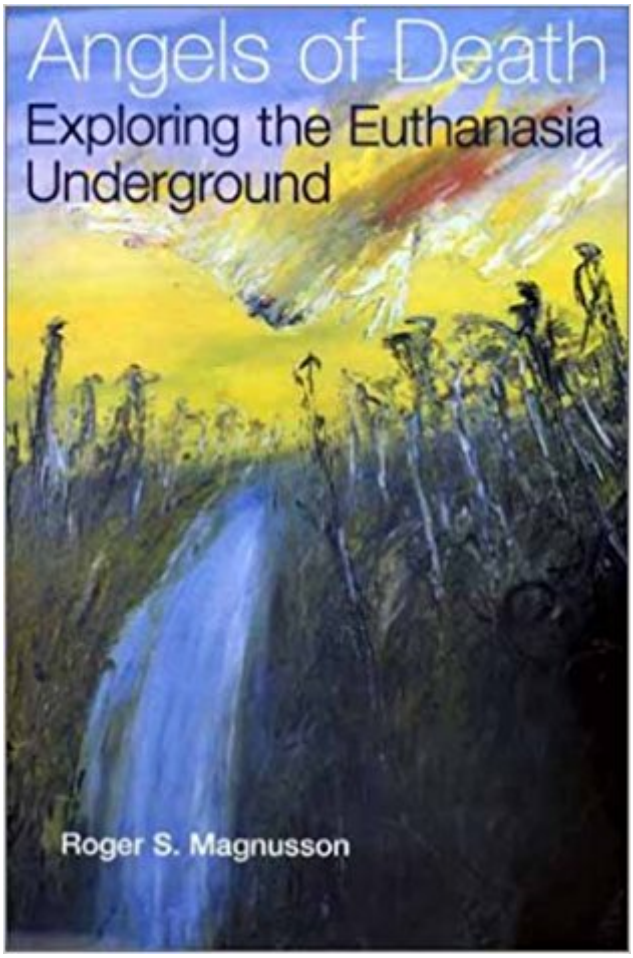
Angels Of Death: Exploring The Euthanasia Underground



Synopsis

An exploration of the hidden world of illicit physician-assisted suicide and euthanasia. Through the frank and often troubling first-hand accounts of health professionals who have been involved in assisted death, it records this secret but real area of medical and nursing practice. Through face-to-face interviews with these "angels of death", Roger S. Magnusson explores the social practices, relationships and networks that constitute "underground" euthanasia. How is assisted death actually practised within health care settings? What are the issues that surround the making of such a momentous decision? How do health care workers justify their attitudes and actions in this area? This volume aims to offer detailed answers to these questions and many others. The doctors, nurses and therapists who were interviewed pseudonymously for this study work in the HIV/AIDS communities in the United States and Australia. Their perspectives and practices, attitudes and feelings, should illuminate the assisted death debate and expose a variety of disturbing issues, including the reality of "botched attempts", euthanasia without consent, and unduly hasty measures to bring about death.

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Customer Reviews

Roger Magnusson’s Angels of Death describes the practice of extralegal assisted suicide and euthanasia by physicians, nurses, technicians, and other health care professionals who provide care to seriously ill patients and patients with AIDS who are dying. It is based on a snowball sample of 49 detailed interviews carried out over a period of three years with health professionals

specializing in the care of patients with the human immunodeficiency virus and AIDS, principally in Sydney and Melbourne, Australia, and in San Francisco. This book is about cooperative euthanasia -- that is, physician-assisted suicide and euthanasia occurring underground, mainly among patients with AIDS at home and those in large, tertiary-care hospitals in the United States and Australia. It describes networking among sympathetic physicians, nurses, and other health care workers and traces patterns of referral. It portrays ways in which health care professionals provide advice about drugs, assistance to those who wish to obtain drugs (often from an underground pharmacy), and informal psychiatric assessments. It also describes how they manipulate hospital procedures, fabricate information when signing death certificates, and collaborate with funeral directors in the orchestration and general facilitation of assisted dying at the bedside. It describes ways they may support both the patient and the family as well as debrief the family after a death. In Angels of Death (the name given to informal groups of physicians and nurses known to be willing to provide assistance in suicide or euthanasia), Magnusson finds, as have other researchers, that cooperative aid-in-dying is easier and more direct in the community than in the hospital but that it frequently still occurs in hospital settings. Some occasions of cooperative euthanasia involve direct, deliberate, life-ending measures: "A common example of shared involvement was for one health care worker to access the patient's vein, while another injected the drugs." Other occasions involve stretching applications of the principle of double effect, particularly in deaths that involved "understood," deliberate overdoses of morphine: The physician in charge of Erin's unit . . . approached Erin [a nurse] about another distressed patient they were caring for. Ã¢â ¬ËœUse as much morphine as you need,Ã¢â ¬â„¢ said the physician. Ã¢â ¬Ëœ'll sign for it.Ã¢â ¬â„¢ Erin was taken by surprise. Ã¢â ¬ËœDo you know what I mean?Ã¢â ¬â„¢ said the physician. Ã¢â ¬Ëœ'm not sure,Ã¢â ¬â„¢ said Erin. Ã¢â ¬ËœDo you want me to make him comfortable, or do you want me to make him ultimately comfortable?Ã¢â ¬â„¢ Ã¢â ¬ËœYes,Ã¢â ¬â„¢ replied the physician, ambiguously. The patient died that night. Magnusson, professor of law at the University of Sydney, and his associate, Peter H. Ballis, of Monash University, also in Australia, applied considerable skill in eliciting first-hand accounts from physicians, nurses, and other health care professionals working in legally delicate settings, and as a result they obtained very revealing interviews. They stress that the physicians involved in these cooperative networks are "not isolated and wild-eyed miscreants acting from the fringes of their professions" but rather respected, mainstream physicians. Underground euthanasia is a "culture of deception," and it is practiced everywhere, although Magnusson observes that it is "more deeply entrenched, with a longer and richer history" in California than in Australia. Angels of Death has several limitations. The study was limited to patients with AIDS in

cities where large, interactive, and mutually supportive populations of gay men have helped shape the nature of health care. Its methodology involved reportorial interviews that were not cross-checked by interviewers of different background commitments. Most irritating, the book does not clearly identify the three-year period during which the interviews were conducted, so the reader cannot know when, during the years of the AIDS epidemic, the practices described were implemented, whether before or after the development of protease inhibitors and other drugs. The study is also presented with a certain sensationalism, which its title betrays. And it does not explore the philosophical issue of whether occasions of the "understood" overuse of morphine -- as in the example of Erin, noted above -- are conceptually closer to a "double effect" and hence legally permissible or, as Magnusson clearly believes, closer to euthanasia. Despite these shortcomings, Angels of Death is a comprehensive, compelling, and deeply responsible description and analysis of practices in contemporary health care, and it includes an extensive bibliography. A superbly thought-provoking book, it should be read by both opponents and proponents of the legalization of assisted dying. It is here that Angels of Death has its greatest strength, as an importantly ambiguous, litmus-test book. Opponents of physician-assisted suicide, euthanasia, and aid-in-dying generally will see it as an account not merely of a potential abuse but of an already existing abuse of seriously ill and dying patients within the health care system: a wink here, a nod there, and the patient is dead. Proponents of legalized aid-in-dying, in contrast, will see the same account, with the same rich observations of winks and nods, as a comforting reassurance that seriously ill and dying patients can still manage to obtain what they want -- easeful death -- even in a climate of legal suppression. What Magnusson describes is a fact that both proponents and opponents of the legalization of euthanasia must face: practices such as those delineated in the book occur when a practice is kept illegal. Magnusson’s view is not to be mistaken for the naive belief that such practices can be stamped out; he believes that this is simply not possible and that "it is not a choice between having no euthanasia and making euthanasia legal." Moreover, he does not think that the cooperative practices he describes are the only forms of euthanasia now being used. "Protestations aside," he writes, "there is little doubt that hospitals do provide euthanasia, under the guise of sedation." Although Magnusson believes that the prohibition of such practices is not tenable, that the existence of "euthanasia networks illustrates the failure of the policy of prohibition," and that the legal prohibition of assisted dying produces a culture of silence, resulting in flawed transmission of information, botched euthanasia processes, substantial stress for care providers, and "a complete absence of stable criteria for involvement in assisted death," he does not supply a remedy. That will be the work of the many physicians, nurses, policymakers, and patients who should be encouraged

to read this book. Reading it will permit them to diagnose their own biases; it will also allow them to see that there are multiple ways to view the phenomenon of collaborative, underground aid-in-dying. Whatever one’s view of the stories he tells, Magnusson is clearly right about one thing: "the closing times of life are too important, and patients deserve better." Margaret P. Battin, Ph.D.

Clearly written...[A] good basic reader...[for] both students...and seasoned professionals. -- Choice

From soldiers put to sleep after sustaining horrific wounds on the battlefield to medical murder under the coroner’s nose, Roger Magnusson’s thorough investigation into the hidden world of assisted death and cold-blooded murder (two chapters are devoted to very troubling issues, including euthanasia administered when patients have expressed a desire to continue the fight).The author himself changed his stance during the course of his work. Although he strongly supported the right to die early in his work, he soon realised that stringent safeguards were required (as most people who study this issue come to conclude). The first few chapters summarise the state of the worldwide debate. In this portion, his strongest arguments and conclusions come in pointing out the hypocrisy in letting people who are dependent on life support choose to die (as in the case of Mrs. B in the UK) and the absolute prohibition against any other forms of compassion at the end of life. Consent is not recognised in most of the "civilised" world. As Roger trenchantly points out, the law would not allow a murderous thief to go free after trespassing into a hospital and disconnecting babies from life support. Despite the law though, almost no one is prosecuted. The double effect defense is almost impossible to disprove (and is inherently hypocritical; if an outcome is foreseen, it must also be intended). Jack Kevorkian was only convicted after years of openly flaunting the law. The case of Freeda Hayes in Western Australia confirmed the veracity of every poll since the 1980s with a jury returning a not guilty verdict in under fifteen minutes.The most scathing critique of the anti-choice position? "...they dislike euthanasia because it would lead to free will."The interviews and analyses reveal something many people have suspected all along - most anti-choicers have not seen people die in pain, beyond the reach of palliative care. Some deaths require brutally violent interventions (such as smothering) because the estimated lethal doses turned out to be inadequate. The prevalence of non-voluntary and involuntary euthanasia (at least in Sydney and California, where the research was conducted) shows that the slippery slope argument is, in Roger’s own words, a half-argument at best, because it neglects to address the level of abuse that is ALREADY

HAPPENING. Loopholes are easily exploited (as in the case of two doctors who report that only half an ampoule of morphine was used, while using the whole dose). When terminal sedation is used, the patient is not informed that "This dose will be the last one. You won't wake up."This engrained, endemic culture of deception follows naturally from a legal system that prohibits patient choice at the end of life. Also troublesome are the cases of medical abandonment due to patient "depression", something that would not be permitted in the psychological profession. Evading problems doesn't make them go away; they only lead to miserable patients and erode the trust that should always be present between physicians and the patients in their care.Roger looks at several policy positions for the future. Legalisation would make sense from a perspective of harm reduction. Getting this practice out in the open (many anti-choicers and even doctors continue to pretend this never happens, despite evidence to the contrary) would provide peace of mind and reduce the incidence of euthanasia without consent. Continuing with the status quo would keep choice in the hands of the wealthy and fortunate (as Marshall Perron eloquently put it in his ROTI act). Prosecuting the offenders would be unlikely to succeed, and shatter the alliance between religious bodies and the medical profession. And, of course, one could always attack the credibility of the research while ignoring the mountains of evidence that illustrate the dangerous practices already occurring. But honesty was never high in anti-choice mission statements to begin with.Further reading: Kuhse H , Singer P. Doctors' practices and attitudes regarding voluntary euthanasia. Med J Aust1988;148:623-7.Baume P, O'Malley E. Euthanasia: attitudes and practices of medical practitioners. Med J Aust1994;161:137, 140, 142-4Kuhse H, Singer P, Baume P, et al.End of life decisions in Australian medical practice. Med J Aust1997;166:191-6

Roger S. MagnussonAngels of Death: Exploring the Euthanasia Underground(New Haven, CT: Yale University Press, 2002) 325 pages(ISBN: 0-300-09436-6; hardcover)(Library of Congress call number: R726.M276 2002) This book explores all the dynamics of helping victims of AIDS to die.The research took place in Australia and San Francisco, USA.But the experiences of these doctors, nurses, social workers, & other friendscan easily apply to the situations of any patientswho need aid and support in the process of dying. Once we understand that aid-in-dying is already taking place,we should be willing to bring the process out into the open.What is now an underground practice--with no public safeguards--can in future decades become an open and honest process,which can be endorsed by almost everyonewho thinks carefully and deeply about the process of dying. Extreme opponents of the right-to-die want to prohibitany action that might hasten death.Extreme advocates of the right-to-die want no regulations at all:Let the patient

decide.Problems are created by both of these extremes.Perhaps a rational middle ground can be created.Exploring what is actually happening nowshould empower us to create wise and compassionate waysof helping people who have good reasons to die. Doctors and nurses often conspire to help patients to die,sometimes with the cooperation and helpof friends and relatives of the patients.Because all of the cases discussed in this bookwere people dying of AIDS, secrecy was not very difficult to achieve.The gay-and-lesbian communities where these deaths occurredwere close-knit and therefore easily able to cover their tracks.The deaths were all recorded as having occurred from natural causes--almost always from complications of AIDS. However, the necessity for secrecy meant thatno public safeguards could be applied to these deaths.The doctors or nurses were acting alone,without consulting anyone who might have provided different perspectives. Giving excessive amounts of pain-killing drugsis one of the most common methods of helping the patients to die.Another common method is turning off the life-supports (without authorization). Secrecy means that there is no paper-trailthat would show that anything out of the ordinary occurred.Because merciful death is still not legal,these 'angels of death' needed to operate in secret.A system of public safeguards could have achieved the same endwith much less stress and danger for the helpers.It would have taken a few days longerto approve a voluntary death or a merciful death,but under a system of careful public safeguards,the process of planning for deathcould have begun days or even weeks earlier.And everyone concerned could have been consulted. (This book proposes no safeguards for assisting others to die,but here is a discussion of 15 proposed safeguards for life-ending decisions:Search the Internet for this precise title:"Fifteen Safeguards for Life-Ending Decisions".In the opinion of this reviewer,almost all of the cases discussed in this bookcould have fulfilled these 15 safeguards.And the very few doubtful casescould have been clarified by using these safeguards.) Doctors are divided concerning the right-to-die.But the general public is more favorable.And AIDS victims are overwhelmingly in favorof the right-to-die for themselvesif their medical conditions become hopeless. Usually the AIDS patients are the first to raise the issue of voluntary death,but in some rare situations, the option of choosinga less painful pathway towards death is first mentioned by the care-givers. The fact that the patients are dying of AIDSsometimes creates family chaosbecause the other members of the family-of-originare learning for the first time that their son or brother is gay.It is sometimes too difficult to ask the family to deal withboth homosexuality and death at the same time. Terminal sedation is one medical alternative to the more controversialvoluntary death with assistance or merciful death.In terminal sedation the physician prescribes enough pain-killersto keep the patient unconscious until death occurs by natural causes.(Sometimes the drugs shorten the process of dying by suppressing breathing.)This

method protects and doctor, hospital,& anyone else involved in the life-ending decisionbecause no laws have been broken.But terminal sedation takes awaythe autonomy of the patient for the last few days,since an unconscious patient can make no decisions. (However--here back to this reviewer's opinion--all the applicable safeguards for life-ending decisionscould be fulfilled before the terminal sedation begins.Then it would be a fully voluntary death or an approved merciful death.) Doctors and nurses sometimes refer to a "tacit understanding"about the effects of increasing the sedation.The care-givers believe that the patient and the familyunderstand that the medication being given will shorten the dying process.But no one wants to say out loud:"This is the final dose."or "This medication will bring death."When the right-to-die is openly affirmed by all,then no such unspoken decisions need be taken. Some palliative-care nurses interviewed for this bookadmit to using 'left over' morphine to bring death.Whenever morphine is used, the dose ordered by the doctormight be less than the full amount in the ampule.Whenever some morphine is not needed for this patient,the nurse is supposed to destroy the excess--witnessed by another nurse.But they can easily agree not to destroy the excess(and to create a false record that they have discarded the unneeded morphine)so that they can use the excess morphine later for a merciful death. Some doctors interviewed always refuse requests for death.They do not want to violate the laws as now written.But they call for changes in the lawsthat would permit more rational decisions about end-of-life care,including the possibility of choosing an earlier deathwhen the only other alternatives is lingering suffering.Doctors do need to protect themselves,so they can continue to care for other patientsinstead of languishing in jail because they helped a patient to die. At the other end of the spectrum, there are doctors and nurseswho readily cooperate with requests for death.They admitted to the authorthat they had assisted in dozens of voluntary deaths.But these care-givers would also like to see changes in the lawsso that the process of making such life-ending decisionscould be more transparent.Fulfilling public safeguards would preventsome abuses and mistakes that probably now occur.But until the laws are changed,these compassionate care-givers will continuetheir secret and informal assistance in the process of dying. There are a few doctors in the euthanasia undergroundwho resist the creation of public safeguards for life-ending decisions.These doctors believe that they have enough experience of attending deathsso that they can decide the most appropriate pathway towards deathwithout any input from others.They make life-and-death decisions every day.Why bring in other doctors to second-guess their choices?The doctor already knows everythingabout the physical condition of the patientand has already chosen the wisest course.Why call for a psychiatrist?The doctor already knows that the patient is perfectly sane.Why involve the family in a very-traumatic choice for death?The doctor knows best and can take the

burden of choice upon himself. These free-lance ’angels of death’ do not want more regulation.They do not want to see the creation of a bureau of death-decisions.Legalizing what they now do in secretwould only create more paperwork and use up valuable timethat could be devoted to caring for more patients.These agents of death want to rely oncommon sense and their professional judgments. Legalizing voluntary death and merciful deathcould either make life-ending decisions too easy or too difficult. The process could become too easy if a panel of expertsroutinely approved all requests for voluntary death or merciful death.Then some doctors would be tempted to dispose of difficult casesby applying for approval for deathrather than working to save a difficult patient. The process could become too difficultif a new system created a large bureaucracy of professionalswho had to become familiar with all the facts of each casebefore approving a voluntary death or a merciful death.If the process became too difficult and time-consuming,some doctors and nurses would continue to help their patients to diewithout consulting the bureaucrats. Almost all of the ’angels of death’ interviewed for this bookhad second thoughts about the process of helping others to die.They wondered whether some other treatment might have been tried.They worry about being caught in illegal or unethical behavior.They wonder whether their religious beliefs support what they are doing. (This reviewer points out once again,that if there were open public safeguards for life-ending decisions,then many more people would have been involvedin making or supporting these decisions,which are now taken in secret by only a few peopleacting alone and acting outside the law.) The author did uncover some poor medical practices:(1) Prescribing death-pills without ever seeing the patient.(2) People willing to help with deathwho were completely unknown to the patientbefore the request for death.This made it a kind of dial-a-death service,like ordering a pizza on the telephone.(3) Doctors and nurses who were tiredand just wanted to "get it over with" so they could go home.(4) Some care-givers were too casual about helping people to die.They were willing to agree with any request,without checking to see how wise it was for this patient.(5) In one case, the doctor sent the family awayand ordered termination sedation--without consulting anyone.The nurse told the author about itbecause she did not think this death was wisely decided.The patient wanted to live.And the family would not have agreed if they had been consulted. Angels of Death ends without any specific recommendations for change.It mostly describes what is happening now.Many care-givers are helping their patients to die.This is done in secret because such actions are illegal.No public safeguards are applied.And this underground aid-in-dying is likely to continuein more or less the same patterns for the foreseeable future. The only major change might be more legal recognition of the right-to-die,which would create some safeguardsto prevent abuses and mistakes that do occurwith free-lance assistance in dying from self-appointed ’Angels of Death’.

Even more specifically, this reviewer has writtenabout controlling free-lance ’angels of death’.Search the Internet for the following precise title:"Controlling Free-Lance Angels of Death".Thirteen specific safeguards are suggested,which would prevent almost all the present-day abusesby self-appointed agents of death.At the same time, fulfilling these safeguardswould permit wise and compassionate voluntary deaths and merciful deaths.If you would like to know about other books on helping people die,search the Internet for this following precise expression:"Books on Helping People to Die".James Leonard Park, advocate of the right-to-die with careful safeguards.