

Physician-Assisted Suicide (PAS)/Physician-Assisted Death (PAD): the Rise of Lifeboat Ethics

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The Economic Rationale for Death Panels

In discussions of the need to “bend down the cost curve,” save resources, and thus achieve the goals of affordable and accessible care, there is the explicit or implicit question: Does our society need to eliminate the hopelessly ill?

Progressives and socialists have created existing law and templates to do this, and the concept is becoming popular with Americans. According to recent polls, those favoring assisted suicide now clearly outnumber those who oppose it: a Gallup poll endorsing “strong support” for euthanasia from May 2018 revealed 72 percent of Americans favor PAS.¹

Have the models of physician-assisted suicide (PAS or, now, physician-assisted death, PAD) in California, Colorado, Oregon, Vermont, Hawaii, Montana, Washington State, the District of Columbia, the Netherlands, Switzerland, Germany, and Canada provided evidence that these interventions have reduced costs and redistributed resources in a beneficial way? Canadians assert that “providing medical assistance in dying in Canada should not result in any excess financial burden to the healthcare system, and could result in substantial savings.”² However, the cost savings have not been realized in any of these models for a variety of reasons,³ and benefits have been illusory.

The Ethical Rationalization

How did the ethical quicksand of PAS/PAD come to be public policy and law? This happened because bioethicists have rationalized its philosophical basis in ethics.

The bioethics enterprise claims ownership and authorship of a hierarchy of moral thinking designed to protect society’s interests and the victims of injustice, be they children, the impoverished (and therefore uninsured), the voiceless, the injured, the diseased and dying, or minorities of any stripe, color, or gender. In debates, they—as the certified “ethicists”—characterize any opposing opinion or concept as “unethical.”

In the mid-1990s, Peter Ubel wrote that “setting health care priorities is a value-laden enterprise, requiring us to make difficult decisions about what is most important in health care. Should we spend more money on prenatal care or on treating AIDS patients? Should we emphasize prevention or cure? Nevertheless, it is becoming increasingly necessary to set health care priorities. Health care costs have risen dramatically in recent decades, making it impossible to provide every potentially beneficial health care service to everyone who may benefit from it.”⁴

Ubel was referencing a bioethics debate that had begun in the 1960s in which the technical advance of hemodialysis promised a means to address end-stage kidney disease using the then-recently developed but numerically inadequate and/or unavailable new hemodialysis machines (“artificial kidneys.”) Their limited availability led to the creation of patient selection committees.⁵ The issues that arose were complex at many levels, but scarcity of resources was initially at the core.

In today’s bioethics issues, scarcity of medical resources continues as the primary theme evoked, whether one considers transplantable organs, intensive-care beds, robotic surgical skills or apparatus, availability of trained medical professionals, etc. “Intransigent medical scarcity,” as described by Tom Koch,⁶ has become the accepted unsavory exigency that remains uncorrected, and for which ethical solutions must be found.

For the bioethics enterprise, simply, there are too many people (patients) and not enough resources. Ironically, bioethicists do not directly address the reasons for this state of affairs or the means to correct it: the social, political, regulatory, and financial planning that created scarcity. Rather, for bioethicists, the opportunity to act as triage agents is by far a more desirable, enabling, and convenient role, and thus they obfuscate and avoid the underlying ethical issues.

If scarcity is inevitable, then rationing is required, “if some are to be saved.” Bioethicists have developed complex metrics, analyses, and budgeting programs to determine, in an “ethical manner,” how decision-makers “must set priorities among competing opportunities.”⁷ The bioethical selection process for allocating scarce resources designates those patients who may best profit from them, and de-selects those who cannot profit, or simply cannot be saved.

The Lifeboat Metaphor

A favorite bioethics technique is aptly described by Koch: “Bioethicists are very fond of lifeboat ethics and its assumption that some must be sacrificed that others may survive because there is not enough for all.”⁶ The bioethics model also includes a host of societal goals such as “bending down the cost curve” for expensive medical procedures, supervising the medical profession to eliminate “fraud and abuse,”⁸ etc. Social and economic values displace ethics goals.

Koch describes the genesis of the lifeboat metaphor in his book *Thieves of Virtue*:

By 1991 the argument from scarcity had become a generally accepted bioethical and social truth referred to by the metaphor of “lifeboat ethics.” In 1991, for example, Boston University’s dean of medicine, Dr. Louis Lasagna, analogized the intransigent limits of health resources with those of the original overloaded lifeboat made famous in legal and social history in the landmark case *United States v. Holmes*. . . . Half the passengers drowned when the *William Brown* struck an iceberg in 1841; half were saved aboard its single longboat. Overloaded, the longboat was in danger of capsizing. As a result, the crew threw sixteen passengers overboard in a desperate attempt to assure the survival of at least a few of the remaining passengers. . . .

“The medical system in the United States today [in 1991] finds itself in an analogous predicament. . . .” Lasagna wrote. “The cost of care has soared at roughly twice that of general inflation, partly because of the proliferation of expensive procedures—hemodialysis, organ and bone marrow transplants—that can quickly bankrupt a family.”

...In modernity’s lifeboat the ethical question is assumed reflexively to be not how to save everyone, but how best to choose among the equally needy, some of whom must die if any are to survive.⁶

The fixed notion of scarcity, along with bioethicists’ endorsement of the idea that the lifeboat metaphor represents medical reality, has led to repeated, virtually endless bioethics discussions on the treatment (or non-treatment) of patients with limited prognoses as a “necessity” argument to amplify the need to ration. Examples routinely evoked describe end-stage medical scenarios, such as the ventilator-dependent Alzheimer’s patient with metastatic small cell lung carcinoma, or the severely mentally disabled child with acute lymphatic leukemia, or the multiply impaired adolescent with status post opiate overdose left in a chronic vegetative state, for whom any therapy can be construed as “wasted,” or as is preferred, “futile.”

Hippocratic Principle Pre-empted

Selected examples of human tragedy supply an endless data stream for the bioethicist as points of discussion that support the need to ration: futile therapy at end of life is expensive and, arguably, ineffective. Bioethicists fail to address the principle routinely honored by the Hippocratic physician: “Into whatever homes I go, I will enter them for the benefit of the sick.”⁹ The ethics of setting institutionalized health care policy or even state law based on economics alone has been rendered acceptable in the bioethics paradigm.¹⁰

It therefore becomes easy to understand the repetitively renewed focus on end-of-life (EOL) issues, PAS, brain-death criteria, and medically futile care. Indeed, my reviews and records of the agendas of the Biomedical Ethics Committee of Medical Society of New Jersey (MSNJ) meetings since 1988 shows that a majority of MSNJ discussions were (and continue

to be) devoted to some aspect of these topics.

The immediate past chairman of bioethics for the MSNJ, an affiliate of the AMA, e-mailed the following on Jul 30, 2018: Hello everyone.

I had very few replies about interest in being on a subcommittee to address: (1) The “futility” paper from the medical society—attached. (2) The Brain Death issue—amending with focus on specifics surrounding the religious exemption. (3) Moving forward the issue of PAS. (Physician Assisted Suicide).

Chairman McGeehan then re-emphasized his support and focus on PAS with an attached reference to Robert Klitzman’s coverage for CNN of a California lawsuit about a “right to die.”¹¹ In Klitzman’s article, the current bioethics community’s “more acceptable” description of PAS as PAD (Physician Assisted Death) would somehow defuse the negative connotation that suicide “ends a life” as opposed to “enabling death to occur,” and allow for greater professional support and ethical acceptability.

Futility

The bioethics community has struggled with a “modern” definition for the concept of “futility in medical care” since the 1960s, the accepted birthdate of the neo-discipline. For many centuries and in many cultures a definition of “futility in care” has existed, but it is frequently contrasted with a more “modern” idiom created in the last several decades as technologies provided life-sustaining and lifesaving therapies.

“Futility” as a “post-modern” concept is the mantra used to address rationing of scarce medical resources that are actually effective in maintaining life. Somehow, using medical resources to maintain or to sustain a life that would otherwise be beyond salvage is almost universally considered socioculturally and bioethically unacceptable. As Leon Kass stated:

The welcome triumphs against disease have been purchased at a price of dehumanization of the end of life: to put it starkly, once we lick cancer and stroke, we can all live long enough to get Alzheimer’s disease. And if the insurance holds out, we can die in the ICU suitably intubated. Fear of the very power we engaged to do battle against death and disease now leads us to demand that it give us poison.¹²

As the 19th century ended and the 20th began, the legacy definition of futility implied an untreatable condition unresponsive to any form of therapy, and formed the basis for programs of coercive sterilizations applied mostly to the underclasses of American society. Sterilization in the form of vasectomy, together with rising interest in eugenics, led in the 1920s to the enactment of laws in 25 states for compulsory sterilization of the criminally insane and others considered untreatable inferiors (epilepsy, infant deformities, mental retardation, blindness, deafness, dwarfism, etc.). Policies and legislation were advanced as goals benefiting future generations, the collective betterment, and protection of

society through eugenics.

The current definition officially promulgated by the MSNJ is that "(f)utile medical therapy can be considered to be any treatment that cannot within reasonable likelihood cure, palliate, ameliorate, or restore a quality of life that would be satisfactory to the patient. This includes any treatment in which the burdens greatly outweigh any chances of success or benefit to the patient."¹³

Legal Precedents

Karen Ann Quinlan, Joseph Saikewicz, Shirley Dinnerstein, Nancy Cruzan, Helga Wanglie, Terri Schiavo, Jahi McMath, Alfie Evans, and Charlie Gard were patients whose cases reached the courts for resolution of non-treatment and end-of-life issues. Legal remedies may address an individual set of circumstances, but they do not and cannot resolve these complex and increasingly numerous issues for society, or else the debate would simply be over.

That the legal process is both limited and flawed is illustrated by the *Buck v. Bell* decision of May 2, 1927, when the U.S. Supreme Court upheld the Virginia statute that provided for eugenic sterilization of people considered genetically unfit. The Court's decision, delivered by Justice Oliver Wendell Holmes, Jr., included the infamous phrase, "Three generations of idiots are enough." Upholding Virginia's sterilization statute provided the green light for similar laws in 30 states, under which an estimated 65,000 Americans were sterilized without their consent or that of a family member.¹⁴

Society vs. the Individual

The focus on scarcity crystallized for the bioethics community under the aegis of several influential bioethicists, especially Daniel Callahan, the founder and president of the most prestigious bioethics think tank in the United States, the Hastings Center.⁶ Callahan stated in his 1987 publication *Setting Limits: Medical Goals in an Aging Society* that medical decision-making could only be considered a private matter between patients and physicians if the social cost was minimal, and that medicine's obligation to sustain the fragile was limited. Keeping people alive through technology at a high cost threatened future generations.¹⁵ In July 2009, shortly before the Patient Protection and Affordable Care Act became law, Peter Singer, a professor of bioethics at Princeton University, published an article in the *New York Times Sunday Magazine*, "Why We Must Ration Health Care."¹⁶ His commentary was predictable:

Rationing health care means getting value for the billions we are spending by setting limits on which treatments should be paid for from the public purse. If we ration, we won't be writing blank checks to pharmaceutical companies for their patented drugs, nor paying for whatever procedures doctors choose to recommend. When public funds subsidize health

care or provide it directly, it is crazy not to try to get value for money. The debate over health care reform in the United States should start from the premise that some form of health care rationing is both inescapable and desirable.¹⁶

While the bioethics community and its coterie of moral philosophers continue to insist that intransigent scarcity is the natural state of medical affairs and represents the justification for supporting lifeboat ethics, the reality is that any ethical argument based on scarcity serves primarily as an excuse for the failure to provide necessary priorities and resources. Scarcity, as argued by the bioethics enterprise, is used as a device to advance a progressive agenda, to enhance the relevance of the bioethics community as moral guardians of the public welfare, and to redistribute goods and services for economic and political purposes.¹⁷ The lifeboat concept supports notions of health care reform as a centralized, planned process, supervised by philosopher-ethicists.

In the presence of medical need affecting an entire population, distribution of the means to address such a crisis, such as a vaccine program, or acute respiratory care, or decontamination, cannot be judged or determined by a medically untrained bioethics community that primarily scales the distribution of medical care based on relative social worth, age, prognosis, or other social, non-medical determinants. That is a grievous ethical failure. While scarcity of resources can and will occur, at least at the onset of an acute critical medical problem, such as limited numbers of hemodialysis units available when they were initially approved, the ethically proper focus must be on the causes of a disease and how to address them, not on how to limit distribution of medical services based on considerations of "futility," societal cost-effectiveness, or protection of theoretical future population needs.

From its inception, bioethics has treated resource scarcity as a natural inevitability rather than the result of prior choices. As Koch asserts, this "failure of vision has defined the bioethical role." The bioethicist needs the lifeboat to consolidate the role of who is to be jettisoned, and who is worthy of saving, based on criteria of non-care that can be "ethically justified." As professionals, "bioethicists have a stake in the problem, but not in its structural solution."

Koch says it best: "[W]hat is the good of an ethics that never asks what we ought to do to prevent disaster and sees as entire the pragmatics of triage in disastrous but avoidable situations? Why embrace an ethic that stops where the real work would presumably begin?"⁶

According to Albert Jonsen, a doyen of the bioethics enterprise, the principal emphasis of bioethics is a gatekeeper duty that focuses on community resources and distribution of sparse resources through the prism of a social justice ideology.¹⁸ The worth of the individual, the humanity that the Oath of Hippocrates recognized and cherished, was to be replaced by neoliberalism's progressive post-modernism: based upon the assumption of scarcity and its intractable limitations, triage and rationing must become part of our existence. Bioethicists,

despite their repeated advocacy of personal choice and autonomy as primary bioethical principles, deny the primacy of personal choice on the basis of the state's future economic needs. The elderly, the frail, the multiply impaired, or the injured are a burdensome expense that can be abandoned to benefit the young and the worthy, i.e. those capable of providing a measurable benefit to the state.

When replacing advocacy for the frail, the sick, and/or the dying, on the assumption that they are somehow undeserving of treatment based on cost accountancy, with what is generally called "assistance in dying" rather than the abandonment that it is, the bioethics enterprise has clearly violated every tenet for which it supposedly stood or was created: "moral thinking designed to protect society's interests and the victims of injustice."¹⁸

The "Right to Die"

Rights arguments, like use of metaphors, are another favored device of the bioethics enterprise. The invention of a "right to die," especially as it comes to embrace a right to "aid-in-dying," must translate into a legislated obligation *on the part of others* (namely physicians) to kill or help kill. Apart from the moral and coercive personal offense that such a duty requires, it is difficult to imagine and configure a limited statute permitting homicide by a privileged few and exercised in the name of society. The abuses in Netherlands testify to the effects of this moral breach.¹⁹

There is simply no way to confine the practice to those knowingly and freely requesting death. The clear majority of candidates for assisted death are, and increasingly will be, incapable of choosing and effecting such a course of action for themselves. No one with an expensive or troublesome infirmity will be safe from the pressure to have his "right to die" exercised. The medical profession's devotion to healing, to doing no harm—its ethical center—has been sullied and irreparably damaged, and its trustworthiness ethically compromised by this bioethically designed breach. Was this the goal of the bioethics enterprise: to make the medical professional untrustworthy? Lack of trust in the profession of medicine has certainly been central to the process of progressive "healthcare reform."

There is no recognizable "right to die," and there is no duty to die. Modern medicine can design better methods of caring for the dying, without complicated governmental intervention. The need for access to adequate hospice care—to comfort care—without the need for political posturing, a rights argument, a faux ethic, and a legislative and regulatory mandate based on economic falsehoods, cannot be addressed without the expertise of the medical community.

Conclusions

There is no need to assert a right to die or to create a lifeboat ethic, no need to triage and jettison the "unworthy" as selected by non-medically trained third parties who bear no

direct relationship to the patient. Bioethicists play such a role yet deny responsibility for the outcome for their interventionist advisory function. In rejecting traditional Hippocratic ethics on socio-cultural-economic grounds, bioethics has abandoned the fundamental medical ethical commitment to the person in need. The state has become the patient.

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