Editorial

And Peace at the Last

At this time of writing we are waiting to see what will be the outcome of the likely confrontation between Dr. Jack Kevorkian of Royal Oak, Michigan, and the new Michigan law that makes aiding terminally ill people who wish to take their own lives a criminal act. Although Dr. Kevorkian has been suspended from the state medical society and deprived of his professional license, he has continued to give aid to a number of sick people who had come to the conclusion that they wanted to end their suffering by ending their lives. In no case has he performed any act that could be described as a direct step in ending a life, but he has provided a workable method for ending life available to some who asked him for help. He has refused to help some whose intention he felt was not clear and sustained. He has insisted on more than a mere expression of emotional frustration and despair on the part of those he has helped. He has consulted with them and with their families in order to make sure that they really sought this way out of their illness. He says it is a matter of principle with him and that he will go on with this work no matter what the legal situation becomes. “I don’t care about the law,” he told one reporter. “I have never cared about anything but the welfare of the patient in front of me.” It seems a reasonable position for a conscientious and caring doctor to take. But, of course, it does bring us to the necessity of finding a definition of what the welfare of the patient may mean under various circumstances. Kevorkian has been called “the suicide doctor” and derided as “Dr. Death” by those in his own profession and many others who want to suppress his activities. We think, on the other hand, that he is bravely attacking a health problem that the medical and hospital establishments have long refused to face honestly: namely, the fact that there can be depths in a human situation where the only humane and compassionate course is to help people find a swift, painless, and dignified way to die. The issue that Dr. Kevorkian is raising should be taken seriously not only by doctors and health care providers, but by everyone, since many will sooner or later encounter it in his or her own life or the life of someone closely related by blood or friendship. Death, along with birth, is one of those universal experiences that everyone has and nobody escapes. We cannot choose how we face birth, but we can choose how we think about death and how we may hope to meet it.

Of course, Dr. Kevorkian is not talking about the experiences of depression,
hysteria, defeat, despair, injury, and utter frustration that normal people face temporarily in the course of their lives. Nor are we. There are many ways to treat these periods of sadness and pain, and there are many forms of healing that can be helpful. In this issue we are concerned with terminal situations of injury or disease involving constant and untreatable pain, permanent coma, loss of natural and conscious functions, inability to respond to external stimuli, in short, to life situations where only minimal signs of life remain. We are also dealing even more specifically with sensitive, thinking people who anticipate the arrival of such conditions in their own lives and want to spare themselves and those they love from crippling financial burdens and deep emotional trauma. Many of us have watched somebody we have known and valued die a long and lingering death, painful and humiliating for the patient, stressful for the caretakers. Many of us have said to ourselves and others, “Thank God he or she is free at last.” Too often we have had to add those two words—“at last.” It is to set their loved ones free from the need to say those two brief words that some people facing their own deaths with self-respect and concern for others seek a swifter, kinder ending than natural progress of their affliction will provide. Even more than natural decline, we think, people fear the unnatural prolongation of helplessness and utter dependence offered by the technological wonders and complicated machinery of modern medicine. The needles, bottles, tubes, pans, gauges, monitors, and other paraphernalia of the intensive care unit have meaning and justification only if there is some possibility of their helping return a person to some kind of living. If they are simply prolonging mortal agony or preserving the bodily shell of a former personality in a vegetative state, then they are not serving human health and well-being. If they are being used simply for experimental purposes, then some committee of doctors concerned with medical ethics should put a stop to such a practice.

Once some years ago we asked a doctor who was giving us a physical checkup what his views were about the idea of suspending heroic measures to preserve the appearance of life in hopeless cases. His reply was that he would not let us suffer. But we persisted. “What if I should say to you that I have had enough, more than I can stand. I have no hope, nor have you. Help me out of this situation.” He replied that he thought that would be cowardly. Is it cowardly to accept the reality of one’s own impending death when it is staring one in the face, unavoidable and sure to bring as it draws nearer the pains of decline, loss of control and consciousness itself? Whose courage or cowardice are we talking about here, the doctor’s or the patient’s? The truth that the medical profession must face is that human beings can come to a rational, humane decision about the ending of their own lives and that while they, the doctors, may disagree for Hippocratic or other reasons, a human being’s life is his or her own. It is the human being in the depths of the self who must make the ultimate personal decision about the appropriateness of life or death in the existential situation.