

The point here is that palliative care is not fully effective, even when optimally administered. I suggest that the comment of Smith and associates, that "there is no reason why all terminal pain cannot be abolished," is much too facile a judgment in light of the clinical evidence. The pathophysiology of pain is extremely complex, and today we are only beginning to understand psychic contributions to the experience of pain. Furthermore, the realm of suffering involves far more than physical pain alone. Psychosocial support and artful communication cannot always be expected to be wonderfully effective in the resolution of hopelessly ill patients' existential crises (although sometimes they are). Certainly, better palliative and supportive care is needed. However, I would like to refer the reader to guidelines for implementing a policy of physician-assisted suicide,⁴ and to a commentary supporting it.⁵

JOHN M. SHELDON, MD
Baltimore, Md

1. Smith ML, Orlowski J, Radey C, Scofield G. A good death: Is euthanasia the answer? *Cleve Clin J Med* 1992; 59:99-109.
2. Benrubi GI. Euthanasia—the need for procedural safeguards. *N Engl J Med* 1992; 326:197-199.
3. Quill TE. Death and dignity—a case of individualized decision making. *N Engl J Med* 1991; 324:691-694.
4. Quill TE, Cassel CK, Meier DE. Care of the hopelessly ill—proposed clinical criteria for physician-assisted suicide. *N Engl J Med* 1992; 327:1380-1384.
5. Brody H. Assisted death—a compassionate response to a medical failure. *N Engl J Med* 1992; 327:1384-1388.

■ *In reply:* Like Dr. Sheldon, we are very aware that physician-assisted suicide and active euthanasia are ethical and legal issues that will not disappear quickly. Even as we prepare our response to Dr. Sheldon, there are media reports that Dr. Jack Kavorkian has assisted in the death of his sixth female victim.

We will address three points prompted by Dr. Sheldon's letter: 1) the argument for assisted suicide proposed by Benrubi; 2) the situation of Dr. Sheldon's 35-year-old patient; and 3) the dangerous misconception that assisted suicide and active euthanasia are facile means to a merciful death.

First, Benrubi¹ criticizes physicians for using their full medical armamentarium to defeat disease, often prolonging agony along with life, but then offering no help when it is clear that disease will win the battle. His solution is for physicians, under restricted condi-

tions, to be able to offer euthanasia to patients as an escape from the horrors that medicine has wrought. To us, the problem is real, but the solution is wrong.

We suggest that the following are needed: abandonment of the battlefield imagery that permeates medicine; skilled communication with patients; a consensus about realistic treatment goals and plans; and an awareness that shifting from aggressive to palliative measures may require not less but even more intense caring for suffering, dying patients. Benrubi (and Sheldon) may be highlighting a systemic problem in medicine; if this is accurate, we propose major efforts and energy to change the system of medical education and the delivery of care, rather than treat the symptoms through "medicalized" killing.

Second, in recounting the agonizing, painful dying of his 35-year-old patient, Dr. Sheldon aims to illustrate his belief that palliative care is not fully effective, even when optimally administered. We respectfully question why his patient received such inadequate pain management, and we submit that this case is an excellent example to support our assertion that adequate and appropriate pain management is not being provided to many patients.

Why was this patient receiving patient-controlled analgesia when she could not activate the pump? Why was a continuous infusion of morphine not used? What protocol established the "upper limit of morphine allowed" when, in fact, it was inadequate? The "upper limit" for us is the amount of analgesia that is within standards of pain management, that honors patient wishes (when known) for the desired level of consciousness or unconsciousness, and that breaks the particular patient's cycle of pain. In our view, these criteria are not mutually exclusive; they are ethically supported and justified and do not cross over the line into active euthanasia. We reiterate our position that pain management for the dying is frequently and unnecessarily inadequate, and that this inadequacy needlessly nudges many patients into believing that their only option besides an agonizing death is euthanasia or assisted suicide.

Third, we caution against the misconception that a "happy death" can easily and always be achieved by active euthanasia and assisted suicide. We are concerned that Dr. Sheldon may promote this misconception by referencing Dr. Timothy Quill's actions with his dying patient ("Diane") as a paradigm for proper

response and peaceful death in a terminally ill patient who is suffering without relief. Dr. Quill's essay describes how Diane's husband and son, after she had died, "found her on the couch, lying very still and covered by her favorite shawl. There was no sign of struggle. She seemed to be at peace."²

Gomez,³ after recounting 26 cases of physician-aided euthanasia in the Netherlands, comments that the Dutch practice seems to call for particular drugs with proven efficacy (eg, barbiturate and curare), and that there are protocols which guide a physician's use and administration of those drugs. But, as Gomez also explains, the Dutch practice of euthanasia has occasionally fallen prey to uncertainty, miscalculation, and mistakes (ie, drugs were not given in sufficient quantities and were inadequate to the task). One Dutch doctor, referenced and quoted by Gomez, indicated a desire to establish medical criteria for euthanasia that would be refined by using medical protocol and experimentation with dying patients.

Through personal communication with Dutch physicians, we learned of some cases of euthanasia that "fell prey to miscalculation" and "experimentation." One case involved a 29-year-old blind woman with diabetes mellitus for 12 years, renal failure, neuropathy, and severe pain requiring morphine. At her request, euthanasia was initiated. She was given 100 mg of morphine and 2.5 mg of atropine. She became comatose in 30 minutes, but after 3 hours she was still alive. The same drugs at the same doses were again given. Two hours later she was still breathing. She was then given 100 mEq of potassium chloride, and death finally followed.

A second case involved an 85-year-old woman with metastatic stomach cancer and severe pain who was residing in a nursing home and was refusing food. She

was given 10 mg of diazepam and 40 mg of morphine intramuscularly. Because she did not lapse fully into unconsciousness, she was given an additional 40 mg of morphine and 2.5 mg atropine intramuscularly. After she became unconscious but did not die, 12 mg of pancuronium was given intramuscularly. She died shortly thereafter.

Finally, related to our caution about misconceptions, we note a controversy raging in Germany over a case in which a suicide victim who used one of the 40 methods suggested by the German Society for Humane Dying decided to videotape his death.⁴ The film showed him writhing and retching horribly in the final minutes before he drowned in his bath. It is not clear what role, if any, a physician had in assisting this man's death.

We share Dr. Sheldon's desire that patients experience a peaceful death with dignity. We continue to assert that this can be achieved through adequate pain management and social support for the dying. Advocates of medicalized active euthanasia, whether they be physicians or patients, should know that their solution for the problem of pain and suffering may not always be gentle, efficient, and without complications.

MARTIN L. SMITH, STD

Department of Bioethics

AND JAMES P. ORLOWSKI, MD

Department of Pediatric Intensive Care

The Cleveland Clinic Foundation

1. Benrubi GI. Euthanasia—the need for procedural safeguards. *N Engl J Med* 1992; 326:197–199.
2. Quill TE. Death and dignity—a case of individualized decision making. *N Engl J Med* 1991; 324:691–694.
3. Gomez CF. Regulating death, euthanasia and the case of the Netherlands. New York: The Free Press, 1991.
4. Nicholson R. Euthanasia elsewhere. *Bulletin of Medical Ethics* 1992; 81:6.