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*In my father's case doctors made the decision unilaterally, contrary to what they knew to be the family's wishes and for a patient who was not terminally ill (see HolyCrossHealth.com). Is this the *new* norm?

'Passive Euthanasia' in Hospitals Is the Norm, Doctors Say

By GINA KOLATA
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When the Supreme Court ruled on Thursday that states may continue to ban doctor-assisted suicide, it addressed the kind of death in which doctors actively help patients kill themselves. What was not considered in that decision is the fact that nowadays many, if not most, Americans die because someone -- doctors, family members or they themselves -- has decided that it is time for them to go.*

What might be called managed deaths, as distinct from suicides, are now the norm in the United States, doctors say. The American Hospital Association says that about 70 percent of the deaths in hospitals happen after a decision has been made to withhold treatment. Other patients die when the medication they are taking to ease their pain depresses, then stops, their breathing.

There is less information on the deaths that occur in nursing homes and in private homes. But doctors say they often discharge patients from a hospital with the implicit understanding that they are sending them home to die, with a morphine drip for pain or without the ministrations of what they would call overzealous doctors at a hospital who might start antibiotics to quell a fever or drugs to stabilize a fluttering heart.

"It's called passive euthanasia," said Dr. Norman Fost, director of the Program in Medical Ethics at the University of Wisconsin. "You can ask who's involved and is it really consensual, but there is no question that these are planned deaths. We know who is dying. Patients aren't just found dead in their beds."

Doctors, Dr. Fost said, decide not to provide antibiotics to treat an infection, or they withdraw drugs that maintain a patient's blood pressure, or they remove a patient from a ventilator.

Dr. Maurie Markman, a gynecological cancer specialist at the Cleveland Clinic, said a typical case might involve a woman with ovarian cancer who at first responded to chemotherapy but whose cancer now seemed impervious to the powerful drugs, and had developed bowel obstructions.

He could operate to try to remove the obstructions, but the chances are that it would do no good. Or, Dr. Markman said, "you can put a tube in to drain her stomach so she doesn't throw up." But then, he added, "you have to ask the woman, 'Is that what you really want?' " She would have to live with that tube for the rest of her life.

Dr. Markman, who said he sees such patients "at least once a week," tells the woman that he wants to focus on her symptoms rather than on her underlying disease. He sends her home with pain medications if she is in pain and anti-nausea drugs if she is nauseated, but the woman will never eat or drink again because of her obstructions. She will not return to the hospital for any sort of aggressive treatment.

Dr. Markman said he never bluntly tells the woman that there is no hope and she is going to die, but he, and probably she, know what is going to happen -- and soon.

Is that assisted suicide or assisted death, or is it relief of suffering? For Dr. Markman, the answer is clear. "My intent always is to relieve suffering. If that's my goal, I can look myself in the eye. I can go to sleep at night."

Dr. Joanne Lynn, director of the Center to Improve Care of the Dying at George Washington University School of Medicine, said her typical case might be an old man, fragile and with multiple medical problems. She will finally discharge him from the hospital and send him home to his family, knowing that the decision to send him home is a decision to let death come soon. If he develops a fever, there is no reason even to take his temperature, she said. "The agreement is that he will not come back into the hospital for almost anything."

Dr. Lynn added: "Many of the decisions may be ambiguously articulated. They may be as much as a nod, something brought up in conversation, 'How do you feel about staying here?' "

But underneath the nods and significant glances, she said, is a conclusion that it is time for the patient to die.

Yet, Dr. Margaret P. Battin, an ethicist at the University of Utah, asks, how much do the patients and family members really understand? She said patients and family members might not grasp the hidden message in their doctor's words. "When a patient is asked, 'Do you want to go home and be with your family?' it would be easy to misinterpret that," Dr. Battin said.

Or, she said, if a doctor says, "I can see you're in pain, let's start a morphine drip,' " a patient may not realize that the pain medication will shorten his life. "I can imagine a great many patients who would say, 'I don't want this pain, but if the medication is shortening my life, I can live with the pain,' " she said.

"That lack of candor about how the patient's death will occur and under what conditions is the thing that's particularly troubling," Dr. Battin

added. "The patient is being invited to make a choice without understanding what the stakes are."

It is even worse, she said, when family members make these choices for patients. Dr. Battin said she spoke about the issue to an ethicist when she visited the Netherlands, where doctors who help patients kill themselves are typically not prosecuted.

"You Americans talk so much about the slippery slope," she recalled the ethicist saying, "But we perceive you as being much farther along the slippery slope than we are." Dr. Battin said she agreed.

But that analysis is glib, some doctors say, and they tell heart-wrenching stories to support their view.

Dr. Beth Y. Karlin, director of the Gilda Radner Ovarian Cancer Program at Cedars Sinai Medical Center in Los Angeles, said she had a 40-year-old patient with ovarian cancer. The cancer had spread to her liver and she was jaundiced and in such agonizing pain that she could not sit up. "She did not want to die," Dr. Karlin said, but death was near and living as she was was agony.

Dr. Karlin sent her home with a morphine drip, which soothed her pain, sedated her -- and hastened her death. The woman's death was peaceful.

But Dr. Karlin said she had never specifically asked the woman whether she wanted to die more quickly, and tranquilly, with morphine. "It is the ultimate caring to allow patients to have some dignity," she said.

Dr. Karlin and other doctors recoil from the idea of bluntly telling patients they are going home to die.

"You take away hope when you say that nothing can be done," Dr. Markman said, adding that he does not even tell a patient that he wants to relieve suffering.

"Suffering has a horrible connotation," he said. "I say, 'Let's focus on another aspect of your cancer -- symptom management.' "

Dr. Daniel Brock, director of the Center for Bioethics at Brown University School of Medicine, said Americans debating death and dying have assumed that the decision to allow doctor-assisted suicide is "the big leap where bad things are likely to happen."

"That seems to me clearly wrong," Dr. Brock said, adding that his concern is with the covert managing of death. At least with doctor-assisted suicide, he said, the patients ask to die and take the lethal medicine themselves. But many doctors oppose the notion of routinely prescribing lethal drugs for dying patients, and deny that by managing death they are breaching moral boundaries.

Dr. Fost said: "Every civilization throughout history has had strict rules against killing, but almost none have prohibitions against letting people die. Many people feel that there is a kind of brutalization when doctors kill people, a dulling of sensibilities, a feeling of dirty hands."

Dr. Lynn said: "It's one of these things where the spin is the message. If the question is, 'Is there some decision made that affects the time and manner of dying?' the answer is, 'Yes, and of course there should be.' "

But that is not the same as actively killing, she said, adding: "When a patient is ready to die, I can stop nutrition and hydration. I can stop insulin and ventilation. I can sedate them. I can creatively collaborate with the forces of nature. But if they really want the control of being dead tomorrow morning at 10, I cannot promise that."

Dr. Lynn said that some people "find it startling or worrisome or a little bit scandalous to think that maybe some exercise some discretion over how they die." Others, she added, would say, "But of course."

That is not to dismiss the anguishing questions about how far doctors should go in managing death, Dr. Lynn said. "Almost all who have multiple grounds from which they find their morals find this a terribly troubling issue," she added. "If you don't find it troubling, you aren't thinking hard enough."