Physician Involvement in Life-Ending Practices

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I. INTRODUCTION

Physician-assisted suicide[1] and euthanasia[2] are acts that explicitly and overtly involve physicians in determining the mode and time of their patients' deaths. Understandably, therefore, these aid-in-dying acts raise concern and apprehension among physicians who would be involved. Although our means of dealing with these practices through our legal system affect all of society, the attitudes of physicians, as designated executors of these acts, are central to ultimate social policy.

The public debate over physician-assisted suicide and euthanasia is by no means limited to or even directed by physicians, but I shall restrict the analysis in this Article to examining physicians' practices and attitudes on the subject. Historically and currently, physicians publicly oppose policies in which they are seen as agents of dying, yet they are deeply involved as agents of dying in ways that do not appear to associate them with the acts or to violate the dictum of "do not kill."

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1. Physician makes drug available but patient administers it to self.

2. Direct physician administration of a lethal drug. The term euthanasia has variable definitions, and frequently is modified as voluntary or involuntary, active or passive. Voluntary euthanasia is euthanasia provided to a competent person on his or her informed consent. Nonvoluntary euthanasia is the provision of euthanasia to an incompetent person without his or her consent according to a surrogate's decision. Active euthanasia implies the direct administration of a lethal agent by a physician, whereas passive euthanasia has been used to describe withholding or withdrawing life-sustaining treatment, or the administration of a drug such as morphine which may have the double effect of pain relief as well as causing death. American Medical Association Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229 (1992).

In the American Medical Association report, the word euthanasia means voluntary, active euthanasia only, and assisted suicide means that a physician facilitates a patient's death by providing the necessary means to enable the patient to perform the life-ending act. Aid-in-dying is a general term covering all physician acts that lead to or hasten the death of the patient, and includes euthanasia, physician-assisted suicide, the double effect of death as a consequence of a drug given to relieve suffering, and withdrawal of life-sustaining therapy.

The Hippocratic Oath is best known for the phrase "I will give no deadly medicine to anyone if asked, nor suggest any such counsel."[3] This is the historical root of the admonition against euthanasia, although the majority of physicians of Hippocrates' era thought assisted dying helped, or at least did not harm, their patients.[4] On the surface, the dictum is simple and reasonable, in keeping with the general societal prohibition against killing.

How does the dictum fit contemporary life as a basis for medical policy? This depends on the context or purpose of a physician's use of a deadly drug. In the time of Hippocrates, physicians had no drugs of therapeutic efficacy by present standards, but they did have poisons which were sometimes used on non-dying patients for mischievous purposes.[5] In this context, the Hippocratic injunction against the use of deadly drugs was good public relations for the medical guild, and had nothing to do with terminally-ill patients.

The medical prohibition against euthanasia took hold in the early Christian era, consistent with the church's teaching against killing, and in concert with the developing concept of salvation through suffering. Although euthanasia undoubtedly has occurred over the centuries, there was until very recent times no serious objection to, nor open defiance of, the dictum which presumably has served both the profession and society well.

Why should the dictum now come under challenge? The context in which physicians might end patients' lives has changed. Hippocrates never had a patient on a ventilator. As recently as about thirty years ago no physician had a patient with recurrence of leukemia after bone marrow transplantation.[6] Modern medicine has changed the context in which patients now die, from one of natural death with relative impotence of physicians to change the course of dying, to medical prolongation of life resulting in different and unnatural forms of dying. The injunction against lethal drugs in the old context of dying remains valid, but we rightly should reassess it in the context of modern forms of dying.

This Article explains that we need to acknowledge physicians' widespread involvement in ending patients' lives by a variety of means,

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3. The Hippocratic Oath, *in* 12 COLLIER'S ENCYCLOPEDIA 138 (1991).

4. Darrel W. Amundsen, *The Physician's Obligation to Prolong Life: A Medical Duty Without Classical Roots*, HASTINGS CTR. REP., Aug., 1978, at 24.

5. See Thomas A. Preston, *Professional Norms and Physician Attitudes Toward Euthanasia*, 22 J.L. MED. & ETHICS 36, 38 (1994).

6. Based upon the fact that bone marrow transplants were first performed about 25 years ago.

from withdrawal of life-sustaining treatment to euthanasia. Our inquiry should move from appearance and professional acceptance of practices to the conditions under which society allows physicians to be involved in ending patients' lives.

II. KILLING

Physicians who oppose assisted suicide or euthanasia commonly label these acts as "killing," and therefore as contrary to the perceived proper role of physicians as healers.[7] They further argue that withdrawal of life-sustaining treatment and the use of the double effect[8] constitute methods of "allowing the patient to die naturally," in contrast to the physician as the instrument of dying. In practice, however, commentators do not conform to the standard dictionary definition of "killing," or "to kill," but rather use, or avoid, the words so as to convey disapproval or approval of the act.

Lexicographers define "to kill" as "to deprive of life," but without condition.[9] "Kill" merely states the fact. Thus, one is killed by a falling tree, or by a stroke, or by a person. "To deprive of life" implies an act, or omission of a life-saving act, but makes no judgment as to whether the "killing" involves another person, is intended, desired or undesired, or accepted by the community. Nor does it take into account the viability of the person who dies. The word does not imply a wrongful act; it says only, "but for the act, the person would not have died."

The word "kill," as most use it, is too simplistic and quite inadequate to the task of defining physicians' practices in a fair, uniform, and enlightening manner through which we may advance our understanding of what clinical practices entail. However, language is crucial in shaping attitudes about end-of-life practices.[10] The words one uses to define a procedure may carry a formative value judgment. The use or avoidance of "kill" seems intended more to shape attitudes than to describe specific acts. If we are to use the word "kill" in

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7. *See, e.g.*, Willard Gaylin et al., *Doctors Must not Kill*, 259 JAMA 2139 (1988); Daniel Callahan, *"Aid-in-Dying": The Social Dimensions*, COMMONWEAL, Aug. 9, 1991, at 476-80; Daniel Callahan, *When Self-Determination Runs Amok*, HASTINGS CTR. REP., Mar.-Apr., 1992, at 52-55; Edmund D. Pelligrino, *Doctors Must not Kill*, 3 J. CLINICAL ETHICS 95, 95-102 (1992).

8. Double effect, for the purposes of this Article, refers to the administration of a drug that relieves pain but also hastens death.

9. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY, UNABRIDGED 1242 (3d ed. 1986).

10. Margaret P. Battin, *Assisted Suicide: Can We Learn from Germany?*, HASTINGS CTR. REP., Mar.-Apr., 1992, at 44-51.

describing practices, we must apply a uniform definition in assessing various end-of-life medical practices.

Physicians, for a variety of reasons, do not wish to be seen as agents of dying. This is understandable from the historical context, as in the days of Hippocrates, when a physician's mere presence with dying patients could be construed as the cause of death.[11] The ancient physicians in general did not attend to dying patients, realizing that in such cases they were powerless and their reputations could only be sullied by "the appearance of having killed one whose lot is but to die."[12]

Although the physicians of our grandparents' generation gave much comfort by attending the dying, contemporary physicians are seldom with the patient at the moment of death, which occurs most commonly in an institutional setting with the patient attended by nurses and multiple instruments of technology. Physicians prefer to heal, or to cure, and the modern physician in particular is not trained to step back and allow the patient to die, much less help in doing so.

Physicians see their role as healers, and to assist in dying is to be an anti-healer. This is, in part, an atavistic resort to the ageless claim of the omnipotence of the healer, any departure from which reduces the claim and therefore effectiveness and power of the healer. It is also in great part professionally difficult to think otherwise. The contemporary physician, trained to eke out another month or so of life for the dying patient, and use every weapon to wage unceasing war against death and disease, cannot without great cognitive dissonance reverse roles and hasten the triumph of death. Quite aside from the oft-expressed fear of loss of public trust by not trying to heal to the very end, of perhaps even greater concern to physicians is the perception of loss of professional standing if seen by other physicians as not pursuing all means of healing at professional disposal. Professional standing is likely affected by the traditional role of the physician, which gives strong interdiction against any appearance of involvement in dying because it is contrary to the notion of being a healer.

In light of the linguistic potential to frame meaning to suit personal and professional beliefs, it is important to examine contemporary physicians' roles in ending the lives of their patients. Virtually all physicians are, by various ways and means, involved in the mode and time of their patients' dying. The proposition that physicians do not

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11. *See* Amundsen, *supra* note 4, at 25 (noting that reputation was the primary reason for physicians' refusal to treat terminally ill patients).

12. *Id.*

hasten their patients' dying, or do not kill, strictly speaking, is not tenable.

III. DO NOT RESUSCITATE

The first instance of a widespread clinical practice that determined the time and mode of death of patients arose about fifteen years ago in "do not resuscitate" orders, or DNR orders. Some decried the orders as "killing," and physicians faced possible prosecution for the failure to resuscitate a terminally-ill patient in whom short-term technical success was possible.[13]

Such an omission of an act or therapy that probably would prolong life constitutes killing in the narrow sense. The 1983 President's Commission for the Study of Ethical Problems in Medicine addressed the effect of a physician who knows he or she has the ability and opportunity to prevent the patient from dying but refrains from doing so: "It can be said that the deceased would not have died as and when he or she did had the person responsible not acted in the way he or she did. For death to be killing by another, that other's action must have changed the cause of the person's death, or have hastened the moment of death, or both."[14]

By the strictest reading, DNR may be interpreted as killing, but this use of the word is inappropriate by present medical, legal and societal standards. Our use of "killing" with regard to DNR changed, not because we physicians changed our understanding of the fundamental nature or definition of killing, but because we reinterpreted the meaning of not resuscitating a patient in the throes of dying when to do so would be futile. In the narrow sense we physicians "kill," but two principles lead us to reject the common, negative use of the word: First, we do not harm a patient who is doomed to die even if resuscitated, and second, we do not deprive life from a patient who is doomed to die, except for a few extra days or weeks of suffering. For the physician who manages the end of life in this manner there is causality, but not culpability. The word kill, with its negative connotation, does not fit.

However, through the decision of DNR, the physician has become involved in the time and mode of dying. The changing perception of the propriety or moral worth of this form of physician *involvement* with

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13. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 238-39 (1983).

14. *Id.* at 65 n.75.

dying is what first engendered and later caused rejection of the use of the word "kill" to describe it. Initially, commentators focused on the isolated act, which fits the definition of "to kill," precisely because the physician's involvement at the time of death was evident. But this connection with dying was unacceptable to physicians. After the practice was redefined as "allowing the patient to die naturally," physicians could engage in it without the appearance of causation in the deaths of their patients.

IV. WITHDRAWAL OF LIFE-SUSTAINING TREATMENT

Withdrawal of life-sustaining treatment takes a step beyond passive refusal to sustain life, to an act that in all likelihood causes death to ensue. Although there was never specific legislation making this practice unlawful, many physicians and ethicists considered it unlawful until the development of the patient's constitutional right to privacy and the enactment of natural death legislation began some two decades ago.[15]

Withdrawal of therapy for a patient who is not terminally ill, but who is in a persistent vegetative state, was widely challenged on ethical and legal grounds, and was characterized as killing by the Supreme Court in *Cruzan v. Director, Missouri Department of Health*.[16] In another case, a majority of the justices on the Washington State Supreme Court characterized withdrawal of artificial nutrition and hydration as "euthanasia" or "mercy killing," clearly recognizing that withdrawal causes death.[17] Regardless of intent or propriety, the act deprives a person of life, and so constitutes killing, but not murder.

If a relative of a patient who is terminally ill and begging to die entered a hospital and disconnected the patient from a ventilator, we would surely call it killing. Yet, the motives, purposes, and act of the person are identical to those of a physician who does the same thing. The only difference is licensure, which absolves the physician but not the relative. Licensure can and should certify the physician to perform the act under protection of the law, but the act, not the license, defines

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15. Lawrence O. Gostin, *Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying*, 21 J.L. MED. & ETHICS 94, 98 (1993).

16. 497 U.S. 261, 267-68 (1990) ("All agree that such a removal [of life support] would cause . . . death.").

17. *In re* Guardianship of Grant, 109 Wash. 2d 570, 575-76, 747 P.2d 445, 458, 463 (1987) (Andersen, J., concurring in part and dissenting in part; Goodloe, J., dissenting), *corrected*, 757 P.2d 534 (1988). *See also* Aukland Area Health Board v. Attorney General, 1993 N.Z.L.R. 235, in which a New Zealand judge declined to adopt the view that the acceptability of withdrawing a life-sustaining ventilator in a particular case means that this act is not a cause of death.

killing. The physician has deprived of life, has killed, no less than has the relative.[18]

But the negative connotation of "kill" as synonymous with "murder" is inadequate to describe the withdrawal of life-sustaining treatment, and we physicians seek redress by viewing the act, or the physician's involvement, in a different context. As we physicians have learned to put it, "Not the physician, but the underlying fatal illness becomes the true cause of death."[19] This shifts the focus of killing, and therefore responsibility, away from the physician. A medical ethicist noted, "Some ethicists and many physicians were once reluctant to turn off respirators and stop tube feeding because they mistakenly felt that they would thus be killing patients. I think they came to see that nature, not them, would be doing the killing."[20]

The underlying disease *is* the cause of death. However, the doctor's act is the proximate cause of the patient's dying. The doctor has killed by his act. It is not, however, a harmful or unjustified killing,[21] and it is not murder. The problem is with the word. However, denial of the act as killing screens us from a full understanding of physicians' involvement in the times and modes of their patients' deaths. We physicians refuse to acknowledge medical killing because of the connotation of culpability, but in so doing we deny causality as well. We physicians can not affix moral responsibility for clinical practices if we can not acknowledge our causal roles in them.

Physicians further dissociate from the act of withdrawal of life-sustaining treatment by saying the physician merely "allows the patient to die." This is a descriptive phrase used to connote professional and societal approval of a form of dying,[22] and suggests that the physician was not involved in the act. However, to suggest that the physician merely allows the patient to die is incorrect for two reasons. First, the presence of life-sustaining treatment that can be withdrawn demonstrates exactly that at some prior time the physician did *not* "allow the patient to die." The phrase "allowing to die" is therefore used selectively to indicate non-involvement of the physician, when in fact

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18. Dan W. Brock, *Voluntary Active Euthanasia*, HASTINGS CTR. REP., Mar.-Apr., 1992, at 10, 12-13 (discussing the example of a greedy relative who, for financial reasons, wishes the patient to die).

19. Leon R. Kass, *Why Doctors Must Not Kill*, COMMONWEAL, Aug. 9, 1991, at 475.

20. Confidential communication to the author by a medical ethicist.

21. Erich H. Loewy, *Healing and Killing, Harming and Not Harming: Physician Participation in Euthanasia and Capital Punishment*, 3 J. CLINICAL ETHICS 29-34 (1993).

22. *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 64 (1983).

the physician has chosen the time and mode of her patient's death after previous use of life-sustaining acts that did not to allow the patient to die naturally. Only if the physician has never prolonged life during a given patient's terminal illness can she say the patient has been "allowed to die."

The second incorrect reason given in support of "allowing to die" is the use of intent. Kass argues that " . . . in ceasing treatment the physician need not intend the death of the patient, even when the death follows as a result of his omission."[23] This is a considerable linguistic liberty. In virtually every case the physician withdraws life-sustaining therapy in expectation of the patient dying sooner than would otherwise happen. If the intent were to sustain life, there would be no withdrawal of life-sustaining treatment. The distinction between "killing" and "allowing to die" is meaningless from a volitional standpoint. There is clear evidence of intent to end life in the increasingly common practice of inducing barbiturate anesthesia prior to turning off a respirator, and maintaining the anesthesia until the patient dies. This humane practice spares the patient the agony of suffocation by breathlessness, but the practice virtually ensures death. Whatever the stated intention, the outcome is death of the patient. We obscure the physician's involvement by allowing her to proclaim a different intent.

How we physicians may state or cloak our multiple intentions does not absolve us from involvement in ending life. Nevertheless, the word "kill" is inadequate and inappropriate. We do not harm, and we do not "deprive of life" when life is virtually gone and soon to end. There is causality but not culpability. It is not enough to say a clinical act is or is not killing. We must begin to develop language focusing on the *nature* of the physician's involvement and moral responsibility.

V. THE DOUBLE EFFECT

Under the doctrine of the "double effect," acceptable to church, state, and the medical profession, the physician "intends" to relieve pain by administration of drugs, a consequence of which may well be death. Because the stated intention is not to "kill," we abjure the use of the word in describing the act. This is clearly incorrect linguistically, because, by definition, "kill" is neutral with regard to intent. Moreover, causality is even more direct than in withdrawal of life-

23. *See* Kass, *supra* note 19, at 475.

sustaining treatment. The administration of the drug directly determines the mode and time of dying, regardless of stated intent.

Physicians may say the intent is only to relieve pain, but in most instances, they know the inevitable result is death. The very name of the act implies two effects, and, with uncommon exceptions, physicians who use the method do so with the expectation of both effects. A physician who does not want the patient to die, or who wishes to preserve life using available medical means, will never embark on the double effect. Physicians do what they do because they know what will happen. If a physician knows with a high degree of probability that an act will result in death, the physician who performs that act intends the death, regardless of a stated primary intent to relieve pain. Nevertheless, the linguistic liberty of defining the act by the stated intent to relieve pain allows the act to proceed as a normal medical practice, and isolates the physician from the consequences of the act.

Under the penumbra of the double effect, physicians perform the equivalent of slow euthanasia at home, or in a hospital or hospice. Methods vary, but to be acceptable, the act must extend long enough to preclude the appearance of direct euthanasia. One oncologist tells her patients who ask to die, "I will do it for you, but you must go into the hospital, and it will take four or five days."[24]

Some physicians administer continuous barbiturate anesthesia "for relief of pain," and then allow the unconscious patient to die from starvation and dehydration.[25] By this technique the physician reasons that the intention was to relieve pain, and the consequences of death, although foreseen, was not intended. If the patient pleads for "relief from this terrible pain," the physician feels comfortable "treating the pain" with high doses of morphine even though she knows death will ensue through the double effect. If, however, the patient is ingenuous enough to say "Please take me out of my misery, give me enough morphine to make me die," the physician cannot grant the wish by using the same amount of morphine because of the stated intention to produce death.

Patient and doctor must weave a web of remote probabilities and unspoken secondary intentions—the surest way of screening themselves from the truth. The legality and perceived non-culpability of the double effect rest with the physician's pronouncement of intent to relieve pain, and skirt the issue of causing death. The result is no

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24. Confidential communication to the author by a patient.

25. *See* Robert D. Truog et. al., *Barbiturates in the Care of the Terminally Ill*, 327 NEW ENG. J. MED. 1678 (1992).

professional accountability for the second of the two effects, i.e. dying. No patient ever signs an informed consent for this treatment, although nothing could have more profound consequences. All those associated with this form of slow euthanasia accept it because by proclamation the physician is not involved.

Clearly, the double effect is killing in the narrow sense, and we must acknowledge this; but if done with consent of the patient it is not killing in the more common, negative sense? Is it murder? No. It is a humane and morally acceptable means of relief of suffering. If the patient is terminal and further medical treatment can not extend life, the physician does not harm and does not deprive of meaningful life by the act. The physician is directly involved in the time and mode of the patient's death, but it is the disease that deprives life.[26]

VI. PHYSICIAN AID-IN-DYING

Whether assisted suicide qualifies as "killing" by the dictionary definition hinges on one's perception of the degree of involvement of the person, physician or otherwise, who assists the person committing suicide. By the narrow interpretation, the physician who prescribes lethal drugs but does not administer them, has not killed. Unlike the double effect, in suicide the physician may make the means available, but the patient kills himself. Precisely because the physician does not kill, and because we linguistically confine ourselves to "kill" or "not kill" in assessing the act, acceptance of assisted suicide is greater than for euthanasia, although physician involvement and intent are similar. Opponents of assisted suicide deem it killing for rhetorical purposes, but the physician who assists in suicide does not kill. However, the physician's involvement in the death of her patient makes causality and moral responsibility no less than with the double effect, in which act she does kill. Direct, active euthanasia, a quicker form of the double effect in which intent is unambiguous, is also killing in the narrow sense.

In the ongoing debate over the place of aid-in-dying in clinical medicine, we are really debating whether these practices are morally acceptable and desirable, for individuals and for society. Assisted suicide and euthanasia have important legal and practical differences, but for purposes of examining how these two practices fit into modern clinical medicine, let us consider them as a unit: physician aid-in-

26. *See* Howard Brody, *Causing, Intending, and Assisting Death*, 4 J. CLINICAL ETHICS 112 (1993).

dying. Through both practices physicians would be actively involved in terminating the lives of terminally-ill patients.

The debate over the acceptability of physician aid-in-dying is mistakenly addressed to the isolated acts, and not to the acts as they fit into the context of clinical medicine. We must first recognize physicians' present near-universal involvement in currently acceptable practices that define mode and time of dying. But what of physician aid-in-dying? We must view this also in the context of the physician's total involvement with the patient. Let us take a not-totally-hypothetical example.

A newborn baby has a complicated and fatal malformation and is being kept alive on a ventilator. An operation to correct the defect carries a ten to twenty percent chance of success, but also carries a substantial risk of permanent brain damage or lingering dying over months or years if the operation is only partially successful. The parents and the baby's physicians face the dilemma of uncertainty. They may say the chance of success is too slim and the probability of prolonged suffering too great, and so opt to let the baby die slowly, a medically and morally acceptable decision.

But suppose they say, "Why should we not give the baby the small chance of survival with reasonable quality of life, and if it doesn't work, if after surgery the baby faces no chance of meaningful survival and interminable suffering, we will then provide means for it to die." The moral basis of killing if surgery creates a life of suffering is posited on prior intervention so as not to "allow to die." It is a conditional intervention, and parents and doctors say, in effect, "We will intervene to prolong life only if we are allowed to terminate life if the intervention does not succeed." In this case, is physician aid-in-dying after "unnatural" prolongation of life morally wrong? Is it morally responsible to say the baby's physicians may intervene to prolong life, but they may not intervene a second time to correct harm done by the first intervention?

Examples abound in medicine of physician involvement that unnaturally leads to prolongation of life and suffering. Consider the case of Dr. Timothy Quill's patient Diane, who suffered from acute myelomonocytic leukemia.[27] Before Diane committed suicide with her physician's help, she faced a dilemma of modern clinical medicine. Her physician offered her extensive chemotherapy followed by a bone marrow transplant, with a twenty percent likelihood of long-term

27. Timothy E. Quill, *Death and Dignity—A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991).

survival. Diane's decision to forego this treatment disturbed Dr. Quill, because, although the odds were against her, she might have made it. But Diane made her choice because she knew that the treatment, likely to fail, would bring her and her family further suffering.

Suppose Diane and Dr. Quill had been able to say, "We will proceed with therapy, and if it works, fine, but if at any point along the way failure becomes certain, we will end it all." If, after failure of heroic intervention, after technological extension of life far beyond "allowing to die," Diane and Dr. Quill then choose aid-in-dying, would this be morally reprehensible? Has the physician harmed the patient by consensually extending life to optimal benefit, and then terminating it? Should we say the doctor "killed" the patient after all that?

I believe not. Is it not, as is the case in withdrawal of life-sustaining treatment, the underlying disease that deprived of life, or killed Diane in the end? Moral responsibility begins with the first intervention that prolongs and also changes life and therefore the parameters of dying. Subsequent acts become morally explicable in the context of the physician's total involvement in the care of the patient. The hubris of the physician begins with the first clinical act; it is not isolated to the last one.

Moreover, in both the above examples the physicians' first acts were not the dramatic high-tech operations, but more ordinary life-sustaining therapies, a ventilator for the baby and antibiotics and transfusions for Diane. Today, whether by intravenous feeding or by multiple-organ transplant, almost all patients who die under the care of a physician have at one or many times not been "allowed to die." Approximately eighty percent of annual deaths in the United States occur in health care facilities, and roughly seventy percent of these deaths are medically managed.[28] Most persons in the late stages of dying are in their particular conditions exactly because of medical intervention. The bed-ridden patient with amyotrophic lateral sclerosis, the emaciated cancer patient with multiple drugs and oxygen therapy, the patient with heart failure who is too weak to get out of bed and must sleep sitting up—all have been guided into unnatural conditions by their physicians.

Physicians are not exclusively healers, despite their longings to be so. All physicians are directly and inextricably involved in the time and manner of their patients' dying. Our successes produce the predicaments of dying. Moral assessment of the terminal act of

28. Leon R. Kass, *Is There a Right to Die?* HASTINGS CTR. REP., Jan.-Feb., 1993, at 34.

physician involvement in dying, in isolation from other acts, is medically and ethically incorrect, *for it denies moral responsibility for what has gone before it.* A physician's involvement in a patient's mode and time of dying is an outgrowth and requirement of technological extension of life, and we should judge it in the context of all interventions during the terminal illness.

We need a new moral measure by which to judge the life-ending practices of physicians. The physician who prolongs her patient's life, but who then aids in the patient's request to die, has not violated the Hippocratic injunction, and in fact has fulfilled the physician's duty to heal so far as is reasonable without producing harm. Furthermore, the state's interest in preserving life is served by the physician who first gives a longer-than-natural life and subsequently aids the patient in dying after meaningful life is over.

Whether we assist a patient in dying by withdrawal of life-sustaining treatment, by the double effect, by assisted suicide, or by euthanasia, we are involved in ending life. Culpability is in the mind of the observer. Causality is present and we "deprive of life" in all four practices, and so the term "kill" is narrowly correct for all these practices. However, in the view of the patients who consent to any of them, we do not harm, and the use of the word kill to negatively define these acts is incorrect and counter-productive unless the act constitutes murder.

VII. CONCLUSIONS

Traditionally, physicians have never acknowledged explicit involvement in the deaths of their patients. For psychological, symbolic, and professional reasons, they prefer to dissociate themselves from the deaths of patients by pronouncement of a different intent and by shifting causality to "allowing to die" from underlying diseases, rather than by confronting their contributions to time and mode of death. Professional "ethics" will not let us be close enough to our patients to say honestly what we are doing, which, in turn, supports an ethos under which practices are profession-based rather than patient-based. Physicians are willing to engage in life-ending practices that do not appear to be causal, but commonly refuse to engage in life-ending practices that are apparent as such. Physicians thereby continue their traditional denial of death by denying association with the cause of it.

This inability to acknowledge participation in end-of-life acts precludes an understanding of these practices and prevents development of suitable descriptive language. We need better linguistic expressions than "kill" or "not killing" for thinking about and

experiencing the physician's involvement in dying and whether this involvement is morally responsible to the individual patient and to the community at large. There is a vast difference between "depriving of life" one who is healthy and not dying, and one who can only suffer for the short time left until inevitable death from incurable illness. Physicians are involved in ending patients' lives by a variety of means. However, the inquiry to date has centered on the appearance and professional acceptance of physician practices. This inquiry should now move to the conditions under which physicians can be involved in ending patients' lives. We must examine the circumstances of dying patients who have had medical prolongation of life beyond the point of natural death but for whom there is no further curative treatment. We must also examine the related questions of appropriateness of physician aid-in-dying and state interest in maintaining the lives of such patients.