perform active euthanasia, as "obitriatrists" or "tellastrists."⁶ Doctor Steven Miles at the University of Minnesota School of Medicine⁷, even makes a case for marketplace competition: "Finally, we could empower and finance advanced-practice nurses to provide end-of-life service entirely independent of physicians to improve their care." Thus, nurses, pharmacists, and other health care professionals can hardly consider themselves exempt from the euthanasia conundrum. They, too, need to become well informed, actively involved and articulately opposed.

Meanwhile, regardless of whether pharmacists, veterinarians, PAs, nurses, or even morticians would be willing and able to take over the killing business, at least this much is clear: No doctor is needed!

Hard to Swallow?

In fact, involvement on the part of any member of the health care profession would be not only unnecessary, but extremely ill-advised. The poison trade should be strictly separated from the entire healing profession. Let them place the rack of human poisons, not in the

drug store, but rather in the hardware store – right next to the rat poison display! A vigorous competition might soon spring up, as profit-hungry tradesmen vie for the euthanasia dollar. The competitive edge would go to the pill that is quickest, cheapest, smallest and most pain-free. Most popular would be those preparations which are tasty and easy-to-swallow (and maybe even dietetic!). Nationwide advertising campaigns would promote sales, while side stepping sardonic references to "lifetime guarantees". *Consumers' Report*, not physicians, could best provide the discriminating shopper with penny-wise recommendations.

One need not take too seriously this Orwellian hardware store scenario to understand the profoundly serious underlying tenet that participation by doctors is not necessary to effect euthanasia. Suicide and mercy killing might wrongly but arguably be considered, under extreme conditions, rational options; they should never be considered essentially medical options.

Death-Rows and Death-Throes

Meanwhile, here in America, the public outrage which should attend any suggestion that doctors serve as executioners has so far been reserved almost exclusively for opposition to the proposal that death-by-physician be offered as a legal option for death row felons in our penitentiaries.⁸ By a bizarre rationale, opponents would hold that the same doctor who might earn praise for killing-with-kindness ad lib on the hospital ward, should be ethically precluded from providing a humane demise for convicted criminals. No matter that the prisoner is begging to be executed (so much for "autonomy!"), nor that death-by-injection might be kinder and swifter than its alternatives (so much for "beneficence!"). Even the ethics of a physician pronouncing a prisoner dead, after the fact, under these circumstances, has been challenged – patients, yes; prisoners, no!

Dutch Treat

Laws permitting active euthanasia and physician-assisted suicide under strictly circumscribed conditions will be honored mostly in their breach. Laws enacted to define an extreme, once they have be-

stowed legal status to the act, tend over time to become the norm, rather than the absolute limit. For instance, a speed limit of 55 miles-per-hour theoretically guarantees that absolutely no one will ever exceed 55 mph. In fact, a large percentage of drivers assume that 55 mph is merely a guideline, and driving 10 mph over the so-called "limit" is a widely accepted standard.

Euthanasia advocates would summarily dismiss this warning as "alarmism" and "the old slippery slope argument". However, the brutal reality of mercy killing in Holland today shows that such fears are far from hypothetical. In a 1989 survey of 300 Dutch physicians (conducted by a pro-euthanasia doctor), over 40% of the doctors admitted that they had illegally performed euthanasia without the patient's request, and over 10% had done so in more than five cases each! According to the 1991 *Remmelink Report* of the Dutch government ("Medical Decisions About the End of Life")⁹, over one thousand patients had been killed directly in the previous year, without their knowledge or consent, including more than one hundred persons who were fully competent. Most recently, the Dutch Chief Inspector of Public Health, reporting in *Trefpunt*,¹⁰ the official bulletin of the Netherlands Health Ministry, announced that physicians who refuse to perform euthanasia and who, in addition, refuse to refer their patients to other doctors who are willing to kill, will now be subject to legal prosecution.

Professor Edmund Pellegrino, Director of the Center for Advanced Study of Ethics at Georgetown University, warns, "When the proscription against killing is eroded, trust in the doctor cannot survive. This is already apparent in Holland, that great social laboratory for euthanasia. According to some observers, older and handicapped people are fearful of entering Dutch hospitals and nursing homes. Older Dutch physicians have confided to some of us their personal fears of being admitted to their own hospitals. There is anecdotal evidence of physicians falsifying data to justify euthanasia, making egregious mistakes in diagnosis and prognosis, (and) entering into collusion with families...Present evidence indicates that the slippery slope - conceptual and actual - is no ethical myth, but a reality in Holland. When the physician who traditionally had only the power to heal and to help can now also kill, the medical fiduciary relationship - one of the oldest in history -

cannot survive.”

These excesses occurred in a free, sophisticated, democratic society, with total disregard for the limits of the law, on the part of a medical profession who were certainly under no obligation to become involved. In view of the German holocaust which their nation had so recently endured, one might have hoped that these would be among the last physicians on earth to fall victim to such excesses. If Dutch physicians have proven susceptible to such compromise, can we hope for better among the medical profession of this nation? Professor Leon Kass, M.D., of the University of Chicago¹¹, challenges us: “Is there any reason to believe that the average American physician is, in his private heart, more committed than his Dutch counterpart to the equal worth and dignity of every life under his care? Do we really want to find out what he is like, once the taboo is broken?”

Saving Us from Our Own Worst Enemy

“Even the most humane and conscientious physician psychologically needs protection against himself and his weaknesses, if he is to care fully for those who entrust themselves to him.” Doctor Kass¹² explains, “A physician-friend who worked for many years in a hospice caring for dying patients explained it to me most convincingly: ‘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’. The psychological burden of the license to kill (not to speak of the brutalization of the physician-killers) could very well be an intolerably high price to pay for physician-assisted euthanasia.”

In like manner, anticipating the personal impact of decisions concerning physician-assisted suicide, a doctor from the University of Minnesota Center for Biomedical Ethics concludes¹³, “For myself, I see no clear way to safeguard such decisions from my own limitations as a human being, confronting the profoundly ill or dying persons in my practice...I know that my most insightful clinical relationships with dying persons have been the most emotionally demanding...The essential and difficult intimacy with a dying patient is the crucible in which the choice for assisted suicide will be formed

and answered. I fear to jeopardize the privilege of being a physician to chronically ill persons by belatedly realizing that I had acted on my fears and improperly used my professional position to promote and complete a patient's suicide."

Dial "M.D." For Murder

Physicians' hands, and our reputation in the eyes of the public, have already been indelibly stained with the blood of legalized abortion. At the same time, rampant commercialism and shameless profiteering on the part of a few have caused our medical calling to be compared unkindly with the earliest profession. Legalization of mercy killing will only further, if not fatally impair the plummeting prestige of our vocation. Professor Pellegrino⁶ rightly reminds us of the enormous moral responsibility incumbent upon our profession to resist becoming "moral accomplices and society's designated killers." While we are now presumed by many to be America's first and best agents-of-choice to take the lead in legalized euthanasia, we should, in fact, be our society's last choice, exempted, and indeed barred by oath, from participation. Surely, the label our wounded profession can least now afford is this: "professional killers"!

Hippocrates' Oath and Gerber's Creed

Not only is the involvement of physicians in assisted suicide and euthanasia unnecessary; it is antithetical. The Hippocratic Oath stands as an historical watershed in the evolution of our professional mores. In proscribing euthanasia, the Oath definitively isolated the role of physician from that of those healer-poisoners who had been practicing "medicine" in early Greece, but who functioned much the same as the "witch doctor" and "curandero" does in primitive societies today. A witch doctor may, in the guise of healing, be administering an unsuspected poison or spell, in the secret hire of the patient's enemy. Thanks to the Hippocratic Oath and its profound influence upon the practice of medicine in the West, one could trust, until now, that the physician who approached the bedside held, as his first and absolute commitment, his inviolate fidelity to the doctor/patient relationship.

We in the healing profession might well take our lead from the paraphrasing of a famous baby food slogan. Gerber's Baby Foods used to advertise proudly, "Babies are our business - our only business!" In Medicine, we should be able proudly to proclaim "Caring, not killing, is our business - our only business!" Foreswearing poison lies at the very soul of that which we in the "profession" of medicine are called to profess. There can be no room, not for even a little bit of euthanasia, not even for hard cases or rare exceptions.

The re-introduction of euthanasia into the healing profession will constitute more than a mere blemish or superficial contamination; it will be a death-stroke that pierces to the very heart. Once again, the roles of witch and doctor will have been fatally re-united. The physician who deliberately kills his patient will be assisting at the suicide of our entire profession.

"If euthanasia is legalized", Doctor Pellegrino cautions us⁶, "the medical profession will bear a large burden of the blame, if it does not educate the public to the dangers and if it fails to refuse to participate...Legalization of euthanasia poses a far deeper moral challenge than the profession may appreciate. It challenges us to define what it really means to be a physician."

Training to Kill

With the advent of legalized euthanasia, there will arise the problem of providing specialized physician training in this area. How will training in patient-killing be incorporated into medical school and residency programs? Is death a responsibility for Primary Care? Family Practice? Anesthesiology? Psychiatry? How will both the private sector and the federal government insure an adequate "pipeline" supply of euthanasia physicians? Far from theoretical, this profound concern finds justification in both our past and current experience with abortion training. Congressional intervention has already been required to preclude "pro-choice" Ob-Gyn faculties from deliberately screening out those applicants who openly admit their opposition to abortion. This pro-abortion bias was as much pragmatic as it was ideological. If pro-life residents were accepted, the loathsome workload of assembly line abortions would have to be divided among a smaller number of willing residents. Scheduling

OR cases and clinical responsibilities around the objecting residents could prove problematic, as well. The requirement that all applicants be 100% pro-abortion would avert these and other administrative difficulties. At the same time, it would insure a compliant housestaff who were in lockstep with the pro-abortion biases of the staff; no questions asked. And these future doctors of America would be, from their very earliest training, committed both in the concept and in its execution, to the abortion rights movement.

Today, with pro-abortion forces still powerfully influential in all three branches of the federal government, militantly "pro-choice" academicians are again pressing forward. Hillary Clinton has openly expressed her own personal concern about the shortage of willing abortionists. And now, the powerful Ob-Gyn Residency Review Committee is instituting a change in its regulations that would require all Ob-Gyn residency training programs to provide abortion training. Although a conscience might be recognized for resident physicians on an individual basis, there will be no leeway for faculty, programs, hospitals or universities.

Pro-life physicians are to be segregated not only from residency programs, but from fellowship training as well. In an article published by the prestigious Hastings Center, an Associate Professor of Bioethics at the Einstein College of Medicine joins with the Senior Vice President of the New York Academy of Medicine¹⁴ in advocating the exclusion of pro-life physicians from the entire field of Maternal-Fetal Medicine. (Evidently, so-called "freedom of choice" has its limits.) Only the most naive would expect that an obligation to provide euthanasia-on-demand would be any less rigidly enforced.

Even now, on the euthanasia front, an enthusiast from the University of California-San Diego¹⁵ is recommending, in the *Journal of the American Medical Association* that "mini-fellowships" be initiated with the goal that, with this additional training, select physicians will become board-certified in the new sub-specialty of "Thanatology" or "Terminal Care Medicine". Influential leaders of medicine, from our nation's most prestigious hospitals and bioethical study centers, publishing in mainstream American medical journals, are paving the way for a new world disorder, in which killing of the unborn, the terminally ill, the handicapped and the depressed is considered a standard form of therapy.¹³⁻¹⁸ We are training for the medi-

cine of tomorrow; Christian physicians need not apply.

"It's Over, Debbie!"

Ironically, it was a resident, still in training in Gynecology, who, in his(?) enthusiasm for mercy killing, anonymously submitted to the *Journal of the American Medical Association* his clinical account entitled, "It's Over, Debbie."¹⁶ In it, he relates unashamedly his chance encounter with a 20-year-old woman who suffered from terminal ovarian cancer. Evidently, their first (and terminal) meeting occurred as a result of a middle-of-the-night call for parenteral pain-medication. The young resident, fumbling to find a suitable vein in which to inject an analgesic, evoked from this stranger the cry, "Let's get this over with!" Deeming this expression of frustration and pain sufficient consent, this self-appointed angel of death took it upon himself to deliberately inject a fatal dose of morphine. Celebrating his lethal compassion, he went on to proudly chronicle his execution for the enlightenment of the members of the American Medical Association.

What have we already unleashed? Who will remain safe? Is a patient no longer free to express a momentary sentiment of despair or anger without risking execution at the hands of any physician who might be passing by in the hall? We can no more take solace in the fact that only a small percentage of physicians are killers, than workers in a lumber yard can take comfort in knowing that only a small percentage of their fellow employees are pyromaniacs. When anyone asks why we, Christian physicians, are so adamantly opposed to euthanasia, let them know that it is for the sake of a young lady who once trusted a physician with the honest expression of her feelings, and paid for it with her life. Never again! When they ask what the euthanasia debate is all about, we can simply and honestly reply, "It's over Debbie."

"The Most Dangerous Man in the State"

"If the physician presumes to take into account in his work whether a life has value or not, the consequences are boundless and the physician becomes the most dangerous man in the state." (Doctor

Christoph Hufeland, 1762) With this quote serving as an introduction, in "The Geranium in the Window" (an extraordinary chapter within a most insightful work: *A Sign for Cain*¹⁹), Doctor Frederick Wertham thoroughly documents the crucial role that physicians played in the Euthanasia Holocaust, 1920-1945. The euthanasia movement, which ended with the mass-annihilation of millions in Nazi concentration camps, was conceived and developed, not in Fascist Germany, but in the libertine Weimar Republic. And it was not Hitlerian louts, but a highly respected physician and lawyer, who together first gave birth to the juggernaut. Alfred Hoche, a respected psychiatrist, and Karl Binding, a jurist, co-authored a best-selling book entitled, *The Release of the Destruction of Life Devoid of Value*, in Leipzig, Germany, in 1920. It was they, not Goebbels or Goering, who introduced the concepts of "life devoid of value", of "*leben unwertesleben*" (a life not worthy to be lived) and of "*untermenschen*" (worthless people, subhuman beings). The first experiments in euthanasia were conducted under the auspices of the most highly acclaimed medical centers of the time. And the first victims were neither Jews nor political dissenters, but rather they were the severely handicapped, the retarded and the mentally ill. Large numbers of psychiatrists and other physicians soon willingly joined in, while the number of for death and the clinical "indications" for mercy killing spiraled. Having started with only a few select cases, before long, German mass-technology found itself put to the test, in devising more cost-effective means to dispatch, by the roomful, disabled children and unwanted elderly. When Hitler came on the scene, the Euthanasia Movement was already aggressively in control, under the highly effective leadership of Germany's most prestigious physicians, with the vigorous and voluntary participation of large numbers of civilian health care professionals, and with the protest of nearly none. Buchenwald and Auschwitz were the ultimate, logical extension of this hideous medical experiment. The seeds of the Holocaust were first sown and blossomed in the field of a free and amoral medical profession, which accepted for the first time in modern history, the tool of death as therapy.

Doctor Leo Alexander, Consultant to the U.S. Secretary of War at the Nuremburg War-Crimes Trial, looking back to the root causes of this global travesty, stated, "Whatever proportions these crimes

finally assumed, it became evident to all who investigated them that they had started from small beginnings. 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 a life not worthy to be lived." ²⁰

The monuments to victims of Nazism and the tombstones of our war dead mark the price that the world has paid for the consequences of a medical profession unhinged from its sacred commitment to life.

All the monuments and tombstones, museums, documentaries, and Academy Awards are hollow tributes at best, if we have learned nothing from this holocaust of senseless and gruesome deaths. How quickly we seem to forget! How can it be, within the very lifetime of those who saw and survived this slaughter, that our medical profession would be so eager to take on, once again, the role of Physician-Killer? Have we, then, learned nothing, after all?

Seen, But Not (Yet) Herded

In the not-distant future, if current trends continue, we could find that a "Doctor of the Year" nomination has been awarded to a physician who spends his mornings crushing unborn babies in the womb, his afternoons injecting potassium cyanide into the veins of the unwanted elderly, and his evenings running for national office in the A.M.A. If this scenario seems improbable, more unlikely still, I fear, would be the possibility that Christian doctors, in large numbers, would revolt. A singularly effective accomplishment of militantly secular liberals has been the silencing of proactive Christian voices in the medical field. Like Jews in Poland in the 1930's or Blacks in Selma in the 1950's, we know our place and we know how to get along. There is no tolerance in our social milieu for an "uppity" Christian physician.

Proudly and Proactively Pro-Life

Too long have we, conservative Christian physicians, allowed ourselves to be portrayed as a small and fast-disappearing remnant of dyspeptic reactionaries. Why do we seem to focus exclusively on

defensive opposition to euthanasia? What we now have before us is an extraordinary opportunity to assume proactive and positive leadership, both in the practice and in the persuasive advocacy of wholesome and holistic, life-affirming approaches to terminal care. Sharing the light of Christ's redemptive message, through effective, rational and compassionate medical care, we can dispel for many the allure of "mercy killing." Doctor Pellegrino provides this insightful analysis:

What are the moral obligations of physicians who reject all forms of euthanasia? To begin with, we must accept responsibility for confronting the reality of pain and suffering – the fear and emotional traumata of the fatally ill and dying person and the legitimate desire for a good death. We must counter the destructive force of euthanasia with a constructive effort...What can we as physicians do to help the patient achieve as good a death as possible without killing him? First of all, physicians must recognize that the request for euthanasia is a plea for help and an attempt to regain some measure of control over one's life that fatal illness seems to have taken away so forcibly. Why does this particular patient want to be killed? Is it pain, suffering, loss of dignity, depression?...Is it a test to see if the family really regards the patient as a burden? Is it fear...of being kept alive artificially to no purpose, or a response to the doctor's attitude of futility or disinterest?...Too many physicians are still fearful of talking about death...Euthanasia is not the answer to the physician's inadequacy, frustration or emotional exhaustion as a healer...There are many reasons for the request to be killed and many remedies once we know the reasons.⁶

Not only for us as individuals, but also collectively as a profession, the dire consequences of this present crisis demand that we take a clear and articulate stand. As Doctor Pellegrino relates, "The medical profession is a moral community. Its members have a collective moral responsibility to patients and society. For this reason, the whole profession must oppose the legalization of euthanasia as detrimental to the welfare of patients and the integrity of society."⁶ For all Christian medical societies and, in particular, for the Catholic Medical Association, this call to effective action should be compelling indeed.

"Thy Will Be Done"

"Traditionally, the teaching of the Church in relation to suffering has been that affliction tests, or proves, the quality of one's faith." Professor Robert D. Orr, M.D., Clinical Director of the Center for Christian Bioethics at Loma Linda University²¹ places this difficult issue in a truly Christian framework:

Faithfulness (endurance) in suffering, after the example of Jesus as well as other biblical heroes of faith, has a refining or purifying effect in the sufferer's present life, while holding the promise of reward in the life to come.

Not only this, since every believer is part of a larger community of faith, the truly faithful sufferer will demonstrate the value of knowing God, especially in the valley of the shadow of death.

This inspires the observers, strengthening their own resolve to "keep the faith", providing tangible evidence of the reality of "things not seen." This does not mean that suffering is a good thing, and therefore ought to be sought, but that the combination of faithfulness to God and his faithfulness to his children in times of deep distress can transform suffering into a powerful and substantial witness to God's compassion, grace and presence in life's most difficult times.

Providing a true-life testimonial to these theoretical constructs, B. Douglas Hallmark, M.D.²² shares his personal account of the severe trial he encountered when his own father, facing severe pain in terminal illness, worked through, with him, the temptation to seek a quick and easy death at the hands of his own son. Doctor Hallmark concludes:

Looking back, I'm so grateful that we had that time. We left nothing unsaid, no business unfinished. In the process, I gained a new appreciation for the privilege it is to be a physician, and for the gift of medication, especially the kind that can so dramatically ease suffering for the terminally ill.

If I had to do it again, I think my convictions against euthanasia would be stronger, not weaker. Life is God's to give, and to take. Our responsibility is to make sure that when the end comes, we've invested it wisely, in relationships with God and our family, so we can pass from this life to the next without regrets. For when it comes time to collect the ultimate dividend, it will be clear enough that nothing else mattered.

To Heal the Dying

"Like most physicians, I have had patients die under my care", writes Daniel P. Sulmasy, O.F.M., M.D., at the Georgetown University Medical Center.²³ "Not one has ever asked me for euthanasia or assisted suicide. I would like to think that this is because I have struggled to never let my patients believe the falsehood that they had somehow lost their human dignity because they were suffering or dying or had diminished control over one or another of their bodily functions. I have sensed their suffering in such circumstances, and I have reached out in acts of compassion. I have seen many patients die prolonged yet dignified deaths, full of the knowledge both that their lives had value, and that their lives were not of infinite value. These patients faced their mortality with courage, hope, and love. Watching them and their families confront the mystery of death has been a deeply transformative experience for me as a physician. I was not always able to control all of their pain, despite my best efforts. Some died after a few days in coma. Some died incontinent. Some died demented. With their consent, I withheld and withdrew therapies that would have needlessly prolonged their dying. But I have never killed a patient, nor aided a patient in suicide.

"In contrast to these truly 'good deaths', I have had some patients who have approached their deaths in despair and fear. I struggled with these patients, acknowledging but never ratifying their emotions. I worked to let them know that they were not dying alone. I made sure they knew that even if no one else would be there, I would be there for them. I struggled to let them know that they had not lost all dignity; that they remained connected to the human community by the bonds of love even as they were leaving. Sometimes my efforts were successful, and they died in peace. Sometimes I was not successful, and these patients remained fearful and despairing to the end. I have mourned their deaths most of all. But I never once gave up trying to heal the aspects of their suffering that morphine can never touch – their need to believe in their own value and meaning – their own dignity. This is a daunting task – to heal the misperceptions of the dying about their own value; to remind them that they are not grotesque creatures who have ceased to have importance because they are naked, covered in feces and

blood. But this is what medicine does at its limit. This is what it means to heal the dying...

"The demand for euthanasia and assisted suicide is, in some ways, an ironic demand for a quick technological solution to the problems technology itself has created. But this amounts to a form of denial. It is a stubborn refusal to accept the truth about medicine – its value, its meaning, and its limits. It is at the same time a stubborn refusal to accept the truth about being human – its value, its meaning and its limits. It is absolutely true that physicians must be more affectively responsive and sympathetic to the needs of the dying and absolutely true that physicians need to muster more compassion for the dying. But affect without truth is not mercy. It is mere sentimentalism. The dying need healing from their doctors. The dying must always be assured by their doctors that they have not lost their human dignity -- that they continue to have worth, honor and esteem..."

To Take Up Our Cross

In large part, the lure of euthanasia, for the terminally ill patient, derives its force of attraction, not so much from fear or pain, as from a dehumanizing sense of rejection, of helpless isolation and of hopeless abandonment. The antidote may reside, not so much in things that we do, as in the way that we do them – in the quiet, gentle, simple ways that we convey, even without speaking, that indeed we do sincerely and personally care.

Under the strain of contemporary medical practice, it is easy to become inadvertently ill-tempered, abrupt, and coldly removed. And few patients test the mettle of our bedside manner more than do demanding and dying cancer patients. To every Christian, whether lay or professional, Christ calls, "Let him who would follow, first renounce himself, take up his cross; and come, follow Me." (Matthew 16:24). In an ironic twist, the Lord may be beckoning to those of us in the healing profession, "if any of you would seek the Kingdom of God, you must first forget your self-importance, put down your crossness, and come, follow Me!"

If unmerited suffering is redemptive for our patients, can it be any less so for us? How often, when we were younger, would our

Mom, or some good nun, be sure to remind us, whenever we faced some little pain or unavoidable discomfort, "Offer it up! "? The role to which God calls us, in this great battle against euthanasia and assisted suicide, may merely consist, in no small part, in the simple act of offering up the many little pains and inconveniences that are the inevitable price of humane patient care. It is a pain to stop in the midst of hectic ward rounds and quietly listen for a minute; a pain to stop back again after a grueling day in the office or the OR; a pain to actually touch a patient – to hold a hand or rub a foot; a pain to accept cheerfully a late-night call for yet another change in the orders for pain medication, a pain to breach, on appropriate occasion, the impenetrable wall of professional reserve and share emotionally with a patient. What better prayer to offer our Crucified Lord, than the action-prayer of these little pains, suffered cheerfully and uncomplainingly, in His Name?

Jesus holds up to us as a model the Good Samaritan: It was the lowly Samaritan, and he alone, who stopped, not to lecture the bleeding wretch on the redemptive value of his suffering, nor to prescribe on a distant chart a treatment for others to administer, nor to precertify the financial reimbursement status. No, he stopped to touch, to bind, to soothe, to care personally regardless of the cost. In the light of this example, could it be that the Lord is holding up to our profession today, the vision of a patient in the throes of terminal illness, to challenge us, "Of all the professionals that paraded by this pain-wracked patient in the last days of his life – the primary-care physicians, consultants, diagnosticians, chemotherapists, radiologists, anesthesiologists, nurses, chaplains, corpsmen, aides and technicians – which one was his true neighbor? With so many involved in hastily and officiously caring for him, was there not even one who honestly and compassionately cared about him? Cared about Me?"

"I Am Life"

Every Christian is called to renounce violence and to serve gently and selflessly, as a life-affirming "*alter Christus*" – to represent Christ, reaching out through each of us to those in greatest need. All the more then, should not those of us who are, as Christian physicians, entrusted with this unique profession of healing, be

challenged, in a special way, to model our lives after Our Lord, the Divine Physician? In the death Our Lord suffered for us on Calvary, we are presented a most perfect source of inspiration. Not only through His death, but through His life as well may we come to better understand the higher purpose of living and dying, for our patients and for ourselves. "I have come that you may have life...and have it in great abundance!" (John 10:10) "For I am the Way; I am Truth; and I am Life." (John 14:6)

Christian ethical insights ought not only inform our own individual professional practices, but should move us, as well, to serve as effective advocates of Christian ideals in the marketplace of secular medicine – a light unto our professional colleagues, our patients, our nation and the world.

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