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COMMENTARY

# Physician-Assisted Dying: The Antithesis of Medicine, Says Doc

Arthur L. Caplan, PhD; Farr A. Curlin, MD | March 02, 2017

**Editor's Note:** *Arthur Caplan, PhD, interviewed Farr Curlin, MD, as part of the Medscape video series Both Sides Now. Only a portion of Dr Curlin's interview could be included in the video because of time constraints. Here, we are posting the interview in its entirety. In recent weeks, we have posted interviews with other speakers in that video.*

**Arthur L. Caplan, PhD:** I want to welcome Farr Curlin, a physician and an expert in palliative care at Duke University. He is the Trent Professor of Medical Humanities and also works in the Center for Bioethics, Humanities, and the History of Medicine at Duke. He's certainly one of the nation's leading experts on end-of-life care and has done pioneering work in integrating theology and healthcare. Welcome, Farr.

**Farr A. Curlin, MD:** Thank you.

**Dr Caplan:** Let me begin by asking you a straightforward question: You've got a lot of experience in palliative care; what do you think is the key reason to oppose physician-assisted dying or physician-assisted suicide?

**Dr Curlin:** Art, the main reason physicians should oppose physician-assisted suicide is that assisted suicide directly contradicts the purpose of medicine. It directly contradicts physicians' long-standing profession, which is to maintain solidarity with those who are sick and debilitated. It's not just bad medicine; it's the antithesis of medicine.

**Dr Caplan:** How do you respond to those who say that part of their mission is to relieve suffering, that part of their mission as physicians is to listen to their patients? Let's presume that they are terminally ill. If they want assistance in dying, that is consistent with my ethical obligation to both relieve suffering and honor their wishes.

**Dr Curlin:** Relieving suffering is obviously an essential aspect of physicians' work. But if we have no other objective criteria to decide what suffering you're obligated to relieve and what suffering you're not, then there is literally no boundary on our use of medical technology to achieve things that people want. Whatever conditions that people suffer, they can ask that we take them away.

**Dr Caplan:** We have doctors contacting us with this kind of question. They say, "Certainly, we don't want to be involved with children or psychiatric patients, but at the far end of dying, there are people in the final throes of death. Their MS is overcoming them, their parkinsonism is overcoming them, and dying is imminent—not months, but days. Is there no relief, no mercy to be offered by hastening their death even at that point?

**Dr Curlin:** Art, patients in that situation are taken care of. Without ever making their death our goal, we can treat those symptoms with powerful medications, as much as they need to get the symptoms relieved, whether it's choking on their secretions or gasping for breath or being in pain. And if, as a side effect, the medication hastens their death, then of course, physicians can still do that. They've done that for centuries under what has been called "the rule of double effect." It has been an important heuristic for guiding us. We don't make the death a part of our plan. We make relief of those health-diminishing, health-crushing symptoms our goal, and we work toward it as hard as we need to in order to get it done.

**Dr Caplan:** So, just to be clear, you're willing to take the risk of bringing about death, but you're not willing to aim straight at bringing on death with these types of patients.

**Dr Curlin:** Absolutely. These are cases that make the point more clearly, but all of medicine requires taking on the risk of doing harm. It does not require intentionally doing harm.

**Dr Caplan:** Let me go to a tough personal question. Have any of your terminally ill patients approached you or made a request for assistance in dying?

**Dr Curlin:** I practice medicine in Illinois and in North Carolina. In neither state is assisted suicide legal. I've never been asked by a patient to write a prescription for a lethal dose of medication to be used to end their life. I have been asked by several patients whether I would promise them that if they came to a point in which they did not want to continue living, I would make sure that they "didn't wake up." As the conversations unfolded, those were their ways of asking for me to hasten their death.

**Dr Caplan:** And when they say "don't wake up," do they mean sufficient doses of pain medication to keep them nonresponsive?

**Dr Curlin:** Yes. That is what has generally been described once I ask further questions. "Put me out of my misery" is often the language patients use; "make it be over" or "make sure that I don't go on in that condition."

**Dr Caplan:** So, in your experience, you can achieve a kind of pain-free, nonsuffering existence without bringing about death?

**Dr Curlin:** I don't ever promise that we can entirely get rid of pain, and we certainly cannot get rid of suffering. To be human is to suffer, and we can never take away all of the suffering. What we do have, though, like we've never had in all of history, are powerful and effective means of alleviating distressing symptoms. In my experience, proportionate palliation can be used to effectively deal with distressing symptoms in virtually every case.

**Dr Caplan:** Some patients are simply going to say, "I don't want to go through all of that. I know you could help me medically, maybe you can even help me spiritually or emotionally, or put me in touch with people who can, but it's not the way I want to go." What do you say to those who say, "Let's let people control the manner of their dying"? In this country, they need prescriptions. That's what doctors can write. So, if I waive off a palliated death, even a good one, what would your response be?

**Dr Curlin:** My response would begin with a question. Why is the physician being asked to do this? You mentioned that physicians have the authority to write prescriptions, but the truth is, there are many ways that patients can take their lives that are more efficient and more effective than ingesting an overdose of medications. And physicians already have the authority to refuse all life-sustaining treatment, to refuse the involvement of physicians altogether. But the physician's commitment to the patient is not to satisfy their requests. It's not to just alleviate their suffering without any conditions on what kind of suffering they're going to relieve; it's to attend to the patient's health, to preserve and restore the patient's health in ways that are reasonable and can be done given the kind of situation that the patient is in. It doesn't mean that we do everything, and it certainly does not mean that we pivot to getting rid of the patient in order to get rid of their suffering.

**Dr Caplan:** What would you say to those who point toward Oregon and Washington, states that have had legalization of at least assisted dying for some time? Not assisted suicide, which I'm going to ask you about in a minute. They say, "You worry that physicians are going to be seen as violating their ethical principles, their codes that make them a profession. People worry about abuse, but we don't see it, so why not extend the model as California decided to do and maybe other states may decide to do? The abuses, the slippery slope—we don't see that."

**Dr Curlin:** Art, when a physician is intentionally hastening a patient's death or cooperating with a patient so that the patient can take her own life, that physician has already slid down a terribly long slope. That physician is already detached from centuries of professional railings and boundaries that physicians have maintained so that patients can entrust themselves to physicians when they cannot care for themselves. The physician has already given up the commitment to the patient's health, to the good of those who are sick. He's already given up a historic commitment to not give a patient a deadly remedy that would cause their death even when the patient implores them. The physician has already decided implicitly that their obligation is primarily to satisfy the patient's wishes, not to seek the good of the

patient with respect to health. That's a long slope that the physician has already traveled down to get to that point. You mentioned that we're not seeing a slippery slope. Well, it depends on how you define it. In every jurisdiction where assisted suicide has been made legal, there has been a steady increase in the number of people availing themselves. It hasn't been explosive in Oregon.

**Dr Caplan:** I did want to ask you about the slippery-slope issue. I think that it's a major policy issue and I just want to bore in on it a little bit. Here in the United States, what we've dealt with is physician-assisted dying, meaning that proponents in Oregon, California, Vermont, and Washington State say that they're going to restrict this to the dying. They're going to die anyway; we aren't going to bring about death—people are going to die. We look over at The Netherlands, we look over at Belgium, and we see physician-assisted suicide. They're not dying; they're suffering in some way. Horrible suffering is the claim. Do you think that if we go on the path that we're on, with some states allowing physician-assisted dying, that it's inevitable that we wind up with physician-assisted suicide and the more controversial baggage that it carries?

**Dr Curlin:** I don't agree with the distinction you draw between assisted suicide and assisted dying. Suicide has traditionally been understood as an act taken by an individual with the express purpose of ending their life. I grant that when a person has a prognosis that is quite short, it seems more understandable or more acceptable than if they are losing some of their eyesight and they are 30 years old and are going to live another 50 years. Although you might have a more defensible suicide and a less defensible suicide, they are both suicide. They are both cases where the person is acting to cause their death. That's their intention. If they fail to die, they will have failed in doing what they set out to do. So, we have assisted suicide in Oregon. We have assisted suicide now in California and in Washington and Vermont. What we have in Europe is euthanasia as well.

**Dr Caplan:** Let me push in a slightly different direction as we get to the end of our conversation. I'm interested to know whether your opposition or some of the concerns you have would be different if we said that we're just going to have assisted dying and that it will be done by pharmacists, executioners, or bioethicists. Someone will make the medicine available, but it won't be doctors because they have a separate pledge and a code that says do not kill, do not harm. Is part of the concern over who is doing it more than whether people should be allowed to do it?

**Dr Curlin:** Absolutely. That is part of the concern. That is an enormous part of the concern. If society is going to legalize suicide, let it be almost anyone but physicians doing it. Look—for several years, I've practiced palliative medicine in the context of hospice, primarily in the South Side of Chicago and in Durham, North Carolina. Innumerable times, I've faced patients or their family members who looked at me with the question, "Are you going to just try to get rid of me? Why are you using that medication? Why are you in such a hurry? Why is Mom not waking up anymore?" And a little conversation brings out that they watched Aunt Susie, who battled cancer for years, go into hospice and die 3 days later after the morphine was started. Their concern is that we have detached ourselves from this historic boundary, this historic commitment that we are not going to intentionally hasten the death of our patients. They believe that I respect that commitment, that they can trust me to treat their symptoms. If they don't, every time I give a little more medication and it makes them a little more sleepy, they will worry that I'm just trying to smooth them out, just get rid of them in a nice, unruffled way that doesn't cause too much hubbub. The possibility of people entrusting themselves to physicians depends on this commitment. Insofar as we let it go, we will find that we enter a time in which people's trust in physicians is radically diminished.

**Dr Caplan:** Brittany Maynard, the young woman who went from California to Oregon, publicized her desire to have assistance in dying. She was very photogenic and was splashed all over the media. That probably played a big role in legalization in California.

**Dr Curlin:** Absolutely. She was almost a Hollywood picture of what many Americans long for and are fearful of losing: their youth, their beauty, their freedoms, their independence, and their capacities. So, when she took her life with the assistance of her physician, she had not suffered symptoms that were beyond palliation. Rather, as she said herself, she did not want to face losing those capacities. The irony here is that physicians have traditionally been in solidarity with people who have long since lost their beauty, long since lost their strength and independence. They had illnesses,

injuries, debilities; they suffer. If they can't look to physicians as people who are decidedly and decisively committed to walking alongside them no matter what and not trying to get rid of their suffering by getting rid of them, then we have privileged the desires of the few in a way that does great injustice to the desires of many, the many that physicians have a particular obligation to serve and to be in solidarity with.

**Dr Caplan:** On that note of justice, let me thank you for this compelling and riveting conversation. I think the audience would be clear about why Farr got the standing he has in the palliative care community. Thank you very much for doing this.

**Dr Curlin:** My pleasure. Thanks for having me.



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