CORRESPONDENCE

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Euthanasia: Wisdom or Folly?

To the Editor:—Several aspects of the article by Truog and Berde[1] regarding physician-assisted suicide concern me.

First, I find little evidence for the nationwide acceptance of euthanasia the authors, citing various polls,[2] suggest exists. From the article referenced, it is unclear whether the respondents understood the distinction between allowing a patient to die as painlessly as possible and actively taking life using a painless method. Moreover, the recent defeat of pro-euthanasia initiatives in California and Washington suggest an opposite trend.

Second, I seriously question the rationale offered for such a radical departure from traditional patient care. Certainly, anesthesiologists should provide the greatest possible pain relief for patients, but assisted suicide is at best a truncation of true pain relief. Saunders[3] describes total pain as encompassing physical, emotional, social, and spiritual well-being. A model of truly compassionate care seeking to address all these needs comes not from Kevorkian but from the National Hospice Organization, a medically directed, interdisciplinary program of palliative and supportive services for dying persons and their families that "focuses on maintaining the quality of remaining life."* Significantly, Hospice has soundly rejected the practice of assisted suicide.

Truog and Berde idealize assisted suicide as an act motivated by compassion and respect for individual autonomy, yet, only a generation after the Holocaust, they cannot deny the great potential for abuse. Nonetheless, they brush aside this concern, ignoring the voice of professionals such as psychiatrist Dr. Leo Alexander, expert witness at the Nuremberg Trials, who describes the beginnings of the Nazi euthanasia movement as "merely a subtle shift in emphasis in the basic attitude of physicians . . . the acceptance of the attitude . . . that there is such a thing as life not worthy to be lived."[4] In the light of history, only the naive would assume an idealistic view of human nature. Indeed, the motives of those clamoring for assisted suicide must be scrutinized, for greed and other everyday vices still permeate society.

As anesthesiologists, we stand before our patients as trusted agents of pain relief and sustainers of life. Yet Truog and Berde, in a radical departure from mainstream medical thought, have invited us to become executioners. Is this what we want? Moral parameters, including American Medical Association restrictions against sexual involvement with patients and drug abuse, exist to maintain the integrity of the physician-patient relationship. The American Medical Association stance against physician-assisted suicide is another vitally necessary parameter.† We must, as true professionals, commit ourselves anew to serving our patients and standing with vigilance over their very lives. If we have failed thus far to provide adequately for our patients, it is not in refusing to help them die but in not doing enough to help them live and cope with their pain by finding ways to supplement the services of groups such as Hospice with techniques unique to our specialty. Finally, we must reject absolutely the concept of physician-assisted suicide, the death knell of our profession.

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3. Saunders C: The philosophy of terminal care, The Management of Terminal Malignant Disease. 2nd edition. Edited by Saunders C. London, Edward Arnold, 1984, p 232.
4. Alexander L: Medical science under dictatorship. N Engl J Med 241:39–47, 1949

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* National Hospice Organization; Statement of the National Hospice Organization Opposing the Legalization of Euthanasia and Assisted Suicide: Resolution approved by the Delegates of the National Hospice Organization annual meeting, Detroit, Michigan, November 8, 1990. pp 1–9.

† Council on Ethical and Judicial Affairs of the American Medical Association: 1992 Code of Medical Ethics, Current Opinions. Chicago, American Medical Association, 1992, pp 14–40.