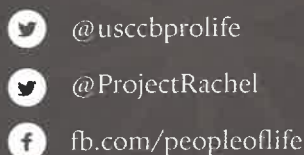




KILLING THE PAIN, NOT THE PATIENT: PALLIATIVE CARE VS. ASSISTED SUICIDE

Assisted suicide is radically different from end-of-life care and the practice of palliative care.



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Assisted suicide is in the news and on lawmakers' agendas. Supporters call it "aid in dying" and claim it is just another option for ending intolerable pain as part of end-of-life care. But assisted suicide is radically different from end-of-life care and the practice of palliative care, the healing art of relieving pain and other distressing symptoms for patients who are seriously ill. In fact, these two agendas are at war with each other.

* Different Drugs, Different Results

When properly prescribed for the pain of serious illness, powerful pain medications like morphine and other opioids are safe and effective. Patients can have their pain well-controlled without risk to life, and generally stay alert as well.

Assisted suicide is very different. Where it has been legalized, doctors can prescribe a lethal overdose of pills to patients whom they think will die within six months, so they can kill themselves. The patient then intentionally swallows a massive overdose of barbiturates to cause unconsciousness and death.

* The Importance of Intent

Besides having opposite results, these two approaches express different intentions.

While pain medication is generally safe under medical supervision, it may have side-effects. For example, barbiturates may be used in rare instances to sedate an agitated patient in the final stage of dying if other pain control methods are inadequate, though this poses some risk of shortening life.

In such cases, the doctor and patient must assess the good they intend and proceed only if this good outweighs the unintended adverse effects. As risk cannot always be eliminated, modern medicine would be impossible without this "principle of double effect." The key is that no one involved intends the bad effects, especially the bad effect of killing the patient.

Assisted suicide, by contrast, directly intends the patient's death, which is never morally permissible. The doctor prescribes an intentionally lethal overdose, with instructions on how to use the pills to cause death. (Interestingly, there is no record that any patient accidentally surviving the overdose has ever tried it again.)

Medical organizations like the American Medical Association and the American College of Physicians oppose doctor-assisted suicide, in part because it destroys this essential distinction between intended and unintended effects of treatment. Patients need to be able to trust their doctors to always care for their lives and never deliberately cause death.

✱ Eliminate the Problem, Not the Patient

Palliative care also addresses symptoms beyond physical pain, in ways that go beyond medication. Patients facing serious illness may feel hopeless and depressed, as though their lives have lost meaning. Addressing psychological, emotional, and spiritual problems is essential to palliative care. Assisted suicide alleviates none of these problems, but gives in to them. Consider that about half of patients who had requested assisted suicide under the Oregon law in its first three years changed their minds when the doctor provided palliative care.²

Yet in Oregon, almost none of the patients receiving lethal drugs are evaluated to assess whether their wish for death arises from treatable depression—and over half say they requested the drugs partly because they feel they are becoming a “burden” on others.³ Offering assisted suicide can only confirm and strengthen that feeling. It ignores the underlying problems, instead abandoning and eliminating the patient who has the problems.

✱ Assisted Suicide Undermines Palliative Care

Assisted suicide is detrimental not only for individual patients, but also for patient care on a large scale. In countries like the Netherlands, where assisted suicide has been accepted for many years, progress in palliative care has stagnated.⁴ In Oregon, legalization was followed by an increase in severe untreated pain among terminally ill patients. During a period when 1,832 hospices opened in other states, only five

opened in Oregon. In other states legalizing assisted suicide, use of hospice care has fallen below the national average.⁵ By contrast, when states pass new laws forbidding assisted suicide, while affirming that doctors may use drugs like morphine for effective pain control, use of these medications has increased—indicating progress in pain management practices.⁶

The reason is obvious. Optimum palliative care requires years of training and experience, as well as a commitment to the patient as someone with inherent dignity who deserves excellent care. Assisted suicide avoids the need for this hard work and erodes this commitment. It provides a “quick and easy,” as well as cheap, answer to terminal illness. Once death is accepted as a solution, why bother to devote resources to more expensive medical progress?

Assisted suicide does not enhance medicine. As noted by a doctor specializing in palliative and hospice care in the Netherlands, killing “becomes a substitute for learning how to relieve the suffering of dying patients.”⁷

✱ True Love and Mercy

Do we see people as the problem, such that our responsibility begins and ends with helping patients kill themselves? Or, do we see seriously ill patients as fellow human beings who deserve our love and solutions for their problems? Will we succumb to the “false mercy” of assisted suicide, or will we endorse what Pope St. John Paul II called “the way of love and true mercy”?⁸ Will we dedicate ourselves to providing genuinely compassionate care, as a society and for our own loved ones? Our answer today determines the care available now and for years to come.

¹ Doerflinger, Richard M., M.A. “Oregon’s Assisted Suicides: The Up-to-Date Reality in 2017.” *On Point*, no. 21 (March 2018): 5. <https://lozierinstitute.org/wp-content/uploads/2018/03/Oregon-Assisted-Suicide-The-Up-To-Date-Reality-2017.pdf>.

² Ganzini, Linda, M.D., Heidi D. Nelson, M.D., M.P.H., Terri A. Schmidt, M.D., Dale F. Kraemer, Ph.D., Molly A. Delorit, B.A., and Melinda A. Lee, M.D. “Physicians’ Experiences with the Oregon Death with Dignity Act.” *The New England Journal of Medicine*, no. 342 (February 24, 2000): 557-63. doi:10.1056/NEJM200002243420806.

³ *Assisted Suicide Laws in Oregon and Washington: What Safeguards?* PDF. Washington, D.C.: United States Conference of Catholic Bishops, February 22, 2018: 2.5. <http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/suicideoregonfeb2018.pdf>

⁴ *Physician-Assisted Suicide: Threat to Improved Palliative Care*. PDF. Washington, D.C.: United States Conference of Catholic Bishops, March 4, 2017: 2-3. http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/suicide_palliative_care-2.pdf

⁵ Doerflinger, Richard M., M.A. “The Effect of Legalizing Assisted Suicide on Palliative Care and Suicide Rates: A Response to Compassion and Choices.” *On Point*, no. 13 (March 2017): 3. <https://lozierinstitute.org/wp-content/uploads/2017/03/The-Effect-of-Legalization-of-Assisted-Suicide.pdf>.

⁶ Brief *Amici Curiae* for the United States Conference of Catholic Bishops, California Catholic Conference, Oregon Catholic Conference, Washington State Catholic Conference, Catholic Health Association of the United States, and Lutheran Church-Missouri Synod as *Amici Curiae* in Support of Petitioners, *Alberto R. Gonzales, U.S. Attorney General, et al. v. Oregon, et al.*, No 04-623, *18-22 (filed May 9, 2005). <http://www.usccb.org/about/general-counsel/amicus-briefs/upload/amicus-sct-gonzales-v-oregon-2005-05.pdf>

⁷ Zyllicz, Zbigniew. M.D. “Palliative Care and Euthanasia in the Netherlands” In *The Case Against Assisted Suicide*, 142. Baltimore and London: Johns Hopkins University Press.

⁸ John Paul II, *Evangelium vitae* (*Gospel of Life*) (Vatican City: Libreria Editrice Vaticana, 1995), no. 66-67.

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