Uncommon Knowledge

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Biomedical Ethics

2,500 years ago, the Greek physician Hippocrates wrote what we now call the Hippocratic Oath as a guide of conduct for the medical profession. The Oath enjoins physicians to do no harm. Are modern medical practices coming into conflict with traditional medical ethics? How should we evaluate physician-assisted suicide or futile treatment theory? What are the benefits and what are the dangers of a new bioethic that emphasizes the right to die as much as the right to life? Guests: **Stephen Jamison**, Executive Director, World Federation of Right to Die Societies. **Wesley Smith**, Author, *Culture of Death: The Assault on Medical Ethics in America*.

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Peter Robinson: Welcome to Uncommon Knowledge. I'm Peter Robinson. Our show today, ***Medical Ethics at the End of Life***. Twenty-five hundred years ago, the Greek physician Hippocrates, often called the father of medicine, created the Hippocratic oath to serve as a guide to medical ethics. Most famously, the oath enjoins physicians to do no harm.

So it was that when the family doctor came to treat a sick patient, he brought with him not only his bag of medicines but a code of medical ethics, requiring him to do his utmost to preserve life.

Today, however, doctors may have more than medicines in their black bags. They may also have drugs intended to hasten the end of life. And that's not just rogue doctors like Jack Kevorkian. In the state of Oregon, doctor assisted suicide is perfectly legal.

Consider once again the Hippocratic oath. Doctors who take the oath swear in part, I will give no deadly medicine to anyone nor suggest any such counsel.

The question on our show today then is simply this, is current medical practice in conflict with traditional medical ethics? For that matter, with traditional morality itself. And what are we to make of a bioethics that concerns itself not only with preserving life but ending it.

With us, two guests. Stephen Jamison is Executive Director of the World Federation of Right to Die Societies. Wesley Smith is author of the book, ***Culture of Death, The Assault on Medical Ethics in America.***

Title: Hippocrates, Call Your Office

Peter Robinson: The Hippocratic oat, physicians who take the oath swear to do no harm, giving their patients only beneficial treatments. The State of Oregon's assisted suicide law, physicians help patients kill themselves. Who's right Hippocrates or Oregon? Stephen?

Stephen Jamison: How do you define do no harm?

Peter Robinson: Do no physical harm?

Stephen Jamison: Do no physical harm.

Peter Robinson: Helping a patient to kill himself is doing the patient physical harm and would stand in direct violation of the Hippocratic oath as it was used through--certainly up until very recent times.

Stephen Jamison: Okay.

Peter Robinson: So when I define it that way, what's your answer, Hippocrates or Oregon?

Stephen Jamison: Well certainly Hippocrates but they don't use it in that--in that sense anymore. They use the basic four principles of medical ethics.

Peter Robinson: Hang on. Hippocrates or Oregon?

Wesley Smith: Well Hippocrates and the shocking thing is that only about thirteen percent of doctors take the Hippocratic oath today. Killing is not medicine.

Peter Robinson: Like that statement?

Stephen Jamison: Well I agree but the whole issue is--is what they do in Oregon, killing or not, that's the question.

Wesley Smith: Well, you know, you have doctors who are helping to kill people who they have not treated, who they have only known indeed for two weeks, who I call death doctors because they're like Jack Kevorkian. They're--they're referred by the Hemlock Society or some other death group. You have doctors giving poison to people who are outside of their specialty. You have a situation in which somebody--they're on Medicaid and there's healthcare rationing for Medicaid in Oregon. If they're outside the line, they can't get treatment. But if they want assisted suicide, they can. I think it's a dangerous precedent to allow…

[Talking at same time]

Stephen Jamison: You're talking about Oregon?

Peter Robinson: In Oregon, yeah.

[Talking at same time]

Stephen Jamison: Eighty--eighty-eight percent of these patients are hospice patients.

Wesley Smith: And you know what's really disturbing about that, Steve, is that as I look at Hemlock Society literature, Hemlock Society folk will say gee, if--of somebody is suicidal, don't tell the hospice professionals about it because we got to help them have their autonomy. Yet a suicidal ideation in hospice is a warning system that something is not being done correct. And so…

Peter Robinson: To a--to a hospice professional, if the patient who is terminal says I'd like to kill myself…

Wesley Smith: Right.

Peter Robinson: …under hospice standards, that's a warning signal that they ought to…

Wesley Smith: Right.

Peter Robinson: …that the pain isn't being treated well or…

Wesley Smith: Something--something's not being done right. I'm a hospice volunteer.

Peter Robinson: Right. Okay.

Wesley Smith: One of the things that happened in my training is that if somebody says to me, I want to kill myself, I am to immediately tell hospice professionals so that they can do an intervention to find out what it is that that patient needs that they're not receiving.

Peter Robinson: But I just want to kind of flush out your--your position on the Oregon law. You'd be in favor of the Oregon law?

Stephen Jamison: I'm in favor of the Oregon law.

Peter Robinson: You're in favor of the Oregon law. Okay now…

Stephen Jamison: It's used so rarely now when we look at the overall statistics. The numbers haven't increased over the last few years.

Peter Robinson: Can you give us some numbers? How many assisted…

Stephen Jamison: Well the numbers…

Peter Robinson: …suicides take place under the Oregon law each year?

Stephen Jamison: Roughly two dozen each year. I mean, the thing--it has not--it has not increased. And again…

Peter Robinson: Let's take a step back and look at the evolution of medical ethics.

Title: Putting the Care Before the Hearse

Peter Robinson: Wesley Smith writes, I quote, "A small but influential group of philosophers and healthcare policymakers are working energetically to transform our nation's medical practice and healthcare laws. They are known as bioethicists." Closed quote. How did the discipline of bioethics arise? Where does this stuff come from in the first place?

Wesley Smith: Well it started with a very important conversation among philosophers in the academy, medical ethicists and theologians.

Peter Robinson: This is taking place when?

Wesley Smith: Back around late '60's, early '70's. How do we deal with the new high tech medicine? How do we make sure that the kidney dialysis for patients, because there weren't enough machines, how do we decide which receive the help and which don't? But I'm afraid what happened is that it moved away from a belief in the sanctity of human life, meaning that each and every one of us is inherently equal which was led by a man named Paul Ramsey. And instead followed a utilitarian, a very harsh approach, which was led by Joseph Fletcher in which they're dividing human beings between persons and non-persons and they're saying that some of us have greater rights and greater moral value than others. And when you predicate medical ethics and public policy on blatant discrimination, you're going to end up oppressing, exploiting and…

Peter Robinson: Okay.

Wesley Smith: …and--and hurting people who are helpless.

[Talking at same time]

Peter Robinson: Is that a fair summary of…

Stephen Jamison: No it's not.

[Talking at same time]

Peter Robinson: Well what I want to…

Stephen Jamison: I'm on an Ethics Committee of a hospital.

Peter Robinson: Okay.

Stephen Jamison: What we do…

Peter Robinson: What I'm concerned now is the--is the discipline of bioethics.

Stephen Jamison: Right.

Peter Robinson: Is that a fair summary of how it arose and the timing and so forth?

Stephen Jamison: It came into being. It is now--is now required under hospital regulations, national hospital regulations in the United States that--that each hospital has to have some kind of an entity like an Ethics Committee to deal with these issues. I don't make decisions on my Ethics Committee. None of us make decisions. What we do is we look at it, we flush out the ethical issues, we bring in the families, we work with the patients. And we say, listen, we put it back into their lap. If it's an end of life decision, for example, where a--a family member wants to end a life or refused to see that--that a patient, you know, di--no longer needs a particular treatment and the patient does not want that treatment, we work together in a team between these…

Peter Robinson: Okay. Let's go through--let's go through several examples…

Peter Robinson: Let's take a look at the ethical issues that actually come into play at the end of life. Scenario number one, the patient chooses to die.

Title: Is That Your Final Answer

Peter Robinson: You are Executive Director of the World Federation of Right to Die Societies.

Stephen Jamison: That's correct.

Peter Robinson: Describe a circumstance, hypothetical or if you'd care to, one from your own experience, in which a patient, in your mind, legitimately and reasonably chose to die.

Stephen Jamison: Let's say that an individual has metastatic cancer, is mentally competent, has been suffering substantially for a period of time. Pain cannot be alleviated necessarily because it's not just physical pain, it's physiological suffering that might be inability to--to breathe, inability to swallow. The individual has worked out his or her issues with family members and has had counseling and--and other sorts of interventions with--with…

Peter Robinson: Okay. So in such a circumstance, you'll--you, as a medical ethicist, would say, that patient has the right…

Stephen Jamison: No.

Peter Robinson: …to make a decision to die.

Stephen Jamison: As a medical ethicist, working for a hospital, I would say no. As an individual who believes in a controlled, conservative approach to end of life decision-making around assisted suicide or euthanasia, I would say yes.

Peter Robinson: The patient has a right to--okay, now let me ask you, such a circumstance…

Wesley Smith: Right.

Peter Robinson: …not assist--I'm just asking now, the patient's decision, patient is in terrible pain yet lucid, rational and wants to die. Does the patient have the right to--to--to die?

Wesley Smith: If they're in terrible pain then there's medical malpractice going on because you--almost all pain can be controlled. The patient has the right to say, I want no more curative treatment. In fact, as I said earlier, I'm a hospice volunteer and that's what hospice is about. It's not keeping people alive and extending their lives. It is helping them die gently, comfortably and naturally. So yes, of course, people have the right to die in the sense that they don't have to take curative treatment. What I'm worried about and what's beginning to happen in bioethics because of the nexus between the philosophy and the economics of medicine, is that people who want their lives extended, people who want treatment, are beginning to be denied it…

Peter Robinson: Right.

Wesley Smith: …unilaterally and that's terribly dangerous.

Peter Robinson: Well--well--well--I want to creep up on those instances but I'd like to take it step by step. By--by the way, do you grant this I--this assertion that terrible pain really can be alleviated? In this day and age, nobody needs to be in terrible pain.

Stephen Jamison: I don't--I don't believe that it can always be alleviated while the patient is--is conscious and cognizant. What--what hospice has done…

Peter Robinson: In some cases, you have to be so heavily med…

Stephen Jamison: Well yeah and--and terminal…

Peter Robinson: …medicated…

Stephen Jamison: …terminal sedation is commonly used in hospice. I have nothing against terminal sedation. Ira Buyant, President of the American Hospice Physician's Association is a proponent of it. But what--but what terminal sedation has been called is slow euthanasia. What you do is if a person is suffering--if a person is suffering, you--

you medicate them to the point where the individual can no longer--then you withhold or withdraw life sustaining treatment which is completely legal and completely ethical under the standards of the American Medical Association.

Peter Robinson: Let's--let's stipulate then that the patient to remain…

Stephen Jamison: How does that differ?

Peter Robinson: …when

Stephen Jamison: …doesn't differ.

Peter Robinson: …when the patient is conscious…

Wesley Smith: It does--it differs tremendously.

Peter Robinson: When the patient is conscious, he's in terrible pain. What is the duty of the physician at that stage? If the patient wants to die, is it the duty of the physician to help the patient die, to assist in suicide? Your personal view.

Stephen Jamison: My personal view is that it's the duty of the physician to follow the desires of that physician, not the patient.

Peter Robinson: It is acceptable if you have a doctor, it's acceptable to--okay so let's see here. You--you then overthrow the--the moral framework of the Judao Christian tradition in favor of the individual conscience of one doctor. And if the doctor…

Stephen Jamison: No.

Peter Robinson: …wants to inject the patient…

Stephen Jamison: No if the doctor…

[Talking at same time]

Stephen Jamison: No what I'm saying is if the doctor…

Peter Robinson: It's okay if the doctor…

Stephen Jamison: …if the doctor does not want to inject the patient…

Peter Robinson: That's also okay.

Stephen Jamison: That is appropriate.

Peter Robinson: But it's also okay if the doctor does want to?

Stephen Jamison: Only, I think, if a number of guidelines have been followed.

Peter Robinson: Okay.

Stephen Jamison: Otherwise I am a proponent of terminal sedation. I'm a proponent of…

Peter Robinson: I'm trying to get you in here.

Stephen Jamison: Let's--of alleviating the suffering of this patient in as many other ways as possible.

Wesley Smith: You know, of this talk about assisted suicide just sucks the oxygen out of the necessary discussions we have to have about pain control, about hospice, about futile care theory in which doctors are refusing life extending medical treatment when it's wanted, about dehydrating cognitively disabled patients to death.

Peter Robinson: The case in which a patient is in pain and makes the decision to die, is it too hard--too hard a case for you to talk about?

Wesley Smith: No, I talk about those cases all the time. The doctor's absolute responsibility is to do whatever it takes to alleviate that patient's suffering. That does not include killing because that is not necessary. But if they allow a doctor…

Peter Robinson: Because that is not necessary or because that is wrong? I'm trying to see whether you're…

Wesley Smith: It is both.

Peter Robinson: All right.

Wesley Smith: Both not necessary because of advances in medicine and it is wrong because it's not a medical act to kill a patient.

Peter Robinson: Got ya.

Peter Robinson: Onto scenario number two. The family of the patient decides to end medical treatment.

Title: All in the Family

Peter Robinson: Well known case of Karen Ann Quinlan, young woman, she's been unconscious for a number of years. The parents sue the hospital. This is all taking place in the seventies when you said bioethics begins to arise. Case goes to the New Jersey Supreme Court which, in 1976, rules that the parents, not the hospital and not the doctors, have the right to decide on care. The respirator is removed. And, as a result of that 1976

New Jersey Supreme Court ruling, that becomes the working legal principle in a number of states and at the national level very, very quickly. The decision is removed from doctors and hospital staffs who were, up to that point, overwhelmingly acting in line with the principle of the Hippocratic oath, we don't--we extend life, we try to preserve it, and given to families instead. You're in favor of that?

Stephen Jamison: I'm certainly in favor of--of individual autonomy. And I think that what--what this does is exemplify what you were talking about in terms of your complaint about--about medicine, about Ethics Committees and so forth. It's the individual be--in contrast to the control of health professionals is what you're saying.

Peter Robinson: Well let me just…

[Talking at same time]

Stephen Jamison: …a balance between the two.

Wesley Smith: The Karen…

Peter Robinson: Go ahead.

Wesley Smith: …Karen Quinlan case is correctly decided. They took away her respirator and, guess what, she didn't die. She lived for about ten years. Where I have a problem is when they say okay, we're going to take away feeding tubes.

Peter Robinson: Go ahead, make the point. Why is that different?

Wesley Smith: Because if you locked any one of us in this studio, in a room for fourteen days without food and water, we'd all be dead. And what you're doing is you're saying, we're going to take away from you basic sustenance. We're going to define it as medical treatment because you get it through a tube. And the point of that is to make sure people die. And that began to be discussed right after the Karen Quinlan case. The purpose of that was to make sure, as was often written in bioethics literature, that certain people die because we've come to a conclusion that if people with significant cognitive disability, they don't have a--a reason to live. They're purpose for existence is no longer…

Stephen Jamison: These decisions are made either by surrogate decision-makers appointed by that patient or by the patient's family in--in concert with the health professionals. It is never an easy decision to make.

Peter Robinson: Let me flush out what Wesley says here. You have asserted that it is certainly in line with the great moral tradition of the western world to refuse respirators, interfering forms of care that prolong a life. But you draw a distinction between that kind of medical care, a respirator, and food and water, basic nutrition, even if it is supplied through a tube.

Wesley Smith: Right.

Peter Robinson: You provide nutrition to anybody. And you…

Wesley Smith: Unless they can't assimilate it medically which is if people are dying and their bodies are shutting down and they stop eating. That's a different circumstance.

Peter Robinson: Okay. But whether they can chew and swallow and use a knife and fork…

Wesley Smith: Right.

Peter Robinson: …or whether it goes…

Wesley Smith: Right.

Peter Robinson: …intravenously…

Wesley Smith: Right.

Stephen Jamison: The whole question is whether or not…

Peter Robinson: That's irrelevant to the moral point.

Wesley Smith: From my perspective.

Peter Robinson: But you say, no. That…

Stephen Jamison: That's right.

Peter Robinson: …that tubes can be yanked out if it's the will of the family…

Stephen Jamison: It is the standard…

Peter Robinson: …following the guidelines and so forth.

Stephen Jamison: …it is the standard of the medical profession.

Peter Robinson: Yes, yes, yes, but that…

Wesley Smith: It became the standard of the medical profession because of this bioethics movement that I'm so concerned about. And you have a situation in bioethics…

Stephen Jamison: It is the standard…

Wesley Smith: Let me finish my point.

Stephen Jamison: …of the American Medical Association which is still in direct opposition of euthanasia.

Wesley Smith: When you take a look at the--when you take a look at the American Medical Association, in 1987 or 1988, they said, okay you can do that if they're conscious--unconscious beyond a reasonable doubt. If they're in a coma beyond a reasonable doubt. Within three or four years, they were doing it to conscious people. There is a case in this state, Robert Wenlon, who could roll a wheelchair down a hospital corridor, he can write his letter "r" and the California Supreme Court's going to decide whether he can be dehydrated to death over fourteen days. And that's just inhumane.

Stephen Jamison: Okay. There are a number of anecdotal details on both sides of the issue that--that we can draw upon for this. This is one case I'll be very interested to see what--exactly what happens in this…

Peter Robinson: This is before the court now?

Stephen Jamison: …in this particular--in this particular court.

Wesley Smith: …before the California Supreme Court.

Stephen Jamison: The issue is, does an individual and his or her family have the right to determine, in advance, or a family on behalf of a patient, do they have the right to determine what treatment including artificial nutrition and hydration, will be provided to a patient. That's the quest…

Peter Robinson: We come now to scenario number three. The doctors decide.

Title: Take Two of These and You Won't Call Me in the Morning

Peter Robinson: Once again, I quote Wesley. Quoting, "Desired medical treatment is now refused in hospitals and nursing homes around the country to patients who are dying or disabled. This justified under a new theoretical construct known as futile care theory, which proclaims the right of doctors and healthcare executives…

Stephen Jamison: You see, dying patients.

Peter Robinson: Hold on, let me finish the quotation here. "…to refuse to provide care based on their views of the quality of patients' lives." Closed quote. Now the decision is not with the patient, not with the families, but with the medical professionals and they get to decide to yank care. Is he right about it as a matter of fact?

Stephen Jamison: No he's...

Peter Robinson: Is it going on?

Stephen Jamison: No, he's not. Futile treatment is defined as treatment that has no physiological benefit to a patient. Futile treatment is not futility of care. There's no such thing as futility of care. All care is beneficial. Treatment however, does not necessarily have to be beneficial. You said dying patients. What kinds of…

[Talking at same time]

Stephen Jamison: We're not saying disabled. We're saying dying patients. Right now, the issue of futility and disabled patients is something that is not really being discussed in the literature and it's not being discussed…

Wesley Smith: That's just absolutely…

Stephen Jamison: …and it's not being discussed.

Wesley Smith: …not true. I'm sorry, the…

[Talking at same time]

Wesley Smith: Well let me explain one…

[Talking at same time]

Wesley Smith: …one such policy…

Stephen Jamison: …not the same treatment…

Wesley Smith: …from the disabled…

Stephen Jamison: …from the disabled.

Wesley Smith: Oh, sure we are. The Alexian Brothers Hospital in San Jose had a futile care policy in which they said if somebody was in a permanent coma, they could have no medical treatment other than comfort care and that would include tube feeding. So we started with saying we could take away tubes from people who were unconscious. And the Alexian Brothers in San Jose said that it was inappropriate care to give that even if the patients wanted it. And if--and they--they talked about taking away care of people who were dependent on life support and they talked about refusing CPR for people with dementia and so forth. These are value judgments being made. And the--and the policies not only of the Alexian Brothers but others around the country say that, if there's a dispute between the doctor and the patient or the patient's family, it goes to an Ethics Committee. If the Ethics Committee decides then that patient cannot have that treatment even if another doctor is willing to do it.

[Talking at same time]

Stephen Jamison: What happens in these particular cases is when there is--when there is a major issue where--if there's family conflict, that's one thing. Public guardians may very well be appointed to make these kinds of decisions. Hospital Ethics Committees don't make these kinds of decisions. Individual doctors don't make these kinds of decisions. The only time that these kinds of decisions are typically made is they're made by the families…

[Talking at same time]

Peter Robinson: Do you--do you dispute as a--do you dispute simply as a matter of fact, that in this hospital down in San Jose, there is…

Stephen Jamison: I'm not disputing any anecdotal story that Wesley comes…

Wesley Smith: That's not an anecdote. That's proof, that's evidence.

Peter Robinson: Hold on, hold on, hold on, hold on, hold on. Hold on, you can't--you really--you really can't…

Stephen Jamison: That's one out of hundreds and hundreds of thousands…

[Talking at same time]

Wesley Smith: The Mercy Hospitals in--in Philadelphia in ***World Progress*** August--July, August, 2000 it wa--a futile care policy was written up in which that very process I talked about takes place. ***Journal of the American Medical Association*** talked about these policies in Houston being put into place. There's literature statements of these kinds of decisions being made all over the country.

Peter Robinson: Stephen, I have to issue you a warning which is that if you try to minimize these statements as anecdotal or instances as merely anecdotal, you're playing into Stephen's--or into Wesley's hands.

Stephen Jamison: Okay.

Peter Robinson: Because it sounds as though well, a human life here, a human life there…

Stephen Jamison: No, no, no…

Peter Robinson: Ah, those are mere anecdotes.

Stephen Jamison: No, no, but we're talking about…

Peter Robinson: Don't you want to make a statement? I mean, can't I kind of…

Stephen Jamison: We're talking about seven million--we're talking about seven million people a year who die in this country. And we're saying yes, there are…

Peter Robinson: His point is that…

Stephen Jamison: …there are…

Peter Robinson: …his point is that even at--even if it's a statistical asterisk, if these things are taking place, it's wrong. They're human lives. Don't you want to agree with that point?

Stephen Jamison: I do agree with that point.

Peter Robinson: Okay. Wesley, let me turn on your for a moment here. Stephen makes the point and every American with an aging parent or disabled child encounters the fact that thanks to the miracles of modern medicine, some miracles but also some nightmares are now possible. That is to say, life can be prolonged and prolonged and prolonged and prolonged when the patient is either unconscious or--so and you, yourself grant that bioethics as a discipline arose as a response to this new situation.

Wesley Smith: Right.

Peter Robinson: So what is the correct way of responding to this?

Wesley Smith: It's to look at every patient as equal and not to say that some patients don't have lives worth living. For us to say that somebody doesn't have a life worth living because say they've got a significant cognitive incapacity, what's happening in bioethics is that they're saying that such people are not persons. There is a movement afoot to say--to divide humanity between persons who would be us at this table because we've got a good cognitive capacity and non-persons. That's creating a basic discrimination in healthcare. And the people who are pushed out of the lifeboat, if you will, as the so-called non-persons, newborn infants, people with dementia, people with significant brain injury are in danger of being exploited as if they were a mere natural resource because there are some bioethicists talking about going after them for their organs. Believe it or not, they're talking about redefining death in some of the highest levels of transplant medicine to include permanent unconsciousness.

Peter Robinson: As a practical matter…

Peter Robinson: So just what path are we on now? A path to greater individual autonomy or to something much scarier?

Title: Paved With Good Intentions

Peter Robinson: Okay, let me read to you someone that Wesley quotes in his book. It's a man called Dr. Leo Alexander who was an investigator at the Nuremberg trials, I quote

this, "Whatever proportion these crimes," he's referring to what ultimately became the Nazi crimes, "whatever proportion these crimes finally assumed, it became evident to investigators that they started from small beginnings. At first, merely a subtle shift in emphasis in the basic attitude of physicians. It started with the acceptance of the attitude basic to the euthanasia movement that there is such a thing as a life not worthy to be lived. This attitude, in its early stages, concerned itself merely with the severely and chronically sick." Closed quote. That sounds almost identical to what you have been saying about certain cases, certain patients, who are severely and chronically sick. They may decide that indeed they--their…

Stephen Jamison: This is the difference…

Peter Robinson: …life is not worthy to be--okay, that's what I'm after. How can you say…

Stephen Jamison: Individual rights, individual liberty. We're talking about what Leo Alexander had to say about Germany and how despicable all of those actions were. We were talking about a totalitarian government. We were talking about the elimination of freedom. We're talking about control of--of the press and control of--of…

Peter Robinson: So to you…

Stephen Jamison: …of knowledge…

Peter Robinson: …the critical distinction is…

Stephen Jamison: We--we have…

Peter Robinson: …who makes the decision?

Stephen Jamison: Yes, as long as we have a free country, as long as we have a free press, and we have a democratically elected government, then we all can stand and we can all be watchdogs.

Peter Robinson: It's television. We're coming to a close here. And what I'd like to do, Wesley, is have you sum up what is it that you fear?

Wesley Smith: I fear that we're in a transition and we have not yet transitioned out of decent moral medicine towards this very crass, very utilitarian, very discriminatory medicine. We can stop it. It's not too late but unless the…

Peter Robinson: How do you stop it?

Wesley Smith: You--you do what we're doing on this show. You let people know what's going on. You get people thinking about these issues and I believe that people are not

going to want doctors to be able to decide who gets medical treatment and who doesn't based on doctor values.

Peter Robinson: Okay. It's television. We've got to close it out. Let me ask you for a kind of summary statement in the form of a prediction. Twenty years ago, 1981, a state law permitting physicians to help their patients kill themselves would, in my judgment, I make this assertion, would have been all but unthinkable as recently as 1981. Today Oregon has one. They're proposed in other states. Twenty years from now, in 2021, I get to--this is Wesley's point. Are we on a slippery slope or are we not? In 2021, how many states will have assisted suicide laws?

Stephen Jamison: I think we'll see probably a majority of states having some kind of…

Peter Robinson: So you grant his point?

Stephen Jamison: No, no but it just doesn't…

Peter Robinson: It's all moving in that direction.

Stephen Jamison: It doesn't mean slippery slope. Right now, over fifty percent of all deaths are--are medically governed. They do not take place naturally. They take place on the decision of--of a family member, the decision of--of health professionals, the decision of the patient.

Peter Robinson: So twenty years from now…

Stephen Jamison: …you know, to unplug or--or what--whatever we're talking about here. The issue…

Peter Robinson: It doesn't bother you that in the arc of--you, yourself grant that in the arc of forty years, we've gone from unthinkable to a majority of…

Stephen Jamison: I have seen a transfer--I have also seen a transformation of medicine from a patronizing patriarchal attitude of physicians towards patients who had no legal rights, no authorities to make any decisions, into--into one where it's a shared decision-making with the patients and their families. And I see a movement afoot that will increase this kind of a--of a dialog to…

[Talking at same time]

Peter Robinson: Twenty years from now, how many states have assisted suicide laws? Are you…

Wesley Smith: Zero because we have created an incredible coalition to stop it.

Peter Robinson: And you can even get Oregon to appeal it back?

Wesley Smith: We're--we're certainly going to try to do that but I would tell your viewers to follow the money. Think HMO. It only costs forty bucks for an assisted suicide. There's tremendous financial pressure on healthcare to cut costs and that means nursing staffs are being cut to the bone, physicians are getting twelve minute face time with patients. So all of this philosophical destruction of medicine from my perspective…

Peter Robinson: Fits into economic imperatives.

Wesley Smith: …has a nexus into the economics and weak and vulnerable people are in danger of being ground up and far more in danger from futile care and other issues than they are from assisted suicide.

Peter Robinson: Wesley and Stephen, thank you very much.

Stephen Jamison: Thank you, Peter. Wesley, pleasure.

Peter Robinson: Modern medical ethics, do they provide greater autonomy for the individual patient or a theoretical framework that enables doctors to refuse care? After today's show, we may all have to rethink that old saying, "just what the doctor ordered." I'm Peter Robinson. Thanks for joining us.