

Intentionally Hastening Death

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A young man whom I cared for is dead. A respected ethicist writes that my act of "intentionally hastening death. . . seems inhumane and immoral." In the harsh milieu of the nineties—as my income is withering and I am surviving animosity from specialists and hospitals about money and power—my morale is fragile. Why am I a family doctor? I need to tell this story to my colleagues.

Entering a career in family medicine meant serving heterogeneous needs: idealism, parental approval, social power, and curiosity. There were also barely recognized, ambivalent needs—like knowing Death. One of my closest friends had died and my young wife was dying when I decided to go to medical school.

I became a family doctor with both the hope and expectation that I would be "better" at it, because of compassion born of maturity and life experience. I believed I could bring comfort because I had personal knowledge of the gifts Death brings as well as the pain it inflicts. I am not friends with Death, but neither is it my enemy. I do not know if I am a "better" doctor, but I do know that caring for dying patients is both the most rewarding and the most disturbing part of my medical practice.

I write to resolve the cognitive dissonance that vexes my best efforts to do the right thing about life and death. So I write about Keith, who died recently and whose death I hastened, as I had promised him. I have read and written about bioethics and the phenomenon of caring for dying patients. This education, indeed, fully informed my care of Keith. I write now to understand the trouble and satisfaction simultaneously brought to me by the act of helping him die.

Keith died of AIDS, the newest plague—something out of Africa, manifesting in a young man who was my age and from my culture. Writing about him exhumes the shadow of death cast upon modern America. The gay

community in America is living a holocaust and knows death intimately. Being a straight Jewish doctor for a dying gay man with AIDS is a dance of intimacy with something both familiar and enigmatic, *eros* and *thanatos*, mystery within mystery.

I remember meeting him—or them, I should say—in my office. He came to his first appointment with his "partner" and another close gay friend, who was his lawyer. They were the "primary agent" and "alternate agent" for his durable power of attorney (DPA) for health care. Keith was loquacious, a little nervous, but feeling OK. He had AIDS, complicated by cytomegalovirus retinitis and extensive Kaposi's sarcoma, and was clearly very ill. They brought me a laser-printed list of his complicated medical regimen. I knew at once that I was going to be involved in his dying and that it was going to be an orderly, decorous, even honorable process.

Keith was moving to my semirural town from the city, where he was planning to return occasionally for consultations with his AIDS specialists. They wanted me to coordinate his care and handle emergencies that would likely occur locally. They wanted me to be aware of the DPA and its meaning.

Keith, who was in his late thirties and articulate, put me on edge a little with his rapid "gay" speech. Beyond this cultural divide, I perceived that he knew he did not have enough time left to speak all that was on his mind—not bitterness as much as bitter sweetness.

His partner, Doug, was direct, sensitive, and HIV-negative. Their friend, the lawyer, was dignified but slightly detached. Keith seemed to have a secure self-image, yet was never really active in decisions about his care. Decisions came from the others. I respected how they cared about each other, all three of them. I worried that a gay doctor could somehow do better, but I found myself comfortable with them.

The lawyer asked me whether, if the time came, I would be able to make Keith comfortable and help him die with dignity. I said I could. Our agendas were mutual and I believed I could provide care that would be "special" to them and meaningful to me. I told them that I

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would do my best to ensure that Keith experienced no futile suffering. I told them that I usually succeeded in that. Each time death faces us, we withdraw from daily life and tend to move toward the deeply personal connection with those we love and care for. The grace with which these three were facing the disorder of death was inspiring to me.

Over the next 6 months I saw Keith monthly. He had been seeing the specialists in the city, who had done all the medical work that needed doing. It seemed important to Keith and Doug to maintain the order of our covenant with regular "checkups." His general well-being remained OK.

One Sunday, I was called by the emergency department at our local hospital notifying me that my patient was there with pneumonia and that the physician who was on call for me had refused to admit him to the hospital because his condition was AIDS related. I intervened and helped all of us feel more comfortable caring for him. It was exactly the role that Keith and his friends had signed me up for.

When I went to see him the next day, it was apparent that he did not have pneumonia, but rather pleurisy and hypoxemia, so I called upon the local pulmonologist for a bronchoscopy and later a pleural biopsy. His symptoms were well controlled; he was using self-administered analgesia (morphine). Over the next few days, I consulted three more AIDS specialists, who assured me we were doing everything possible to diagnose and cure him.

Doug asked me if Keith's family and friends should come. Although still hopeful, I felt this was a good idea. I dimly realized that his chances of "making it" had slipped from likely to survive this episode to not likely to survive, but the momentum of going for a cure was carrying me further medically. At this point, my perspective on this case was almost entirely analytical and diagnostic, but I was vaguely aware of disorder creeping in. I was beginning to be pulled away from orderly medical processes into a compelling drama. Keith was dying, but I was barely aware and did not acknowledge this.

His condition worsened. He became progressively, relentlessly hypoxemic and was transferred to intensive care. On Saturday, the 7th hospital day, the pulmonologist, who was also medical director of the unit, suggested I transfer him to an urban AIDS center. I was thoroughly ambivalent. The pulmonologist was understandably overwhelmed and felt that we just did not know enough about AIDS. I thought he could not trust the fact that I *did* know a lot about AIDS. On the other hand, I felt relieved at the prospect of escaping a deteriorating situation. I made the arrangements, but at the last

moment, the receiving physician judged him too unstable to accept in transport.

Keith's family and friends told me he was far better off under my care and that they had not been in favor of the transfer. I had missed their ambivalence because I was overwhelmed by my own. Giving in to the specialist's suggestion and my anxiety felt like a reprieve from the consequences of my weakness.

Trying to regain some order, Keith's friends, his mother, who had come in from Missouri, and I drew a line together: if a gallium scan suggested pulmonary Kaposi's sarcoma, despite the negative biopsy, we would try a chemotherapeutic assault; if it did not, we would shift to a hospice mode of comfort care only. I was glad Keith's mother had come. I was looking forward to the scan on Monday.

Sitting on the edge of Keith's bed in the ICU on Sunday, the 8th hospital day, I suddenly "saw" that he was dying. I had been busy at the nurses' station, going through the chart, looking for an answer in the lab and study reports. Finding none, I glumly went to visit my patient. There were three more friends present whom I had not met before. I was shocked out of my hiding in medicine and drawn into the event that was unfolding around me. It was an important event, and I wanted to be part of it. This was a death watch. His friends obviously knew this—they were all there. My medical realization actually originated in cues from his friends who knew better than I what was happening. The gallium scan, which I had been so busy arranging, seemed totally irrelevant.

The tone of our relationship changed in an instant. I was moved to ask him how he felt about dying. I told him: "It's OK to die." He took off his oxygen mask and said: "I'm scared, but it's OK. If it's my time, it's my time." He went on a little but became incoherent, probably because he became hypoxemic as he spoke (there was an oximeter above his bed). I fretted that I had upset him. Partially to calm his fear, partially to cope with mine, I held his hand, then hugged his mother and partner. Together, we cried a little. Everyone seemed relieved.

Later, his mother told me that they all felt this had been a powerful therapeutic moment for them all. It seemed that we had let out a toxic secret—death. Saying it aloud made it less frightening. Talking about death felt more real and more comfortable than talking about gallium scans and chemotherapy. This was, after all, our original covenant.

He lived about 36 hours after our "talk." On Monday evening, I received a call at home from the physician on call. Keith had slipped out of consciousness, but was agitated, probably from hypoxemia. Doug and the law-

ver, his primary and alternative health care agents, wanted the oxygen mask taken off and the morphine increased. I was shaken from my domestic tranquility. On one hand, this was exactly what we had set up on the first day of our relationship: when the time came, we were going to make it as easy for Keith as possible. On the other hand, I heard the voice of my ethical superego: this was murder because doing these two things would surely lead to his rapid death. It seemed like active euthanasia—like smothering him with a pillow. I muttered something to that effect to my call partner and left it in his reluctant hands. We agreed that increasing the morphine should make him more comfortable.

My palms were sweating and my mind racing. He was surely dying in any case and I had tried everything to cure him. I knew he was dying and suffering and that withdrawing futile therapy—oxygen—was ethically permissible. It would surely hasten his death but I believed that any discomfort this caused could be treated. It was what we had planned, it was ethically appropriate, and his duly authorized health care agents had requested it.

I called the ICU and spoke with Doug and the lawyer, who reiterated their request while thanking me for calling. They thought the oxygen mask was actually making him feel suffocated. He had been pulling it off frequently. I remembered that he had been complaining about the mask for days. I agreed to honor their request. I explained my position to his nurse, who surprised me by being comfortable with this approach. She called me a few minutes later, saying he was no longer conscious, and that although not as restless, he was not really comfortable and that she wanted to give him some diazepam. This made him peaceful, and he died an hour later, surrounded by his family and friends.

During the next few weeks, his friends and family visited me in my office, sent cards, and gave me a small gift—a desk clock. We had all been deeply touched by his last few days, and I found their visits very meaningful. This had been a good death for them, for me, and I hope for my patient.

This young man died a few hours or perhaps days before Death would have overtaken him, no matter what we did. I have been told by an anonymous but presumably respected ethicist that what I did was immoral and inhumane because I stopped the oxygen and also, I think, because I chose not to hide my intentions behind the principle of dual effect. Ethicists are not always in touch with the realities doctors face. Their rejection of any intention to help someone die seems to be based on complete denial that there is anything good about death.

My friends and colleagues tell me that my work with Keith was good medicine, that I had provided conscientious medical care, and that I had ultimately helped him die as I had promised him I would. I believe in what I did and what we as a team did. Next year, if I were to do this kind of thing again, someone could accuse me of doing it for financial gain because of managed care. The truth is I did it because I liked and respected Keith and his loved ones. I allowed them to influence me because I had promised them I would, and I needed to fulfill that promise. I thought it was entirely ethical and moral. I thought and felt then that it was the right thing, and I still do.

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