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Introduction

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The Hippocratic Oath and the tradition surrounding it served mankind well for several millennia and became the medical ethics and value system that has made western medicine the art that it is. Recently, however, since World War II, this noble tradition has been eroded by a new ethic.

A lot has changed in medicine since the Hippocratic Oath was first taken. Some things, however, have remained the same; or, more accurately, some things have come full circle. The function of the Hippocratic Oath is the same in today's society as it was when it was first spoken. The Oath calls physicians to a higher ethical standard than that of society in general.

The portions of the Hippocratic Oath applicable to this collection of papers are very clear. The Oath could be paraphrased:

> I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them. I will not give poison to anyone though asked to do so, nor will I suggest such a plan . . . . In purity and in holiness I will guard my life and my art.
>
> Into whatsoever house I enter, I will do so to help the sick, keeping myself free from all intentional wrong-doing and harm . . . .
>
> Whatsoever in the course of practice I see or hear . . . what ought never to be published abroad, I will not divulge, but consider such things to be holy secrets.

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In the society that produced the Hippocratic Oath, the lines between physician, witchdoctor and magician had become blurred as had the line between physician and executioner. The laws of the society in which the first Hippocratic physicians took the oath allowed physicians to kill, perform abortions and to abuse the privacy of the doctor-patient relationship.

The Oath called upon physicians to commit themselves to a higher ethical standard. The physicians were not called upon, however, to change the laws of society. The relevant portion of the Oath states:

> I [that is, one of the school of Hippocrates], am above such things. Though others who call themselves physicians do these things, I will not. You can count on my being a responsible physician.

Although not included in the Oath, the promise to do no harm, *Primum Non Nocere*, is irrevocably bound to the Hippocratic principle of the sanctity of human life and proscribes abortion, infanticide, and euthanasia for the Hippocratic physician.

Notably, the prohibition against physician-assisted suicide, "I will not give poison to anyone, though asked to do so, nor will I assist such a plan," arose in an era when the alternatives of pharmacological pain-killing drugs and hospice care were not available.

The Hippocratic Oath's unique and pivotal role in this culture has been observed by Margaret Mead, the late, great cultural anthropologist. Noting that the Oath marked a turning point in the development of this culture, Mead stated:

> For the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world the doctor and the sorcerer tended to be the same person. He with the power to kill had the power to cure. . . . He who had power to cure would necessarily also be able to kill.
>
> With the Greeks, the distinction was made clear. One profession . . . [was] to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect — the life of a slave, the life of the emperor, the life of a foreign man, the life of a defective child . . . .
>
> But society always is attempting to make the physician into a killer — to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient . . . .

After Hippocrates, however, killing and healing parted company. Yet, there are, once again, individuals foolishly attempting to force them together.

The Hippocratic Oath has kept physicians on the right course for more than two thousand years. The Hippocratic teaching affirming that physicians will *never* be involved in the killing of patients should not, therefore, be abandoned. To paraphrase, again, a relevant portion of the Oath, "[o]thers who call them-

selves physicians may suggest and do these things, but as for us, we are above such things and can be trusted to do no harm."

Any euthanasia discussion quickly leads to the consistent depiction of terminally ill patients in severe pain and the notion that, as a result of this pain, the patients should always be put out of their misery. Recently, however, pain as the basis for seeking death has been replaced by not wanting to go through a dying process, not wanting to die of one's diagnosis. Assisted suicide, indeed, has become the ultimate treatment for depression.

The most extreme step, advocated by more and more individuals, is to help these patients by killing them, either through *voluntary* euthanasia, *non-voluntary* euthanasia (without the patient's consent, but with the consent of a competent surrogate) or *involuntary* euthanasia (with no consent except the doctor's decision). The patient could also be aided by the physician in committing suicide, or the physician could stand back at an appropriate time and let nature take its course while making the comfort of the patient the highest priority.

Of this list of possibilities, this writer could only do the last.

It is true that there are times in difficult terminal cases that a physician must tilt the balance between a physician's two aims of saving life and alleviating suffering. There are times when increasing doses of morphine can be given to ease the pain, even with the knowledge that increasing the amount and frequency of the doses will hasten death. There is a great difference, however, between administering a dose of morphine to ease pain and administering a fatal dose of morphine to the patient. Physicians used to practice within the realm of trust between patient and physician. The physician's intent is what is important in this regard.

The intent behind the gradual increase of a pain killer is to keep the patient reasonably comfortable during the patient's remaining hours or days of life. The intent behind administering a fatal dose of a pain killer is to get the patient "out of misery", and off of one's hands by killing the patient as quickly as possible.

An increasing number of voices are calling for this approach through physician-assisted suicide or euthanasia. Yet, as ethicist Daniel Callahan of the Hastings Center says:

> People favorable to physician assisted suicide have not thought it through. They are captured by the argument of self-determination and have not begun to think about what are the implications for the medical profession or the potential for abuses.

There are two principles behind the demand for assisted suicide or euthanasia. First comes the ideal of patient autonomy or

rational self-determination, that each competent patient has the right to decide what treatment the patient wants even if it means a lethal injection. The second notion used to justify assisted suicide or euthanasia is its necessity to relieve suffering, that no patient should be required to suffer beyond that which the patient wishes to bear and can choose death as an escape from suffering.

These principles, however, fail to hold up to scrutiny and do not support each other. Despite the discussion about patient autonomy and patient rights, the doctor-patient relationship is inherently unequal. The patient is generally in a weakened and vulnerable state and the real power lies with the physician. That is why the three essential elements of the Hippocratic Oath, no breach of confidentiality, no sexual relations with patients, and no dispensing of deadly drugs, deal with the possible abuses of a physician's power.

To once again quote Daniel Callahan, "if the principal motive for the physician is relief from suffering, why ought self-determination be required? And why would the duty to relieve suffering not apply to the incompetent just as well as the competent?"

One of the papers in this collection describes the myth of the slippery slope. This author does believe in the slippery slope, as must any student of German history from World War I through the Holocaust. Daniel Callahan, certainly no doctrinaire pro-lifer, said "once the turn has been made down the road to euthanasia, it will turn into a convenient and commodious expressway." No competent individual would be safe from lethal injection if this theory is carried to its logical conclusion in the future climate of America health care with an aging population, spiraling costs, and an unwary public.

The disabled community, to the surprise of many, loves life and tries to live it to the full in spite of incapacity. Many disabled individuals are increasingly fearful that the proponents of assisted suicide will want them out of the way because of perceived disability, which those who support assisted suicide think should trigger the desire for release from a life those individuals would not want to tolerate.

Behind many arguments for assisted suicide lies a fuzzy notion of compassion. Compassion, however, may not always lead to good. Compassion for a family member, for example, has led many individuals to commit a felony. Compassion, therefore, must always pass through the filter of morality.

As Margaret Mead said shortly before her death, "We have come full circle from the pre-Hippocratic days. Once again, the

patient does not know whether the approaching physician is coming in the guise of healer or killer." How sad.

The Hippocratic Oath has been the most enduring ethical legacy of the practice of medicine, passed on from teacher to student, from physician to new physician and from generation to generation. Society will rue the day when it thought members of the medical profession could be killers as well as healers.

The articles that follow have been prepared by thoughtful men and women from throughout the nation and represent theological, legal, philosophical and medical disciplines. For a variety of reasons, yet with a united voice, the authors warn of the grave danger that will result to society from legalizing physician-assisted suicide.