AIDS, Psychiatry, and Euthanasia

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To begin, we need to understand our background assumptions. Most will agree, after a long struggle against religion, that the world can be described in terms of facts. We can parcel these facts out, reduce them to their smallest part, and ultimately subject that smallest part to a truth test: either it is true or it is not. This is to understand the world from a scientific point of view: it has led to the explosive development of knowledge in biopsy, medicine, and even psychiatry.

Ethics, on the other hand, takes account of facts and involves normative claims about what is right or wrong and about what one ought or ought not do, but these claims are not true or false in the way that facts are. Rather, ethical claims are only "true" or "false" by virtue of their coherence with background ethical views, so it is these that we must examine. Our current dilemma about euthanasia and AIDS is based on a conflict not of facts but between two alternative background ethical views. These conflicting background views propose very different methods for determining what to do under specific circumstances.

One is what we can call the "taboo" view. This is an ethical system which asserts that there are absolute moral rules that cannot be broken under any circumstances. Although there are some ethical systems (called "deontological" by philosophers) that recognize moral rules for which rational argument can be offered, taboo systems typically promulgate absolute rules for which little rational basis is available. For example, the Catholic rule that a Catholic man cannot use a condom under any...
circumstances is an example of a taboo which has no rational basis although it may have a religious one. Another example was the medieval medical guild's taboo against opening a human body after death; those who transgressed this absolute taboo in order to find out what was wrong inside the body and hence contribute to the progress of medicine did so at their own peril under both church and civil law. The Reagan administration's edict prohibiting the use of fetal tissue from planned abortions for research (although the use of fetal tissue from spontaneous abortions is permitted) is still another example of taboo-based rules; it is based largely on religious beliefs, not rational argumentation.

The alternative is consequential ethics. A consequential ethics bases its judgments about what is right or wrong on the consequences that result from a particular course of action. A consequential ethics requires that a person think through in detail the ultimate results of decisions and then pick that course of action which will produce the best results for all persons affected by that choice. It seems to us—and we think this is a fortunate thing—that we are moving away from an absolutist, taboo ethics to a consequentialist ethics emphasizing the greatest good for the greatest number as well as other ethical principles; this was, after all, the cornerstone for the United States as an independent nation.

The central notion of this new ethics is that instead of relying on taboos that have no rational basis, humans should determine as best they can what the consequences of their acts will be and do what is in the best interests of all. This is the case not only for ordinary people but for their elected leaders as well, and it is central to what is meant by the separation of church and state: public policy must not be based on religious or other taboos accepted by a few individuals or officials but must rationally assess the effects of proposed policies on all persons. We think we are moving from a taboo ethic to a consequential one, but the transition is difficult—particularly in medicine, as the issue of voluntary euthanasia and AIDS clearly displays.

THE CASE FOR VOLUNTARY EUTHANASIA

Those of us who have thought significantly about euthanasia recognize that there are two quite different, although often interrelated, principal grounds for euthanasia. The first is mercy, to relieve the suffering of the sick in the only way possible in certain cases. Of course, an ethically acceptable appeal to mercy requires a very careful analysis of the consequences: Is the person so sick that there is no other alternative? Are there treatments that have not been tried that would relieve the patient's suffering? Do familial and social pressures compound the patient's physical suffering, and could these be relieved? Consequential thinking insists that all alternatives to voluntary euthanasia be considered, but in situations where that is the only effective way to extend mercy to the patient who asks for it, a kind of medical "coup de grâce" should be granted.

The second, independent ground for euthanasia is that of self-determination. Philosophers often identify this principle as that of autonomy; the law recognizes it in the right of privacy, and it is intuitively understood as a person's freedom of choice or right to conduct personal affairs, especially with regard to a person's own body. Recent case law in the United States has clearly established a patient's legal right to refuse medical treatment even if this will result in death, and both legislative and case law protections for patients' choices of actively caused death are being considered.

The most conspicuous of the proposed legal protections for voluntary active euthanasia has been the Humane and Dignified Death Act (HDDA), authored by the group Americans Against Human Suffering. Despite HDDA failure to gather enough signatures to qualify for the 1988 California ballot, it continues to have a very real chance of success in California and other states in future elections. The proposed Act, based on both considerations of mercy and self-determination, allows the physician to provide assistance in dying to patients who are terminally ill. Multiple polls have demonstrated that between 65% and 85% of the general population support a change in the law to permit physicians to help patients in this way. Although it is usually assumed that most physicians oppose euthanasia, a recent poll by the San Francisco Medical Society of its own members (a group of physicians living in an area where AIDS rates are particularly high) found that 70% agree that patients should have the option of requesting active euthanasia when faced with incurable terminal illness, and only 23% said they should not. Fifty-four percent of these physicians said that if active voluntary euthanasia were legalized, it would be appropriate for physicians to be the ones to carry out such requests (although a substantial number also

*The patient must have been so diagnosed by two independent physicians and be within six months of death; other safeguards also apply.*
thought it should be the patient or the patient’s family; 45% said that if it were legal they would participate in carrying out a patient’s request and 35% said they would not.¹

Vigorously opposed to the growing call for physician-assisted euthanasia, however, a substantial segment of the public, including many physicians, insist that a doctor ought never cause death, regardless of the suffering of the patient or the patient’s considered request for aid in dying. For instance, Laurens White, MD, recent President of the California Medical Association, has stated that “there is no difference between ending a patient’s life with a syringe and ending it with a Colt .45” (oral presentation, Hemlock Society meeting, Spring 1988); like many other physicians, he insists that the physician’s role can never be to cause the patient’s death. But if we look carefully, we see that this is nothing more than another version of the taboo ethics considered earlier, and that this is a taboo grounded perhaps in religious belief but without rational foundation. Even the belief that killing is always wrong is not accepted by our society, since it acknowledges that there are some circumstances (e.g., self-defense or defending one’s family) in which killing may be a morally justified thing to do. The fact that physician-assisted voluntary euthanasia involves the physician killing the patient does not automatically make it wrong; after all, it may be a kind of killing that, like killing in self-defense or to protect one’s children, are sometimes morally sound reasons to do.

Even the Hippocratic Oath, revered as the traditional code of medical practice, does not provide adequate reason against it. Although the original Greek version of the Oath does prohibit the physician from giving the patient a lethal drug, it also prohibits the physician from performing surgery and from taking fees for teaching medicine. If these latter two provisions are no longer respected, there may be no reason why the former should be upheld. Hence, in order to support the anti-euthanasia taboo, sufficient reason would need to be provided why the physician should never cause the patient’s death, even when there is no other help the physician can provide and the patient earnestly requests that the physician ease the dying process. But sufficient reason, we think, cannot be found.

One of the reasons for medicine’s reluctance to adopt a more modern ethical standpoint in which actions are to be judged in terms of their consequences is that it would require additional thought, reflection, and concern in each and every case. Compare, for a moment, the absolute taboo-based ethic which holds that the physician’s responsibility is never to cause death but to preserve life in all circumstances. Such a rule is fairly easy to follow in hospital practice and gives the physician a clear guideline about what to do. The physician need not consider the misery of the patient, the patient’s refusals of treatment or requests for aid in dying, or any other matters, because the taboo dictates the physician’s actions in every case. But under an ethics which requires that the physician act in the manner resulting in the best consequences, the merits of each case must be considered; this is much harder to do than to blindly follow a rule.

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Nor can the physician merely rely on the opinions of colleagues or of the medical profession in general; some will say it should be done this way while others will say it should be done that way, and in the end the physician will have to arrive at a reasoned moral decision about which way to act. That is one of the great difficulties of the transition from taboo thinking of the middle ages to consequential thinking of the twentieth century: under the newer way of thinking, each person must decide how to act. One of Nietzsche’s great insights was to discover that with the loss of religion, individuals would have to ride out a stormy sea of morality to determine their own ethics: actions can no longer be based on rules laid down by religion but only on a careful consideration of the consequences of those actions. This is neither easy nor guaranteed: in hindsight, you may have been wrong.

AIDS AND THE ETHICS OF EUTHANASIA

How does AIDS affect our thinking about these kinds of issues? AIDS raises many moral issues, including questions about privacy in testing and justice in the distribution of health care resources. All of these can be described as involving conflicts between taboo and consequential ethics, but it is the issues AIDS raises about euthanasia that this article concentrates on.

If any disease makes the case for euthanasia, AIDS surely is the one. It speaks directly to the argument for mercy since it often means a slow, inevitable, horrible death. It also speaks to the argument for self-determination since many AIDS patients plead with their doctors for help in ending their lives. Generally, by the time they ask for help these patients are already in a situation in which they do not have access to medications and are so weakened that they cannot obtain them. The callous response that AIDS patients can always commit suicide is both insulting and unrealistic. Jumping from a bridge or turning on the exhaust in one’s car are hardly an answer for persons who are bedrid-
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depression. But AIDS in particular also produces characteristic mental changes and deterioration, producing abnormal mental function even early in the disease and pronounced dementias or psychoses in a large proportion of patients later in its course. The neurological literature suggests that at least 60% of AIDS patients are affected. A personal observation is relevant here: as a psychiatrist trained to recognize the symptoms of altered mental function, I believe I am among this majority of patients whose symptoms include altered mental function (although I have been tested and found competent). For instance, I find that I have forgotten large amounts of information I once knew—not just innumerable facts learned in medical school, but other more recently acquired information. I sometimes forget when a visitor has been to see me, particularly during an episode of acute illness. But changes in mental function of this sort do not prevent me from thinking clearly about the issue at hand, and seeing that there are two clear replies.

First, a distinction may be made between competency at the time a request for euthanasia is first made and competency at a later point in the course of an illness. Given recent advances in diagnosis and testing, many persons come to know they are seropositive long before they develop symptoms of the AIDS disease. These persons, like those diagnosed in the earliest stages of AIDS itself, may reflect on and express their desires concerning eventual treatment should or when their disease progresses, and their competency to do so at this early stage can hardly be disputed. These early assertions of choice function much like the Living Will in that they reflect a person's considered—and, for the Living Will, legally binding—choice about how the person is to be treated in the event of later incompetency.

Second, we must distinguish between competency for various purposes. Just because a person has the symptoms of dementia does not mean that that person is incompetent for all purposes, although some incompetence may be apparent. For example, some AIDS patients go through hypomorphic states in which they become unable to manage their money, typically spending outrageous sums without regard to the future, and it may be appropriate to appoint a friend or relative as conservator for financial matters. But memory loss or inability to manage money does not entail that a person is no longer able to understand and make choices about the most fundamental things, and especially about whether to try to continue to live or to die. It is not a choice between living and dying but between dying now and dying later in a more difficult way, and this is a choice for which memory skills, financial skills, or other sophisticated cognitive processes are not required. All that is required is the capacity to reflect on one's current experience in light of informed understanding of what is about to come.

The more usual psychiatric response to such choice by patients is that of invalidation. When a patient requests to be allowed to die, to refuse food and water, or to have the physician provide a lethal injection, the medical staff's reaction is typically one of anger and frustration at not being able to carry out what they conceive of as their inviolable role, that of preserving life. This reaction is of course not unexpected when taboo-based beliefs are threatened, and only with difficulty do physicians stop to examine thoroughly and without bias what the consequences for the patient will be. Instead, an appeal is often made to the psychiatrist to identify the patient's psychosis; this, in effect, suppresses the patient's right of self-determination and invalidates the request. The patient's body can then be manipulated in order to preserve life: the patient may be strapped to the bed, intubated, sedated, and so on. Anyone who has worked in a hospital has seen the results of psychiatric invalidation. To be sure, this is sometimes appropriate, for instance when the patient is suffering a transient psychosis, will benefit from treatment, and can expect good functioning when the psychosis has passed. But it is up to the psychiatrist to distinguish between psychosis and rational assessment, or reaffirmation of an earlier rational assessment, of a hopeless situation. It is this latter situation that AIDS so often presents.

EUTHANASIA AND PSYCHIATRY: A PARADIGM

We would like to close with a story familiar in the history of psychiatry: the story of the death by euthanasia, almost 50 years ago, of Sigmund Freud. It is an example of the kind of understanding that can grow between doctor and patient, and of the kind particularly relevant in illnesses exhibiting a long term decline and a predictably fatal outcome, as in the throat cancer Freud had, or AIDS. In retaining Dr. Max Schur, Freud insisted on only three rules regarding their relationship. The first was that Schur tell him the truth in all instances, and promise never to lie to him. The second was that Schur not follow the Hippocratic Oath, but charge Freud a reasonable fee for his services. The third, and this was the most important agreement that Freud sought, was that when the end came, Schur would not allow Freud
to suffer needlessly. Freud endured his disease as long as he could (through 16 years and 33 operations) but when he chose to endure no more, Schur kept his part of the bargain and gave him "adequate sedation," a deliberately lethal injection.

This agreement is a model of the way in which the physician can both exercise mercy and respect the patient's right of self-determination, and we think an agreement of this sort is the moral right of every patient with AIDS who wishes help in dying. One of the worst aspects of AIDS is not being able to trust one's doctor to help at the end. We think that the social recognition and legal protection of physician-assisted voluntary euthanasia, superseding outmoded, rationally insupportable taboos, is one way to restore that trust.

REFERENCES

"Why should we pay for visits to the shrink? Just tell him to get his act together."

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