Euthanasia is one of the most controversial issues rising in the medical field today. It is the act by which a patient is assisted by the respective physician or another third party to be granted a relatively more peaceful death than that given by the course of nature. There are two basic forms of this procedure: passive euthanasia and active euthanasia. Passive euthanasia is the deliberate withholding of drugs or other life-sustaining treatment ("Passive Euthanasia"). This is where a doctor could advise elderly patients with chronic illnesses to go home and be with their families, in this way subtly not giving the patient so-called necessary hospital treatment that would in fact only interfere with their quality of life in the last days. On the other hand, active euthanasia is a mode of ending life with the intent of causing the patient's death in a single act ("Active Euthanasia"). An example of this would be in cases where patients are given release through the administration of lethal injection.

Moreover, Physician Assisted Suicide (PAS), which has come to be better known as Physician Assisted Dying (PAD) is a similar but very different circumstance. PAD is defined as occurring when a physician provides a patient with the medical means, in addition to or instead of, medical knowledge to end his or her own life. This method is known as a more humane way of dying ("Physician-Assisted Suicide"). Euthanasia, by far, is illegal in all states of the U.S, but PAD has been legalized in Washington, Oregon, Montana, and Vermont (ProCon.org). Although these states allow physicians to comply with patients' needs and their demands to be induced into a peaceful death, there are repercussions that come as a result of such a decision.

Dr. Jack Kevorkian, famously known as "Dr. Death," engaged in the administration of PAD by allowing terminally ill patients wanting peaceful deaths to 'pull their own plug.' His first patient, Janet Adkins, was diagnosed with Alzheimer's disease; and in accordance with her

family, wanted to end her life before it deteriorated further. In 1989 Oregon, Dr. Kevorkian allowed Mrs. Adkins to end her own life by pulling a cord on a machine he had designed. This machine automatically delivered lethal medication to her body through an intravenous needle that Dr. Kevorkian prepared, prior to the execution of her will ("Adkins, Janet"). This incident, and many that followed, no doubt greatly impacted the patients' families. However, Dr. Kevorkian was firm in his beliefs that the right thing to do was to let a patient die with dignity. Thus, he seemed to express no remorse as he told TIME in 1993, "My specialty is death" (Chua-Eoan Howard, 2011). He is one doctor, in the history of medicine, who prides in his engagement with Physician Assisted Dying. However, not all participating doctors feel the same way.

It has been accepted that when someone dies, even if it is peacefully, the family and friends left behind are struck just the same by the loss; it negatively affects the dynamics of relationships. This truth has been recognized and accepted by many people. And in order to adequately deal with it, a lot of them turn to support from more family and friends, and consultations with therapy sessions as necessary. Nevertheless, one aspect of such situations has been neglected to be addressed. In circumstances of PAD, the patient and the family are able to get their needs met, and have well developed ways to deal with their loss. But, what about the participating doctors? Who follows up with the physician that helped a patient attain death, to see how what he has helped bring about is affecting him? Not many people consider such questions and put the doctors' plight under the microscope. Hence, it is imperative to also understand the existential truth about what goes on behind the mask of a doctors' seemingly unfeeling face after he assists a patient to die with dignity.

At the beginning of their training, physicians are taught to follow the Hippocratic Oath, and are required to do all good unto their patients. They are called to "practice medicine with the

underlying motive and commitment to improve health and restore life (Abramson, N., et al., 1998). However, different reasons could push them into complying with this procedure. Some of the doctors reported feeling pressured into agreeing to administer PAD when they were applying for jobs at hospitals They even felt pressured by patients who sought the doctors as a window of opportunity to intimidate them into assisting their deaths, so as to seek relief from chronic pain and other such discomforts (Stevens, Jr., Kenneth R, 2006).

An example of intimidation and coercion can be seen with Dr. Peter Reagan, who had to write a lethal prescription for one of his patients.

"I had to accept that this really was going to happen. Of course I could choose not to participate. The thought of Helen dying so soon was almost too much to bear, and only slightly less difficult was the knowledge that many very reasonable people would consider aiding in her death a crime. On the other hand, I found even worse the thought of disappointing this family. If I backed out, they'd feel about me the way they had about their previous doctor, that I had strung them along, and in a way, insulted them."

When asked about what he learned from this experience, he said, "I think the most important thing is for doctors to understand how huge of an experience it's going to be for them and that they must have ways of dealing with it for themselves" (Stevens, Jr., Kenneth R, 2006). In this way, Dr. Reagan clearly conveys that PAD has a strong impact on the physicians involved, and they need to find ways to deal with the act of euthanasia afterwards.

In an effort to secure good hospital jobs and bring relief to the patients, the doctors may agree to PAD, not realizing if that was the best long term action to take. By getting caught up in the thought that the patient has the right to choose death for his life, the doctor may grant that wish, without fully considering the consequences that could be brought upon him as a result of

agreeing to that (Berry, 2000). This phenomenon has proven to have significant emotional and psychological effects on the participating physician. The change in practice of medicine has transformed from once having a goal of bringing complete healing to patients, to now taking their life away. Such an evolution can have profound unpleasant effects on the physician. Gerrit Kimsma, a Dutch family physician and medical ethicist, writes that, “some professionals become dysfunctional and may require a lot of time to recover" (Stevens, Jr., Kenneth R, 2006). In accordance with his statement, it is evident that such a traumatic experience could leave participating physicians with a sense of powerlessness and isolation from what their calling was originally assigned to do.

For some doctors, dealing with the after effects of PAD may not be so harsh, if they are able to reason themselves out of the negative thoughts. Dr. Maurie Markman, a gynecological cancer specialist at the Cleveland Clinic, is one such individual who says, "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” (Kolata, 1997). Her response is that of a doctor who has built around herself a wall of resolve that physician assisted dying is an acceptable way to let patients die peacefully. Her stance parallels with the ideals of Dr. Beth Y. Karlin, who is the director of the Gilda Radner Ovarian Cancer Program at Cedars Sinai Medical Center in Los Angeles. Dr. Karlin believes that “it is the ultimate caring to allow patients to have some dignity.” For doctors who agree with physician assisted dying and feel that life can be taken away for a ‘better cause,’ which in this case would be painlessness and diminished suffering, then coping with the after effects may not be so difficult (Kolata, 1997).

However, for doctors who do find it challenging to live with the fact that they helped to take away a life, when in their core beliefs they know that “even in the absence of a God, life is

still sacred" (Berry, 2000), it becomes extremely tormenting to live with that action. And when asked about how far doctors should go in managing death, Dr. Joanne Lynn, Director of the Center to Improve Care of the Dying at George Washington University School of Medicine, said that, "Almost all who have multiple grounds from which they find their morals find this a terribly troubling issue" (Kolata, 1997). Thus, it leads to the belief that in coping with situations like assisted dying most doctors feel utterly distressed.

In a study conducted by 'Physicians for Compassionate Care Education Foundation' (PCCEF), it was found that doctors who engaged in PAD suffered "substantial" mental disturbance as a result of the incident. A doctor from the Netherlands, where euthanasia was first legalized in the year 2000, proclaimed that "many physicians who had practiced euthanasia mentioned that they would be most reluctant to do so again." The PCCEF study was also found to directly match with German reports from World War II, which showed negative psychological effects on the doctors and nurses who were a part of the euthanasia program, T-4. This T-4 program was directed by Hitler, initially targeting handicapped and orphaned children as well as mentally disabled adults. These populations were starved to death or killed by lethal medication. In the book, Origins of Nazi Genocide, which was published in 1997, author Henry Friedlander discusses that the psychological condition of nurses and doctors from the T-4 movement was drastically negative. He accounts that they suffered alcoholism and serious mental disorders after working for long periods of time in the killing centers (Stevens, Jr., Kenneth R, 2006). In this way, a striking parallel can be drawn between the proclamation of the doctor from the Netherlands about the reluctance of doctors to practice euthanasia again, and the negative effects upon the medical professionals of the T-4 program from committing actions that resulted in the killing of many a people.

In an issue of *Law and Medicine*, one of the reports written by Dr. Kenneth R. Stevens, who is the Vice President of Physicians for Compassionate Care, describes the details of a study analyzing the after impacts of committing physician-assisted dying. Although the doctors in the Netherlands have been practicing euthanasia legally since the year 2000, they are still unsettled about the issue. “To kill someone is something far reaching and that is something that nags at your conscience," one physician expressed. "I wonder what it would be like not to have these cases in my practice. Perhaps I would be a much more cheerful person" (Stevens, Jr., Kenneth R, 2006). Statements like this clearly show the doctors’ unfavorable feelings toward such an act.

With the legalization of euthanasia in Oregon during the year 1998, its doctors continuously feel displaced regarding this issue. An annual report by the state of Oregon describes the physicians’ feelings even further. Documented quotes from two physicians state, “But my thoughts are about the fact that I know that it is a very difficult thing as a physician . . . I wonder if I have the necessary emotional peace to continue to participate” (Physician D). “I find I can't turn off my feelings at work as easily . . . because it does go against what I wanted to do as a physician” (Physician I). Additional responses from physicians unable to cope with their participation read, “It was an excruciating thing to do . . . it made me rethink life's priorities.” “This was really hard on me, especially being there when he took the pills.” “This had a tremendous emotional impact” (Stevens, Jr., Kenneth R, 2006). From such reactions it can be seen that the resulting guilt and feelings of wrong-doing can work to severely impair physicians’ psyche and emotional well being.

Other physicians also spoke of frustrations with the fact that they could not talk about their experiences with anyone, due to the fear that their patients and colleagues may shun them if

they found out the truth about their participation in PAD. Such strong emotional impact left on these doctors engaging in PAD, seems to be encompassing and hindering their quality of life.

The after effects of PAD restrict the lifestyle of doctors and negatively control their emotional state of being. Dr. Kenneth R. Stevens states that in cases of PAD, "Physician participation in assisted suicide or euthanasia may have a profound harmful emotional toll on the involved physicians." In addition, "Doctors must take responsibility for causing the patient's death. There is a huge burden on conscience, tangled emotions and a large psychological toll on the participating physicians" (Stevens, Jr., Kenneth R, 2006). The unfortunate aspect of this turmoil lies in the fact that doctors feel that sharing such a burden with others would be a difficult task since many may not identify with their individualized pain.

When Dutch physicians were interviewed in the same study about their feelings on euthanasia and PAD, they responded to many of the questions in a negative manner. When asked how they felt about their first time administering PAD, Dr. Van Coevorden replied, "Awful." Dr. Mensingh van Charente followed by saying, "It is not a normal medical treatment. You are never used to it." According to the Dutch custom, most doctors take the following day off after practicing PAD. This is because they feel so weighed down by the impact of something that is so drastically opposite to what they usually do, which is promoting health and saving the lives of their patients. When asked about the emotional impact of PAD, Dr. de Graas responded by saying the following:

"It certainly has been [draining], but I think that a lot is changing in that regard. The first letter of SCEN [Support Consultation Euthanasia Network] is the 's' for 'support,' and that is essential. Also as a nursing home physician confronted with euthanasia, I know that it is

emotionally draining; but it is absolutely important to discuss it, not only with the SCEN doctor but with all your colleagues, to keep yourself healthy."

Finally, Dr. de Grass concluded by saying, "For the individual physician it never becomes less stressful. That is absolutely impossible…" (Stevens, Jr., Kenneth R, 2006). This statement gives concrete insight into the impossible task that participating physicians undertake.

The guilt chip on the shoulders of physicians, who assist in PAD, is a great force to be reckoned with. They struggle on a daily basis to find ways to properly cope with their distress. Dr. deGrass brings up a very important point and resource for other participating doctors in this unsettling state. By maintaining a good support system of colleagues who are in the same position and work with the same driving purpose, the PAD physicians will have peers with whom they can share, discuss, and pour out their grief regarding the difficult administration of the euthanasia procedure. Though physicians themselves may not want to take up the burden of committing this deed, the pressures of work and demands from patients may compel them to take that step. Hence, for times when physicians need the support, a group of like-minded individuals in the equivalent career field would serve as an invaluable source of comfort and understanding.

Along with the support from family and friends, The Consultation Euthanasia Network, located in the Netherlands, is also a helpful resource for practicing physicians to be able to refer to twenty specially trained physicians for advice and consultation regarding PAD. This facility, available in Europe, is an influential and necessary means for physicians to have as a resource during times when they need to reach out and talk about the issues they are facing, with seasoned professionals in the field (Onwuteaka-Philipsen, B. D., and G. van der Wal., 2001). Additional institutions like the SCEN should be established in the US, as well as around the world, so that practicing physicians of euthanasia may have the access to the help they so greatly require.

In addition to institutionalizing more facilities like the SCEN, it is essential that physicians who are willing, and in the position to administer PAD, must be given appropriate counseling sessions. These sessions should be held every few months, or even every few weeks, based on the magnitude of the requests from patients to have doctors administer PAD. This would provide an outlet for those practicing doctors to talk about what they have gone through, get advice and help on how to work through the situation, as well as receive feedback for how well they are doing to date.

Death is never an easy topic for people to digest, especially if one person is causing it for another, even if it is by request. Therefore, it is essential to have therapy meetings between practicing physicians as a supplement to the SCEN, support from family, friends, and understanding colleagues. Unless proper assistance is provided for physicians providing PAD services to humanity, it is unreasonable and unjust to expect those same doctors to continue their daily duties as they had flawlessly done prior to administrations of PAD. Since the doctors work hard to satisfy the needs of their patients, they must also be given adequate amounts of support to help cope with their own needs as well.

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