

Assisted Suicide and the Corruption of Palliative Care



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For the past two decades, euthanasia/assisted-suicide ideologues have worked overtime to conflate palliative care—the medical alleviation of pain and other distressing symptoms of serious illness—with intentionally ending the life of the patient. The movement’s first target was the hospice, a specialized form of care for the dying created forty years ago in the United Kingdom by the late, great medical humanitarian Dame Cicely Saunders. Determined to treat what she called the “total pain” of dying patients, Saunders’ great innovation was to bring a multidisciplinary team to the task of ensuring that their physical pain, existential suffering, spiritual needs, and mental health are all properly attended.

Saunders believed that suicide prevention, when needed, is an essential part of the package, crucial to fulfilling a hospice’s call to value the lives and intrinsic dignity of each patient until the moment of natural death. Indeed, when I was trained as a hospice volunteer, my instructor pounded into my head the importance of reporting to the hospice team any suicide threats or yearnings my patient might express so they could initiate proper intervention. As a consequence of this philosophy, many patients who might have killed themselves were later very glad still to be alive to get the most of the time they had remaining.

But assisted-suicide advocates wish to transform hospice into “hemlock” (as one advocate once put it), a facilitator of suicide rather than a preventer. They believe that access to lethal prescriptions should be considered merely another menu item available for dying patients (and ultimately others) “to control the timing and manner of their deaths.”

Toward this end, advocates often point to a statistic involving assisted-suicide deaths in Oregon. According to the state, approximately 86 percent of people who died by swallowing poisonous overdoses under the Oregon law were receiving hospice care at the time they committed assisted suicide. Promoters of such “aid in dying” claim that this proves dying patients need the additional choice of a lethal prescription to ensure a “good death” if hospice care does not suffice.

But there is another way to look at it. What advocates don’t mention—and this is an issue about which the state bureaucrats seem utterly indifferent—is that most of Oregon’s assisted suicides were facilitated in some way by people affiliated with the assisted-suicide advocacy group Compassion and Choices (formerly the Hemlock Society), either

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as end-of-life “counselors” or as prescribing doctors after the patient’s own physician refused to write a lethal prescription. This means that the patients in the hospice who committed assisted suicide under Oregon’s law most likely did not receive suicide prevention—either because the hospice team was not alerted to their patient’s suicidal desire or perhaps the Oregon law has effectively short-circuited the prevention response by hospice professionals. In other words, rather than showing the need to expand hospice “services,” Oregon demonstrates how assisted suicide actually interferes with the proper delivery of hospice services—at least as the hospice was envisioned by Saunders.

If undercutting proper hospice medical prac-

tice were not bad enough, now assisted-suicide advocates have launched an effort to Shanghai an important but rarely needed method of end-of-life pain and symptom control known as “palliative sedation” into the assisted-suicide cause. Palliative sedation offers relief for the very few cases in which either agonizing pain or other symptoms such as severe agitation cannot be alleviated through more conventional medical methods at the very end of life. In such cases, the patient is placed into a drug-induced coma until death comes from the underlying disease.

But assisted-suicide advocates want to give patients a right to demand palliative sedation whether they actually need it or not. In California, for example, Assembly members Patti Berg (D–Mill Valley) and Lloyd Levine (D–Van Nuys)—who have tried for years without success to pass an Oregon-style assisted-suicide law through the California legislature and are soon to be term-limited out of office—have sponsored AB 2747, a bill to establish the legal right of dying patients to demand palliative sedation and then refuse medically supplied sustenance so they dehydrate to death.

The effect of the bill would be insidious. If AB 2747 becomes law, doctors would be required to facilitate death by dehydration on demand for terminally ill patients—and this “treatment” would not be reserved only for those at the very end of life, since the bill defines terminal illness as having one year or less to live. Moreover, if the doctor believes that palliative sedation is medically unnecessary and/or believes it to be ethically wrong under the circumstances, he or she would still be legally required to be complicit in the patient’s dehydration death under the requirement that refusing doctors refer a requesting patient to another doctor willing to go along.

Anyone who cares about the proper practice of medicine should be up in arms about the assisted-suicide movement’s attempt to make hospice and palliative sedation stalking horses for backdoor assisted suicide. Not only

do such schemes subvert medicine by transforming legitimate medical interventions into life-terminating protocols, but proposals such as AB 2747 effectively deprofessionalize medical practice by reducing physicians to mere order-takers. Alas, this is par for the course for a movement obsessed with transforming killing into a legitimate answer to the problems of human suffering.

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