Is There a Safe Place Between 
*Terra Firma* and the Slippery Slope?

In my younger days, I was quick to espouse a view that some things in life were “absolutes.” It seemed to me then that some things remained true and right regardless of the situation or environment. Age has softened my stance somewhat. Yes, a belief in the absolute rightness of certain things is simpler and less messy in the long run. After all, the way is clear and the decisions are made without any pesky mitigating factors to get in the way. But as life has become less simple, so too have our choices and dilemmas. Nowhere has life become less simple, so too have mitigating factors to get in the way. But as the decisions are made without any pesky long run. After all, the way is clear and the decisions are made without any pesky criers, things are more palatable and acceptable. In the end, however, the question is straightforward if not simple: Should medical care encompass control over the physical act of death or should that event be left completely in the hands of whatever force or power governs and determines life as we know it? The answer to this question used to be easy, but it is no longer. Physicians, nurses, and ethicists have been examining the issues, struggling with growing numbers of older and dying patients and caring for too many at the end stages of extraordinarily debilitating or painful diseases such as AIDS and cancer. As our success with disease treatment and life extension has increased, so has the level of patient and family suffering and our exhaustion with the fight when faced with the inevitable. Thus, not surprisingly, we face the question of whether helping someone die as actively as we have helped them live is appropriate.

As I read the thoughtful and scholarly work appearing in the “Forum Focus” articles in this issue, I found myself wondering whether some gray area exists—some safe place between absolute rejection of the idea of actively helping someone die and embracing its tenants, slippery slope and all. Well, such a place exists, but what a bog it is, full of hidden dangers, fog, and no landmarks to follow with any certainty. This middle ground is what most rational people strive to find. The problem is that, unlike many dilemmas in this life, the middle ground related to assisted dying often presents us with more insurmountable challenges than the ends of the spectrum. In this murky territory, slipping and falling over the edge is easy, even if we manage to take a few successful steps here and there. When we lift our foot to put it down, we can never be quite sure whether the ground will still be solid. Therein lies the real crux of the matter.

Some of us have taken the position that actively assisting patients to die or take their own life is not acceptable and contrary to our professional role and purpose. Our professional organization, the American Nurses Association, has taken this position also. Despite the fact that some deaths will be hastened or facilitated by large doses of drugs given to achieve pain or symptom control, by and large, things are pretty straightforward for nurses espousing this view. They will not participate in efforts to facilitate suicide or purposefully induce death.

Others believe in the right of patients to choose the time and manner of their death and in the appropriateness of a healthcare professional’s role in assisting these efforts. Admittedly, this is not the most sanctioned stance, so we cannot be sure how many people hold this view. But these individuals do exist, and I cannot help but wonder if their numbers are growing.

How many of us wish there was something in between—some way to help patients die without breaching ethical and moral covenants, some middle ground between the two extremes? A number of state legislatures are trying to describe this middle ground and put it down on paper. But will making it legal relieve us of our moral and ethical responsibilities? Some nurses will try to decide for themselves on a case-by-case basis. But do we really want these decisions made by anyone without regard to any sort of objective process? And what about the cases themselves? What about all those situations that do not fit neatly into categories—the person with Lou Gehrig’s disease or early Alzheimer’s who wants to act before he or she is incapable of acting; the person in a persistent vegetative state who is minimally conscious; the person who is more depressed by his or her disease than physically suffering? The Oregon experience described in this issue offers some hope that the decision-making system will not be inundated by “inappropriate” or marginal cases, but when we are treading around in that murky middle ground, can we be sure that enough safeguards are in place?

In the end, I have come to believe that I am not yet confident that we can control the abuses, and, after much thought, I remain unconvinced that helping someone die, under any circumstance, should be sanctioned. I guess I still believe that this world does hold some absolutes. Whether or not we can explain away an act as justifiable, understandable, or forgivable does not take away from its inherent wrongness. Our time is better spent looking for ways to ameliorate pain and suffering at all levels, accepting that sometimes we will not succeed, and realizing that doing the best we can under the circumstances presented is the safer path.