

It's Over, Debbie

(an article published in the Journal of the American Medical Association, 1988)

The call came in the middle of the night. As a gynecology resident rotating through a large, private hospital, I had come to detest telephone calls, because invariably, I would be up for several hours and would not feel good the next day. However, duty called, so I answered the phone. A nurse informed me that a patient was having difficulty getting rest, could I please see her. She was on 3 North. That was the gynecologic-oncology unit, not my usual duty station. As I trudged along, bumping sleepily against walls and corners and not believing I was up again, I tried to imagine what I might find at the end of my walk. Maybe an elderly woman with an anxiety reaction, or perhaps something particularly horrible.

I grabbed the chart from the nurses' station on my way to the patient's room, and the nurse gave me some hurried details: a 20-year-old girl named Debbie was dying of ovarian cancer. She was having unremitting vomiting apparently as the result of an alcohol drip administered for sedation. Hmmm, I thought. Very sad. As I approached the room, I could hear loud, labored breathing. I entered and saw an emaciated, dark-haired woman who appeared much older than 20. She was receiving nasal oxygen, had an IV, and was sitting in bed suffering from what was obviously severe air hunger. The chart noted her weight at 80 pounds. A second woman, also dark-haired but of middle age, stood at her right, holding her hand. Both looked up as I entered.

The room seemed filled with the patient's desperate effort to survive. Her eyes were hollow, and she had suprasternal and intercostals retractions with her rapid inspirations. She had not eaten or slept in two days. She had not responded to chemotherapy and was being given supportive care only. It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words to me were, "Let's get this over with."

I retreated with my thoughts to the nurses' station. The patient was tired and needed rest. I could not give her health, but I could give her rest. I asked the nurse to draw 20 mg of morphine sulfate into a syringe. Enough, I thought, to give Debbie something that would let her rest and to say good-bye. Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world. I injected the morphine intravenously and watched to see if my calculations on its effects would be correct. Within seconds her breathing slowed to a normal rate, her eyes closed, and her features softened as she seemed restful at last. The older woman stroked the hair of the new-sleeping patient. I waited for the inevitable next effect of depressing the respiratory drive. With clocklike certainty, within four minutes, the breathing rate slowed even more, then became irregular, then ceased. The dark-haired woman stood erect and seemed relieved.

It's over, Debbie.

Name Withheld by Request

Response to It's Over, Debbie (JAMA, 1988)

To the Editor,

The story entitled "It's Over, Debbie" raised profoundly troubling ethical issues – the more so because its sentimental surface masks a dark and worrisome underside.

On the surface of the story, a hassled but resolutely caring resident physician ends the hollow-eyed suffering of a young woman named Debbie by putting a stop to the cruel, "gallows"-like technology that mocks her youth and former vitality.

Just beneath the surface of these heartwarming themes lies the real point of the story – that in cases like this, it is ethical for physicians to kill patients. Unfortunately, "It's Over, Debbie" only disguises and distorts the debate and clarification that are necessary for a moral assessment of mercy killing. First, the story's rhetoric (which is equated with the way the physician thinks) masks the act of killing Debbie with such euphemisms as doing one's "job," giving Debbie the "rest" she needs, and enabling her "to say goodbye." Second, the physician's premeditated manslaughter is associated only with such positive themes as heroically resisting a blind technological imperative within medicine or displaying unique empathy for this cancer patient's plight. Debbie's physician never struggles with opposing moral issues, such as whether this action could be

generalized or whether killing constitutes a betrayal of one's promises to self and peers or what would happen if the term "physician" is also associated with putting persons to death. In fact, the resident kills Debbie with no moral qualms whatsoever.

Even more problematic than the morality of premeditated manslaughter *per se*, however, are the terribly murky grounds for killing in this instance. The physician's database on this new patient was gathered entirely while walking toward the patient's room (when the chart was scanned and as the nurse was talking), followed by a single visit to the patient. The one sentence uttered by the patient at the time, "Let's get this over with," was taken to be a firm request for a painless death from a fully competent adult. There are no consultations, no further conversations with anyone, no sophistication regarding pain relief as a beginning point, and no worries that Debbie's intentions may well have been misread and that the physician may be committing murder in the second degree. The story ends with the physician observing that the "older woman" standing next to the patient the whole time "seemed relieved" when the morphine overdose (quickly supplied by the nurse) ended Debbie's life. Anything but relieved. I believe "It's Over, Debbie" needs a sequel entitled "It's Not Over, Doctor."

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