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Killing the Pain, Not the Patient: Palliative Care vs. Assisted Suicide

Excerpts of an article by Richard M. Doerflinger and Carlos F. Gomez, M.D., Ph.D.

Some time ago an ad appeared in a medical journal promoting a new pain-killing drug. To emphasize that this new product could relieve pain without sleepiness or other side-effects, the ad began with a slogan: "Stop the pain. Not the patient." The outcome of our society's debate on physician-assisted suicide may depend on how well we communicate—and act upon—a similar message. …."Kill the pain. Not the patient."

The Facts About Pain Control - Many doctors hesitate to give dying patients adequate pain relief because they fear that high doses of painkillers such as morphine will suppress the breathing reflex and cause death. Yet we now know that this fear is based on false assumptions and on inadequate training of physicians in pain management techniques.

In reality, a very large dose of morphine may well cause death—if given to a healthy person who is not in pain and has not received morphine before. But when administered for pain, such drugs are taken up first by the patient's pain receptors. In fact, patients regularly receiving morphine for pain quickly build up a resistance to side-effects such as respiratory suppression, so they can easily tolerate doses that would cause death in other people. Fortunately they build up a tolerance to the side-effects far more quickly than to the drugs' analgesic effects—so doctors need not hesitate to increase dosages when needed to relieve pain. The question, "What is the maximum dose of morphine for a cancer patient in pain?" has one answer: "The dose that will relieve the pain." As long as a patient is awake and in pain, the risk of hastening death by increasing the dose of narcotics is virtually zero. Unrelieved pain is itself a stimulant, which overwhelms any depressive effects of narcotics.

Patients whose unrelieved pain is distorting the very fabric of their lives need adequate pain control the way a diabetic needs insulin to function properly.

Very rarely it may be necessary to induce sleep to relieve pain and other distress in the final stage of dying. Euthanasia advocates call this "terminal sedation," but it is the same kind of sedation that is sometimes needed to calm distressed or restless patients with non-terminal conditions. While some terminally ill patients may die under such sedation, this is generally because they were imminently dying already.

In competent medical hands, sedation for imminently dying patients is a humane, appropriate and medically established approach to what is often called "intractable suffering." It does not kill the patient, but it can make his or her suffering bearable. It may also allow a physician the time to re-assess a patient's pain needs: The terminally ill sedated patient may later be withdrawn from the sedatives and brought back to consciousness, with his or her pain under control.

The factual evidence supports these claims. In 1992 the Journal of the American Medical Association (JAMA) reported on 97 terminally ill patients who died after life support was withheld or withdrawn. Sixty-eight of the patients received painkilling drugs or sedatives to relieve pain and other distress while dying—and they lived longer than the patients who did not receive drugs. The study found that the dosages of these drugs were chosen to ensure relief of suffering, not to hasten death.

Only recently has the medical profession begun to appreciate that unrelieved pain can itself hasten death. It can weaken the patient, suppress his or her immune system, and induce depression and suicidal feelings. It can keep patients from living out their lives with a modicum of dignity, in the fellowship of their families and friends. Adequate pain relief can actually lengthen life. According to a JAMA news item of March 25, 1992, part of modern medicine's task may be that of "killing pain before it kills the patient." Or as the Catholic Health

Association says in its 1993 guide Care of the Dying: A Catholic Perspective: "Unrelieved agony will shorten a life more surely than adequate doses of morphine."

In short, when dosages of painkilling drugs are adjusted to relieve patients' pain, there is little if any risk that they will hasten death. This fact alone should put to rest the myth that pain control is euthanasia by another name.

Assisted suicide undermines good pain management. During the Supreme Court's January 1997 oral arguments on its assisted suicide cases, Justice Stephen Breyer noted a remarkable fact from a report by the British parliament's House of Lords: The Netherlands, which has allowed assisted suicide and euthanasia for years, had only three hospices nationwide, while Great Britain, which bans these practices, had 185 hospices. He had placed his finger on one of the most insidious effects of legalization: Once the "quick and easy" solution of assisted suicide is accepted in a society, doctors lose the incentive to pursue more difficult but life-affirming ways of truly caring for patients close to death. The converse is also true: prohibiting assisted suicide sets a clear limit to doctors' options so they can commit themselves to the challenges of accompanying patients through their last days. As one physician said after years practicing hospice medicine: "Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying" (quoted in Leon Kass, "Why Doctors Must Not Kill," Commonweal, Sept. 1992, p. 9).

In short, pain control and other elements of palliative care must be clearly distinguished from intentional killing of patients. In trying to blur this distinction, euthanasia advocates only show their own indifference to the goal of promoting better care for dying patients.

In logic and in practice, two very different paths lie before the medical profession and our society: What Pope John Paul II has called the "false mercy" of assisted suicide and euthanasia, and the "the way of love and true mercy" that dedicates us to compassionate care (The Gospel of Life, No. 66-67). It is literally a choice between death and life.

For the full article, see http://www.usccb.org/about/pro-life-activities/respect-life-program/killing-the-pain.cfm

Mother and Career Woman A Good Match

How often we hear that a baby will ruin a woman's chance of advancing her career, or that a woman can't have a family and a career… Ergo, women have to have access to abortion. WRONG! In her article "Why Mothering Makes Us Better at Work," Amy Henderson debunks the myth that when a woman becomes a mother she will be less effective at work and her career will inevitably suffer.

Mrs. Henderson's own personal experience and her interviews of more than 100 high-performing mothers, as well as academic research from a variety of fields, including neuroscience, evolutionary biology, game theory, primate patterns, leadership studies, and more, show that women who become mothers develop the capacity to outperform their former non-mom selves in their careers.

In late 2014 her husband, an involved Dad, turned white when the pregnancy test revealed two pink lines – Pregnant!.. They already had two toddlers—a 3-year-old and an 18-month old, and she was working more than full-time as the co-founder of a start-up. Being committed to both being present to her toddlers and performing at a high level in her career, she was sleeping an average of 4-5 hours a night. How would she ever balance another child in her already overly-scheduled life?

She reached out to other "career moms" she admired to learn if it is possible to balance parenting and building a successful career. With her sleeping infant in her arms, neck kinked to hold the phone between her cheek and shoulder, she asked these other mothers "How are you doing it?"

The results were quite enlightening. These women —senior vice presidents at tech companies, CEO's, computer programmers, partners at law firms, nurses, doctors, and more—were performing better in their careers because they had children, not in spite of them.

Mrs. Henderson realized that motherhood teaches a woman where she needs to grow, and gives an opportunity to stretch past self perceived limits to meet the challenge of raising a family. More than 80% of the moms she interviewed commented that

they had encountered at least one painful time of reckoning, when they were forced to face difficult things about themselves and/or their relationships with others.

And while these moms had a range of unique and specific areas where they were forced to grow, when the interviews were coded, one common theme stood out: nearly all of them developed more and better relationships with the people around them.

This drive to establish stronger bonds with others is neurologically supported. Oxytocin, also known as the 'bonding hormone,' is released during childbirth and breastfeeding. According to a 2014 study led by Dr. Ruth Feldman at Bar-Ilan University in Israel, oxytocin is also produced in non-birth parents who engage in caretaking activities for their children. And when oxytocin is present, Dr. Shellye E. Taylor at UCLA has found, people are more likely to respond to stress with the impulse to "tend and befriend," rather than to fight or flight.

Almost every mother interviewed said building a community of support was essential. Julie Miller-Phipps, the regional president for Southern California Kaiser, commented, "When you become a parent, it's not doable to have everything fall on you. I quickly discovered that I couldn't do it all myself, and I didn't need to. Others couldn't do it by themselves either, and I could help them. I built a network of people in my child's life and in my work life, who help me ebb and flow and be resilient." Building a community of support is step one.

Step two is learning to deepen and sustain those relationships. Or, as Amy Pressman, the President of Medallia, a 1,000-employee company she co-founded with her husband while raising three small children put it: "You can't fire your kids, so you must grow and evolve as a person to adapt to their needs and wants. As a result, parenthood has increased my capacity to nurture the best in others, a skill I strive to integrate into our company."

Motivated to succeed in our careers and at home, moms want to accomplish more in less time. Working with others makes this possible. In Feldman's lab, they found that oxytocin positively impacted the regions of the brain associated with emotional processing, social understanding, and cognitive empathy. In other words, showing up for our children makes us more emotionally intelligent. And this allows us to work more effectively with others; which, according to game theorist Martin Nowak, is the most successful form of engagement. Nowak says Darwin was wrong: collaboration, not competition, is the key to survival. In the long run, cooperators, those who work well with others, are the ones most likely to win anywhere—the animal kingdom, in computer simulations, and even in corporate environments.

To sum up Mrs. Henderson's research, working while mothering mandates that one develop broader, better relationships with others. And this lies at the heart of motherhood's potential to positively transform careers, especially in the rapidly approaching workplace of the future.

The preceding is based on an article by Amy Henderson - Founding CEO at Tend Lab

A Day at the Mall

Friday of Mother's Day weekend we did an Information Table for Life. While the quantity of visitors to our table was not as large as in the past, the quality far exceeded any previous encounter.

Mother's Day often brings forth memories and laments of past abortion(s). Several women alluded to the loss of a child through abortion years ago. We provided several resources including "Silent no More" and the Rachel's Vineyard weekend information pamphlets on "post abortion healing."

Another lady asked if we could help her daughter who is having difficulty trying to conceive a child and they can't afford "fertility clinics." We gave her a copy of the May newsletter article on NFP and later did some further research and provided her with information on pro-life doctors and organizations willing to offer ethical pro-life reproductive assistance, including the California Natural Family Planning (www.canfp.org) and the Pope Paul VI Institute, one of the leading resources for FertilityCare and NaProTechnology http://www.popepaulvi.com/about.php

We continue to have folks who stop just to thank us for being there, and perhaps pick up a precious feet pin or some literature to share with a friend. The

most touching moments are often when a pregnant couple will be drawn to our table by the fetal models, looking to see the development of their baby; interesting that they never call it a “fetus.”

The teens are the most energizing, asking great questions and often leaving the table with a silicon bracelet proclaiming “Life is Precious” or “Pro-life” or one of our abstinence program “Real Love Waits” bracelets. The Precious Preborn 10-12 week babies and the precious feet pins are always crowd pleasers for all age groups. The little children handle the precious preborn baby like it is a fragile figurine; it is so precious.

It is your donations that provide all this, including literature, internet access and the phone to do research. And let us not forget even this newsletter is only possible because of your generosity.

THANKS to all our donors; we couldn’t do it without you!

Calendar of Events

For the latest updates of events see www.calendarforlife.org

Survivors Camp - July 18th-28th, San Francisco for Pro-Life Christians between the ages of 14-29. In Northern California for the first time ever! Join The Resistance at the 20th annual Survivors Pro-Life Training Camp - 11 days of intense training and activism that will prepare you to stand against the worst evil of our day: abortion. More info http://www.survivors.la/southern-california-prolife-training-camp **NOTE Change in dates and Location.**