'Unity' benefits extend beyond AOA public relations programs

To the Editor:

In response to the editorial, "Osteopathic unity must continue," (*JAOA* 1999;99:510) by Kenneth E. Ross, DO, I extend kudos to Dr Ross and his colleagues at the Missouri (the "Show Me" state) Association of Osteopathic Physicians and Surgeons. They should be recognized for showing all of us that the benefits of professional unity extend far beyond public relation programs of the American Osteopathic Association (AOA).

Just like osteopathic distinctiveness, osteopathic unity comes in many forms. For Missouri, this includes scholarship, convention funding, and loan programs to support its students. For others, unity activities might include community outreach initiatives such as career days or health screenings. And while at the national level we will continue working with BSMG Marketing Firm on our public relations objectives, we will also be working with all affiliates and DOs on our shared goal of increased public awareness.

As we proceed with year 2 of the Campaign for Osteopathic Unity, we will also be examining opportunities to build unity in the clinical setting. It is our hope that increased use of osteopathic manipulative treatment in patient treatment and diagnosis will bring physicians, hospitals, and directors of medical education closer together.

John B. Crosby, JD
Executive Director
American Osteopathic Association

In defense of Dr Kevorkian

To the Editor:

I, too, read with interest the editorial by Frederick J. Goldstein, PhD, on physician-assisted suicide.[1] Dr Hartman's rebuttal to this rather one-sided view on end-of-life issues[2] was both eloquent and representative of the views of both myself and many of my colleagues.

With all due respect to my former pharmacology professor, Dr Goldstein's reply to Dr Hartman was equally as one sided.

First, I find it very difficult to believe that Dr Kevorkian would simply take people at their word and not perform at least a rudimentary inquiry to find if they have a terminal illness. If, in fact, this were the case, would not Dr Kevorkian have been charged and convicted of murder several years earlier? And, if "certain autopsy results" indicated no identifiable pathologic process, then what exactly were the circumstances behind their deaths? Dr Goldstein failed to elucidate these so-called "facts."

Second, Dr Goldstein seems to demonize Dr Kevorkian, charging "[he] kills patients in motel rooms....[he] has no interest in trying any form of treatment—other than termination of life." Perhaps so. But, does Dr Goldstein imply by this statement that physician-assisted suicide is okay as long as it is done at the patient's home and only after all other forms of palliation are exhausted? It seems that Dr Goldstein wants to paint a disparaging picture of humane physician-assisted suicide by using "Dr Death" as its sole example. Dr Kevorkian is evil. Dr Kevorkian practices physician-assisted suicide. Therefore, physician-assisted suicide is evil.

Finally, Dr Goldstein's clinical research undoubtedly should be applauded. Thank God for people like him who have such an active role in palliative care and end-of-life issues. But let us leave the ivory tower for a moment, and join me in the real world. Most patients do not have access to large research-oriented institutions. At best, their diagnoses are made by their family physicians, they are treated by specialists, and if those physicians are especially astute, their treatment will involve hospice well in advance of the disease process. The problem is that palliation and end-of-life issues are not simply a matter of titrating the right dose of opioids and selective serotonin-reuptake inhibitors—they are also spiritual, family guided, and extremely personal. I have often thought, would I want to go on living as long as my pain is under control, and I was receiving therapy for comorbid depression as a result of my illness? Well, that depends. I suppose if I were happy being bedridden...or ventilator dependent...or dependent on others for round-the-clock care to do everything from feeding me to bathing me, then I would want to go on. But I cannot say that at this point. Should I have the choice? Absolutely. Physician-assisted suicide is absolutely in keeping with the osteopathic perspective. Like osteopathic manipulative treatment, it is another weapon, which if used rationally and in conjunction with patient and family education, hospice, and the research of people like Dr Goldstein, can help to eradicate pain and suffering. Is not that our job?

Society will ultimately decide if physician-assisted suicide has any place in our arsenal against pain and suffering. I honestly hope it decides for it. That way we can regulate it, control it, and use it only when appropriate. Gone will be the days of white coats skulking the corridors of hospitals at 3 o'clock in the morning "adjusting" morphine drips to respiratory rates of zero. And I'll say "Amen."

Michael E. Suls, DO
Corpus Christi, Texas

References

1. Goldstein FJ. Kevorkian kills patients along with the clinical research to help them. *JAOA* 1999; 99:77.

2. Hartman SE. Kevorkian plays important role in advancing physician-assisted suicide. *JAOA* 1999; 99:393.

Responses

To the Editor:

I appreciate having the opportunity to respond to Dr Suls.

■ **Terminal status of patients killed by Dr Kevorkian—**Of 39 patients whose lives were ended by Dr Kevorkian, 32 were *not* terminal. The majority of these cases were reviewed by Oakland Medical Examiner Ljubies J. Dragovic. Patients in whom there was no identifiable pathologic process include:

☐ a 58-year-old woman who complained of "severe pelvic pain," but physicians could not find a physical cause;

☐ a 39-year-old woman "treated" for multiple sclerosis, but again, no signs were found at autopsy;

☐ a 42-year-old woman with "chronic

fatigue syndrome" and some "muscle disorder" of unknown origin (this patient's husband, who was present at the killing, had been previously arrested twice for assaulting his wife);

□ another patient in whom only Alzheimer's disease had been diagnosed.

■ **Death site—**In my reply to Dr Hartman,[1] I identified the environment that Dr Kevorkian uses only to show that nothing he does is humane. For Dr Suls to extract this segment of mine and expand it as he did is inappropriate logic and misses my primary point.

■ **Clinical research—**Dr Suls fails to recognize the contributions to the practice of family medicine that are made not only by "large research-oriented institutions" but also by others such as the Philadelphia College of Osteopathic Medicine (PCOM), where research is very important but not a primary focus. We take our scientific mission seriously. We target clinical problems that are dilemmas for nonresearch-oriented physicians and develop studies to try to find solutions. When positive results are obtained—and lead to new approaches in treatment—researchers make their findings known at national meetings and in medical journals to reach as many health professionals as possible, including physicians in community medicine. Therefore, it is unfortunate that Dr Suls cannot make this connection.

■ **End-of-life procedures—**Dr Suls can narrow his written response to mesh with his views, but they do not—and never have—represented mine. As pointed out in my February 1999 editorial,[2] I directly observed and collaborated with staff members at Walter Reed Army Medical Center who provided emotional and spiritual support to terminally ill patients. Further, I have never advocated pharmacotherapy as the sole means of end-of-life treatment. However, it is this part of terminal care to which I can offer my scientific expertise.

My final comments are directed at two other statements made by Dr Suls. He says that "physician-assisted suicide is in keeping with the osteopathic perspective." I have been on staff at PCOM for 7 years—and have served for 5 years as director of our second-year medical school course in oncologic sciences, in which we have several sessions on the dying patient—and I have never heard any of my osteopathic physician colleagues make (or even acknowledge) such a statement. In addition, Dr Suls referred to "white coats" in hospitals who "at 3 o'clock in the morning 'adjust' morphine drips to respiratory rates of zero," and my reply here is that any physician who knows of such an occurrence needs to report it because it is murder—as Jack Kevorkian can now attest from his jail cell.

Frederick J. Goldstein, PhD, FCP
Professor of Clinical Pharmacology
Philadelphia College of Osteopathic Medicine
Philadelphia, Pa

References

1. Goldstein FJ. Kevorkian plays important role in advancing physician-assisted suicide: Response. *JAOA* 1999;99:393.

2. Goldstein FJ. Kevorkian kills patients along with the clinical research to help them. *JAOA* 1999; 99:77.

Editor's response

I have reviewed the letter that was sent to me by Michael E. Suls, DO, concerning the editorial by Frederick J. Goldstein, PhD, on physician-assisted suicide (*JAOA* 1999; 99:77).

I agree that end-of-life issues are not simplistic and require a great deal of skill when dealing with patients who are dying and their families who are going through this very difficult process. We as osteopathic physicians are obliged to care for the patient in a way in which we can minimize pain and suffering. I believe that our osteopathic oath, which we each took at the time of our graduation, states that we should do everything possible to treat the pain and suffering. However, I do not believe that it gives us the right to practice physician-assisted suicide. I firmly believe that this practice is not part of the osteopathic perspective.

I strongly believe that physician-assisted suicide is unnecessary and that terminally ill patients can be treated with palliative therapy and therapy to relieve pain and suffering.

The American Osteopathic Association stated the profession's position in a 1997 resolution concerning physician-assisted suicide.[1] Physician-assisted suicide is wrong. Our oath states that it is our responsibility to preserve the health and life of our patients and further, not to use deadly drugs, even though such use may be requested by the patient or the patient's family.

Our profession has encouraged our schools to specifically address this issue in the course of study and to concentrate on pain management and palliative treatment of the terminally ill patient. The American Osteopathic Association (AOA) has encouraged our schools to focus specifically on the goals, objectives, and value of hospice care and intervention. Furthermore, continuing medical education programs are being encouraged by the AOA to present to physicians information and resources on supportive care which are valuable to our patients who are in the dying process.

Again, I want to make my position perfectly clear. Physician-assisted suicide is *not* in keeping with the osteopathic perspective. In fact, it is directly contrary to what we should be doing and what we promised to do, by our osteopathic oath, at the beginning of our career. I believe that Dr Suls' opinion is emphatically wrong.◆

Gilbert E. D'Alonzo, DO
Editor in Chief

Reference

1. American Osteopathic Association: *1999 Yearbook and Directory of Osteopathic Physicians;* 615-616.