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Coming of Age

Euthanasia and Assisted Suicide

For many of our patients, chronic obstructive pulmonary disease (COPD) is a terminal diagnosis. The chronic debilitating and progressive worsening of the disease will eventually lead to death. COPD is currently the fourth leading cause of death in the United States.

Depression is not an uncommon co-morbidity in COPD patients. If unrecognized and untreated, depression can lead to thoughts of suicide. Assisted suicide and euthanasia, once considered taboo, are becoming acceptable in some countries.

Is assisted suicide or euthanasia something our COPD patients will investigate? As therapists, is this something you understand?

Changing attitudes among people in the United States, along with the increased number of older adults in the population, may influence the practice of assisting suicide among terminally ill elderly patients. Euthanasia comes from the Greek words for "good death." It is often associated in popular thinking with mercy killing, similar to putting pets to sleep.[1] The motivation is to hasten the death of a suffering creature and thus minimize the pain and disability that might not be otherwise avoidable. The concept of putting a pitiful animal out of its misery, however, confuses the complex ethical and factual dimensions of assisting or hastening a patient's death. There are, in fact, four types of euthanasia: combinations of active and passive, voluntary or involuntary.[2]

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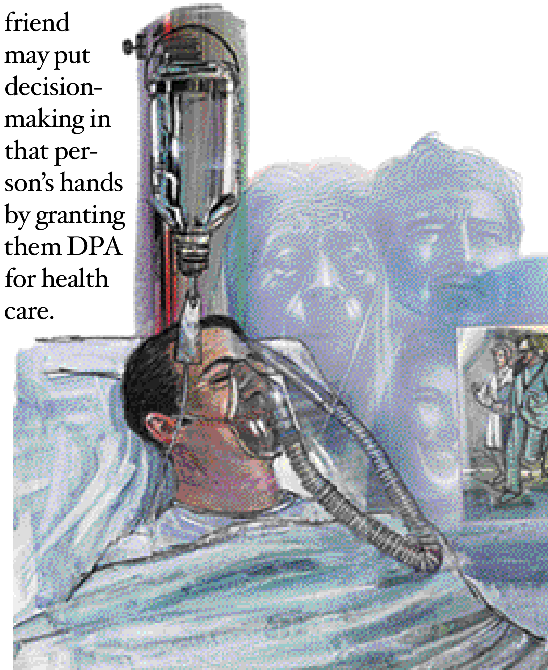
Voluntary passive euthanasia

As the term implies, voluntary euthanasia is done at the request or with the agreement of the individual, and passive usually implies the withdrawal of life-sustaining treatment or support. It is often called for in advance directives such as a living will or durable power of attorney (DPA) for health care.[3] The Federal Patient Self-Determination Act of 1991 mandates that hospitals, nursing homes, home health care programs, hospices, and other health care programs that receive federal funds must give newly admitted patients the opportunity to execute an advance directive. It is often the case that people may specify certain treatments on these documents — for example, rejecting feeding tubes or CPR.

Ideally, being able to fill out orders in advance will help patients to continue feeling in control. Patients with a trusted relative or friend may put decision-making in that person's hands by granting them DPA for health care.



The ethical problem that emerges with voluntary passive euthanasia is: When is treatment extraordinary? Withdrawal of radiation or chemotherapy in the instance of an advanced cancer patient who hasn't long to live may be a typical decision. The patient may then be sedated and kept as comfortable as possible until the end. This is done all the time and is not controversial. But what if withdrawal of treatment involves hydration or nutrition? Many health care professionals object to the withholding of what they consider to be basic maintenance.[4]

Similarly, making the decision for terminal weaning can be agonizing. Decisions at the bedside are painful and difficult.[5]

Involuntary passive euthanasia

The ideal means of passive euthanasia, the withdrawal of life support, should involve the patient choice. Most people probably would agree that there comes a time when enough is enough, particularly if the individual is willing to give up the fight and simply wants palliative care.

Withdrawal of treatment, however, is not always voluntary. The case of Nancy Cruzan is illustrative. Like Karen Ann Quinlan before her, the public became aware of her when she entered a persistent vegetative state after a 1983 automobile accident. Quinlan had apparently left her parents with the understanding that she had no wish to be kept alive in such a condition. This type of understanding was evidently not the case with the Cruzan family. The Missouri courts decided that without such an advanced understanding, the state had an interest in keeping Nancy alive. In effect, the courts ruled against involuntary passive euthanasia while leaving the door open for voluntary passive withdrawal of life support. The U.S. Supreme Court upheld the Missouri decision in 1990.

It was only later, when the parents claimed that Nancy would not have wanted to be kept alive, that the Missouri court agreed to let the feeding tube be discontinued. Nancy died Dec. 26, 1990. The voluntary versus involuntary nature of the decision is therefore critical. For this reason, withdrawal of life support for demented older people who have no spokesperson or who have left no directive fails to meet most ethical standards.[4] Unfortunately, many of our older COPD patients fall into this category.

Voluntary active euthanasia

Voluntary active euthanasia is the intentional intervention, rather than a passive withdrawal, to end a person's life at their request. It is assisted suicide. The controversy involved with this currently is the recent attempt by the U.S. Department of Justice to prevent assisted suicide in the state of Oregon where voters have twice approved it. The U.S. Attorney General ordered the Drug Enforcement Agency to arrest physicians who gave Oregon patients, even at their request, lethal doses of barbiturates. A federal judge has since ruled, however, that the Administration lacks the authority to overturn a voter-approved law.

Thus, it is again the *voluntary* nature of the act that provides the crux of the argument. Assisted suicide is now legal in Oregon, as well as in the Netherlands,[6] and is currently under consideration by the Belgium Parliament.

It apparently has been practiced with control. In the past two years there have been fewer than 100 cases in Oregon, which does not seem to represent a moral collapse of the society and is a welcome option to many. While pain management in recent years has improved, there remain a number of people for whom assisted suicide is viewed as an appropriate choice.

Involuntary active euthanasia

Involuntary active euthanasia is capital punishment; it might be seen as differing little from giving lethal injections on death row.[4] Usually considered in the context of "it was only the better part of mercy," active euthanasia against someone's will could also be considered premeditated homicide.

There is only anecdotal literature on it, stories of nurses or therapists who sometimes take it upon themselves to boost doses of opiates. Some health care providers seem to reluctantly admit that it does go on, perhaps more often than one might think.[3,4] It is often seen as a gray area, crossing the line from doing nothing to intervene (the slow code, initiating CPR long after the individual might be resuscitated) to taking action to end a life by increasing a morphine drip. Each has the same intent and the same result. The problem, of course, is when the family is not present or cannot come to agreement and there is no directive from the patient or their advocate. This controversy is the dangerous area one enters when deciding who should live and who shall die.

In an extended article about the German eugenics movement gone mad, Alexander detailed the active euthanasia of mentally ill and/or retarded people that took place in Austria and Germany in the 1930s and 1940s.[7] He argued that this

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was the beginning down the slippery slope that led to extermination camps where political prisoners, Jews, gypsies, and other "undesirables" were murdered by the Nazi death machine. It is a chilling example for those who advocate active intervention to end the lives of those who cannot speak for themselves.

Terminal weaning and RTs

It would seem that the willingness of the individual is the key issue in euthanasia or assisted suicide. Respiratory therapists see patients on a daily basis who struggle for each breath. We participate in terminal weaning, often with morphine as a palliative agent. Technically, as defined by Matthews, this is voluntary passive euthanasia.[2]

What makes this acceptable? Congress mandated advance directives in the Patient Self-Determination Act of 1991, which by implication gave approval to voluntary passive euthanasia. The courts have upheld that voluntary active euthanasia is acceptable in the instance of voter-approved initiatives in the state of Oregon. Physician-assisted suicide is also legal in the Netherlands.

In 1990 the U.S. Supreme Court affirmed that it was the *voluntary* nature of withdrawal of life-sustaining treatment that would make it acceptable. Involuntary passive euthanasia would not be acceptable according to the court's decision. Involuntary passive euthanasia violates most commonly accepted moral and ethical standards.[4,7]

Voluntary passive euthanasia, with the emphasis on *voluntary*, may not be a term we are comfortable with, but it is a reality in health care today. As respiratory therapists, the more we know, the more we understand, the better we can serve our pulmonary patients in all stages of their disease.

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AUTHOR'S NOTE

Also see the Ventilation for Life column in this issue for a related story on "Dealing with End of Life Issues."

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