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Doctors shouldn't be ending lives

By Ira Byock

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On one point proponents and opponents of physician-assisted suicide can agree: A public health crisis surrounds the way we die. Our modern technological prowess in fighting disease has inadvertently made dying hazardous.

It occurs despite the best intentions of professionals, relatives and friends. We matter to one another and don't want to lose the people we love. Yet the unintended consequences are undeniable. Patterns of excessive, ultimately futile, disease treatments and inattention to patients' personal needs and priorities are commonplace. Many Californians today receive state-of-the-art treatments for their cancers or heart, lung or liver diseases, but go on to receive astonishingly bad care during the waning months, weeks and days of their lives.

Let's be clear: This is one crisis we can solve. Taking much better care of dying people is possible and actually saves money. The highest quality centers tend to have the lowest costs because doctors there help people weigh complex treatment options, thereby avoiding unneeded and unwanted treatments and hospitalizations. Clinical teams there focus on coordinating home and community services, preventing emergencies and supporting patients' caregiving spouses, sons and daughters, enabling people to stay at home whenever possible. These meticulous attributes of care are too often ignored, causing needless suffering and wasting money. Regulations and payment reform could go a long way to making the right care routine.

Doctors do not deserve blame, but they are undeniably part of the current predicament. Medical schools and residency programs are culpable for continuing to under-train and graduate well-meaning physicians who are ill-prepared to effectively treat patients' pains or counsel people who are facing the end of life. Instead of correcting these deficiencies, SB 128 would simply give doctors authority to write lethal prescriptions. And this is good government?

Many people seem surprised that a palliative care physician would oppose physician-assisted suicide. "You must be a conservative Republican" or "You must be Catholic," they say. I am neither. I'm a liberal Jew (although my observances lead me to delis more often than synagogues). This is not about religious morality. It's

basic civics. We don't allow bankers to steal from depositors or prosecutors to lie to judges and juries. We don't allow doctors to kill patients.

Professional boundaries are the I-beams of civil society; undermine them and scary things happen. In an era in which providers of health care – doctors and hospitals – share financial risk with payers of health care, vigilance is warranted. Lethal prescriptions will always be less expensive than comprehensive whole person care and family support.

Proponents of SB 128 contend that Oregon-style safeguards would prevent abuses and keep insurers from offering suicide as an alternative to costly treatments. Then how does one explain the Oregon Health Plan's initial refusal in 2008 to pay for expensive treatments for Barbara Wagner's lung cancer or Randy Stroup's prostate cancer, while informing each of their right to prescription drugs to end their lives. "The state can't cover everything for everyone," an Oregon administrator explained. An honest response, but the optics were bad so the agency later reversed the decisions.

Under provisions of SB 128, anyone who is terminally ill and desires a hastened death would be eligible. But in order to receive hospice services, the person would also still have to give up medical treatments intended to help them live better or longer. When did a right to die take the place of human caring?

To glimpse the future, we need only look to Holland, Belgium and Switzerland where assisted suicide and euthanasia have long been practiced. There, despite universal health care, it is no longer uncommon for doctors to euthanize people who request to die due to non-terminal pain, depression, early dementia or loss of desire to live. In the United States, the Final Exit Network, one of the national groups promoting assisted suicide legislation, advocates for a right-to-die for people with non-terminal and nonphysical suffering. Asked about assisting people with dementia to end their lives, the president of Compassion and Choices said, "It is an issue for another day, but is no less compelling."

Legislators can take boldly brighter actions. Bills could impose real curriculum reform on California's medical and nursing programs, ensuring that they teach and test for basic palliative care skills before awarding degrees and licenses. The state could report staffing levels and quality ratings for hospitals, nursing homes, home care and hospice programs so that people could make informed consumer choices. Instead of offering a lethal solution to this social crisis, we could make it safe for seriously ill people to live fully and die well.

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