Their Pain, Their Choice, Their Time to Go

Christina Merrick-Gharib

University of Central Missouri

2nd Place Graduate Paper Competition

Missouri Sociological Association

2013

A once vibrant young mother looks through eyes of despair as her two-year-old child cries, his arms outstretched for Mommy to hold him. The lasting effects from the numerous treatments cause her arms to be too weak to comfort him, and the tears slide down her colorless face. A loving husband of fifty years is now a shell of his former self. He sees everything yet nothing through cloudy, blue, lifeless eyes. His wife busies herself with wiping the escaping dribbles from his chin and then emptying the catheter bag for the umpteenth time. Tears silently slip from her crinkled, brown eyes as her heart breaks at the sight of her withering groom. In a

fleeting moment of clarity, thousands of miles apart, both sufferers reach out to their loved ones and beg for assistance to end their misery.

The purpose of this paper is to examine the impact of assisted suicide, voluntary euthanasia, and as some call it, self-deliverance. The definition used for these three terms is one that was also utilized in a nationwide survey of physicians polled on their opinion of the issue. That is, "the practice of providing a competent patient with a prescription for medication for the patient to use with the primary intention of ending his or her own life… [or] the practice of injecting a patient with a lethal dose of medication with the primary intention of ending the patient's life" (Meier, M.D., Emmons, Ph.D., Wallerstein, Ph.D., Quill, M.D., Morrison, M.D. & Cassel, M.D., 1998). In this context, these measures are strictly targeted towards those individuals who have a terminal disease or illness, intolerable pain or loss of bodily functions, who have sought out all possible alternatives for the alleviation of their pain, disease or illness, who have a zero quality of life, and who were completely competent at the time of the request.

The United States has a large, older and aging, adult cohort. Millions in the baby boomer generation are now reaching their early and late 60's. This practice is a significant area of interest that is of the utmost pertinence to the current older adult cohort, in addition to the future members of society in general. In the previously mentioned nationwide survey it was found that, "a substantial number of physicians in the United States have received one or more requests for assistance with suicide or euthanasia…legalization could lead to a large increase in the willingness of physicians to participate in the hastening of death and perhaps to an increase in its prevalence…the majority of patients who request assistance with suicide appear to satisfy many of the criteria currently proposed as regulatory safeguards for this practice" (Meier, M.D., Emmons, Ph.D., Wallerstein, Ph.D., Quill, M.D., Morrison, M.D. & Cassel, M.D., 1998).

Medical and technological inventions and interventions that were created and improved by these very boomers have now led to situations where life-sustaining machines are being utilized to prolong a life, sometimes indefinitely, at the cost of a zero quality of living, not to mention thousands upon thousands of dollars' worth of bills.

So the questions become, at what point does society allow life-ending measures to become legal for those, who in addition to living longer, must now also face this longer life with multiple chronic illnesses or diseases, intolerable pain, and sometimes a zero quality of life? Additionally, with more women outliving men, fewer financial resources, and fewer children to help with the decision-making and care regarding their aging parents and grandparents, who is going to step in to fill this void?

With three states already allowing for physician-assisted suicide and several other states taking the matter under consideration, in time, it will inevitably be expanded and legalized. The training and work of the social gerontologist is going to play an extremely important role. For it is through the social gerontologist's research, recommendations, and education of persons in the professional and public sectors, that the practice will be informatively and ethically carried out, in addition to providing possible alternative measures such as better palliative care instead of self-deliverance when appropriate, and filling this void that older adults may be faced with.

In every state in America except Washington, Oregon, and Montana, it is illegal to honor a loved one's request and assist in their death. In states where it is illegal, current laws could find mercy givers, such as those in the fictional opening stories, guilty of second-degree murder and, jail time of ten to twenty-five years. Yet, do not all individuals deserve the right to a quality life? What if there is no hope for that quality? Should it be considered a crime to help those begging for the suffering to stop? In spite of the fact that euthanasia opponents have the law on their side

stating that assisted suicide, voluntary euthanasia, or self-deliverance is murder, this action should be considered a right and not based of the viewpoints of families, physicians, and patients who think otherwise.

Opponents against voluntary euthanasia offer various reasons for their positions. Some of their concerns are the fear of suicide spreading to non-terminal patients, abuse of the elderly and disabled, rampant corruption in healthcare insurance companies and doctors, and the undermining of religious and moral values, leading to a world with little value for life. Current laws validate their concerns.

The Euthanasia Prevention Coalition states, "There is a growing tendency to promote 'mercy killing' as a solution to suffering, pain, aging, mental or physical challenges, social ills, rising health costs and cost containment" (Concerns, 2013). However, could it not be said that the undermining of religious and moral values and the little value for life can already be found in many parts of the country, with a pathway leading directly to the addiction and abuse of drugs and alcohol, in addition to rampant corruption in religious organizations?

Opponents contend that with voluntary euthanasia and assisted suicide written into law, the incentive for further medical research into new medications to control pain and palliative care advancements would be lost. However, one issue with this argument is the fact that according to the book titled, The Case Against Assisted Suicide: For the Right to End-of-Life Care, "at this time only a minority receive such care" (Foley & Hendin, 2002). How can one justify this argument if so little receive the proper treatment in the first place?

The opposition coalition also states that it is their belief that depression plays a large role as a cause of assisted suicide pleas for help (Concerns, 2013). Additionally, author Herbert Hendin writes, "Close to 95% of individuals who kill themselves have a diagnosable psychiatric

illness in the months preceding suicide. The majority of these individuals suffer from a form of depression that can be treated. This is particularly true of the elderly, who are more likely than younger victims to take their lives during the type of acute depressive episode that responds most effectively to modern available treatments…More than 40% of suicide victims have suffered from some medical illness at the time of their death. For 25% of the victims, problems derived from a medical illness were an important factor in their suicide. The percentage for whom illness was an important factor rises to 70% when dealing with individuals who were more than sixty years old when they killed themselves" (Hendin, 2004). So in essence, according to this argument, if the depression is managed and controlled, so are the pleas. However, this is a difficult argument to accept, because the treatment of depression still has not lessened the physical pain and agony, along with the terminal illness or disease that has caused it and are behind many of these pleas.

Right-to-die proponents view suicide in two ways, emotional suicide, and justifiable suicide (Humphry, 2010). Emotionally driven suicide has no place in the argument in favor of voluntary euthanasia and assisted suicide. A person contemplating suicide based on emotional issues is in need of mental health professionals and still has hope and other avenues available. The focus groups for euthanasia proponents are terminally ill patients, with less than six months to live and still mentally competent. These patients have exhausted all avenues available to them, are still living with intolerable anguish, and have zero quality of life (Humphry, 2010).

Viewing life as such a precious gift, the request of voluntary euthanasia and assisted suicide by a loved one can be a gut-wrenching decision for a family member. Witnessing a loved one, lying helpless and hopeless, begging for mercy and death, places an unimaginable burden

on the family. In the book, The Ethics of Belief: Application, author Kenneth Cauthen writes the following:

> When medical science has done all it can and death has not brought merciful relief, family members suffer a sense of powerlessness and despair as they watch in horror someone they love dearly writhe in torment as they wait and hope for a quick end to their awful suffering… Why do we force good people full of love, mercy, and compassion to such extreme measures to bring an end to hopeless torment when no cure or relief is possible for the dearest people on earth to them? (Cauthen, 2001)

One solution is to make voluntary euthanasia and assisted suicide legal, as long as a trained professional carries it out under strict rules and regulations. By allowing a trained professional to handle these situations, it removes this currently criminal act, and horrendous burden from the family.

Current laws regarding voluntary euthanasia and assisted suicide place physicians in a compromising position. As part of the medical ethics, physicians swear by the Hippocratic Oath, which forbids any actions that would cause harm or death to their patients. On the other side, it is also their responsibility to do what is in the best interest of their patients. The compromising position occurs when what is best for their patient is death. Additionally, Cauthen writes,

> Physicians are more fortunate in that they can take refuge in the principle of the 'double effect' and write on the death certificate the cause of death. Many of us have heard doctors report that they have, out of compassion and mercy, given heavy doses of morphine to relieve the intolerable distress of patients who are

> near to an inevitable death, knowing full well that the result will be to hasten the end. (Cauthen, 2001)

One example is the following:

> A man had a mother who was a nurse. Several years ago, the mother was diagnosed with stage 4 lung cancer, which had metastasized, to her brain. She lived for one year after diagnosis, dying two days after her fiftieth birthday. Her last two days of "living," if one could call it that was the worst experience of the son's life. Because the mother was transferred to hospice care in a nursing home that she had previously worked in, the nurses on staff did not want to give her the prescribed morphine that the doctor had ordered. They knew this would speed up their friend's death and told the son so. However, unbeknownst to the nurses, the mother had informed the son of the process, her wishes, and what she had expressed to her physician. The son knew what to expect. Those last two days the mother did not eat or drink anything. The only way for her to receive her pain medication was via the liquid morphine, Roxanol, under the tongue. The son had to request the mother's friends be removed from her care because he could see the pain on his mother's face because the nurses were not giving his mother the prescribed dosage. During those last two days, the son sat at his mother's bedside and listened to her lungs filling with fluid, expecting each one to be her last. (Smith, 2013)

When his mother was dying, the son felt that he should not have had to deal with the additional fears of the nurses for the repercussions of his mother's hastened death. In the chapter titled "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide," authors

Timothy E. Quill, Christine K. Cassel, and Diane E. Meier write, “One of medicine’s most important purposes is to allow hopelessly ill people to die with as much comfort, control and dignity as possible” (Quill, Cassel & Meier, 2005). One way to remedy the issue is to remove the criminality associated with voluntary euthanasia and assisted suicides when a patient’s health is in this dire of a condition and their wishes have been made known during a time of mental competency.

In his essay, “Why I believe in Voluntary Euthanasia and Assisted Suicide,” terminally ill patient Derek Humphry writes, “I have struggled for twenty years to popularize the term ‘self-deliverance’ but it is an uphill battle with a news media which is in love with the words ‘assisted suicide’ and suicide. They are headline grabbers” (1). The negative connotation connected with the term suicide leaves little to no compassion for the act. The word suicide often brings to mind visions of hangings, gunshot and knife wounds, and unstable mental conditions. Could the words self-deliverance offer up a softer, more compassionate view in today’s society? If it could, and if the current laws change so that self-deliverance is legal, the impact could be enormous on society in general but with the baby boomer generation in particular. This generation is known to be in the forefront of overseeing that their wants and desires are fulfilled. They are known to be a generation, which controls the direction of their lives. Why would this pattern all of a sudden end when it comes to how they handle their deaths? Financially, many of these boomers may find it impossible or even inconceivable to finance staggering amounts of money into an ending of life with zero quality. Legalization would lift tremendous burden, suffering, and pain off the shoulders of physicians and family members, and especially those who are the true sufferers, those who in those fleeting moments of clarity are reaching out and begging for mercy and an end to the misery, the patients.

Currently the states of Washington, Oregon and Montana in America and countries like the Netherlands, Switzerland, and Germany allow assisted self-deliverance. The right-to-die movement is showing great momentum in its quest to legalize strictly monitored self-deliverance. This issue will remain controversial with heated debates surrounding it. It is not the right of a society to tell a patient their appropriate length and level of suffering. The decision for self-deliverance, if chosen, should be a well-contemplated, educated decision made between patient and physician on a case-by-case basis without fear of criminal action.

As a modern society, many cannot fathom the thought of watching an animal suffer in pain and oftentimes will recommend euthanasia, without hesitation, to end its agony. Yet, in the same breath, these very individuals will inflict incredible guilt, shame, accusations of selfishness and negativity on a human being who is suffering and considering the act of self-deliverance. Euthanasia is not a choice agreed upon by everyone. However, it should be the constitutional right of mentally competent, terminally ill, zero quality of life patients to make that choice if desired and to be supported in a kind and loving manner.

With millions of boomers beginning to reach old age, this is an issue that many people, whether they wish to or not and whether directly or not, may have to face in some way, shape, or form in the near future. Becoming knowledgeable of that, which is unfamiliar, generally helps to ease the anxiety of such uncomfortable issues, enabling a pathway for clear thinking and rational decisions. By delving into clearly defining what is and what is not a qualifying self-deliverance situation, and openly providing both sides of the issues with their legitimate points and counterpoints for further discussion, this paper attempts to contribute to the relevant sociological literature and overall understanding of the human social life.

Bibliography

Concerns. (2013). Retrieved from Euthenasia Prevention Coalition: http://www.epcc.ca/about-us/concerns/

Cauthen, K. (2001). *The ethics of belief: A bio-historical approach vol. ii: Application.* Lima: CSS Publishing Company, Inc.

Foley, K., & Hendin, H. (2002). *The case against assisted suicide: For the right to end-of-life care.* Baltimore: The Johns Hopkins University Press.

Hendin, H. (2004, June 26). *Suicide and the request for assisted suicide: Meaning and motivation*. Retrieved from http://www.nightingalealliance.org/cgi-bin/home.pl?article=185

Humphry, D. (2010, August 30). *Why I believe in voluntary euthanasia and assisted suicide*. Retrieved from Euthanasia Research & Guidance Organization: http://www.finalexit.org/essay_why_i_believe.html

Meier, M.D., D., Emmons, Ph.D., C., Wallerstein, Ph.D., S., Quill, M.D., T., Morrison, M.D., R. & Cassel, M.D., C. (1998, April 23). A national survey of physician-assisted suicide and euthanasia in the united states. *The New England journal of medicine*, (338), 1193-1201. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJM199804233381706

Smith, T. (2013, April 28). Interview by CM Merrick-Gharib. Assisted suicide experience.

Quill, T., Cassel, C., & Meier, D. (2005). Care of the hopelessly ill: Proposed clinical criteria for physician-assisted suicide. In J. Monagle & D. Thomasma (Eds.), *Health care ethics: Critical issues for the 21st century* (1 ed., Vol. 1, p. 295). Retrieved from http://books.google.com/books?id=mjqryswV1D4C&pg=PA295&lpg=PA295&dq=one of medicines most important purposes is to allow hopelessly ill people&source=bl&ots=QkBKRbWReC&sig=0nb3mQKLIZw7eLdOqmwLkJDbeJw&hl=en&sa=X&ei=B1GIUamhCqO-yQGeyoDoBQ&ved=0CC0Q6AEwAA