

CEJA Report 8 – I-93 Physician-Assisted Suicide

INTRODUCTION

Physician-assisted suicide presents one of the greatest contemporary challenges to the medical profession's ethical responsibilities. Proposed as a means toward more humane care of the dying, assisted suicide threatens the very core of the medical profession's ethical integrity.

While the Council on Ethical and Judicial Affairs has long-standing policy opposing euthanasia, it did not expressly address the issue of assisted suicide until its June 1991 report, "Decisions "Near the End of Life."¹ In that report, the Council concluded that physician-assisted suicide is contrary to the professional role of physicians and that therefore physicians "must not...participate in assisted suicide."¹ Previously, the Council had issued reports rejecting the use of euthanasia. In June 1977, the Council stated that "mercy killing or euthanasia...is contrary to public policy, medical tradition, and the most fundamental measures of human value and worth."² Similarly, in June 1988, the Council reaffirmed "its strong opposition to 'mercy killing.'"³

Broad public debate of assisted suicide was sparked in June 1990, when Dr. Jack Kevorkian assisted in the suicide of Janet Adkins (NY Times, June 6, 1990:A1). The debate was advanced in March 1991 when Dr. Timothy Quill disclosed his assistance in the suicide of Diane Trumbull.⁴ Other public events quickly followed. Physician-assisted suicide, together with euthanasia, was placed on the public ballot in Washington State, in November 1991, and in California, in November 1992. Both times, voters turned down proposals to legalize physician-assisted dying (USA Today, August 9, 1993:13A). In September 1993, by a vote of 5-4, Canada's Supreme Court denied a woman's request to end her life by assisted suicide (NY Times, October 1, 1993:A8). In 1994, voters in Oregon will decide whether to legalize assisted suicide in their state.

Resolution 3, introduced at the 1993 Annual Meeting by the Medical Student Section and referred to the Board of Trustees by the House of Delegates, requested an ethical study of assisted suicide. In this report, the Council revisits the issue of physician-assisted suicide.

DEFINITIONS

Assisted suicide occurs when a physician provides a patient with the medical means and/ or the medical knowledge to commit suicide. For example, the physician could provide sleeping pills and information about the lethal dose, while aware that the patient is contemplating suicide. In physician-assisted suicide, the patient performs the life-ending act, whereas in euthanasia, the physician administers the death-causing drug or other agent.⁵

Assisted suicide and euthanasia should not be confused with the provision of a palliative treatment that may hasten the patient's death ("double effect"). The intent of the palliative treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a possible side effect of the treatment. It is ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death.¹

Assisted suicide also must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient's death occurs because the patient or the patient's proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its advantages and therefore that treatment is refused.¹

ETHICAL CONSIDERATIONS

Inappropriate extension of the right to refuse treatment

In granting patients the right to refuse life-sustaining medical treatment, society has acknowledged the right of patients to self-determination on matters of their medical care even if the exercise of that self-determination results in the patient's death. Because any medical treatment offers both benefits and detriments, and people attach different values to those benefits and detriments, only the patient can determine whether the advantages of treatment outweigh the disadvantages. As the Council has previously concluded, "[t]he principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity."¹

Although a patient's choice of suicide also represents an expression of self-determination, there is a fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment. The right of self-determination is a right to accept or refuse offered interventions, but not to decide what should be offered. The right to refuse life-sustaining treatment does not automatically entail a right to insist that others take action to bring on death.^{6(p.121)}

When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide, however, death is hastened by the taking of a lethal drug or other agent. Although a physician cannot force a patient to accept a treatment against the patient's will, even if the treatment is life-sustaining, it does not follow that a physician ought to provide a lethal agent to the patient. The inability of physicians to prevent death does not imply that physicians are free to help cause death.

For a number of reasons, the medical profession has rejected assisted suicide as fundamentally inconsistent with the professional role of physicians as healers. Indeed, according to the Hippocratic Oath, physicians shall "give no deadly drug to any, though it be asked of [them], nor will [they] counsel such." Physicians serve patients not because patients exercise self-determination but because patients are in need. Therefore, a patient may not insist on treatments that are inconsistent with sound medical practices. Rather, physicians provide treatments that are designed to make patients well, or as well as possible.⁷ The physician's role is to affirm life, not to hasten its demise.

Permitting assisted suicide would compromise the physician's professional role also because it would involve physicians in making inappropriate value judgments about the quality of life. Indeed, with the refusal of life-sustaining treatment, society does not limit the right to refuse treatment only to patients who meet a specific standard of suffering. With refusal of treatment, the state recognizes that the patient (or the patient's proxy) alone can decide that there no longer is a meaningful quality of life.

Objections to causing death also underlie religious views on assisted suicide. Most of the world's major religions oppose suicide in all forms and do not condone physician-assisted suicide even in cases of suffering or imminent death. In justification of their position, religions generally espouse common beliefs about the sanctity of human life, the appropriate interpretation of suffering, and the subordination of individual autonomy to a belief in God's will or sovereignty.⁸

The physician's role

The relief of suffering is an essential part of the physician's role as healer, and some patients seek assisted suicide because they are suffering greatly. Suffering is a complex process that may exist in one or several forms, including pain, loss of self-control and independence, a sense of futility, loss of dignity and fear of dying. It is incumbent upon physicians to discuss and identify the elements contributing to the patient's

suffering and address each appropriately. The patient, and family members as well, should participate with the physician to ensure that measures to provide comfort will be given the patient in a timely fashion.

One of the greatest concerns reported by patients facing a terminal illness or chronic debilitation is the fear that they will be unable to receive adequate relief for their pain.⁹ Though there is some basis for this fear in a small number of cases, for most patients pain can be adequately controlled.^{10,11} Inadequate pain relief is only rarely due to the unavailability of effective pain control medications; more often, it may be caused by reluctance on the part of physicians to use these medications aggressively enough to sufficiently alleviate the patient's pain. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area.

Pain control medications should be employed in whatever dose necessary, and by whatever route necessary, to fully relieve the patient's pain.⁹ The patient's treatment plan should be tailored to meet the particular patient's needs. Some patients will request less pain control in order to remain mentally lucid; others may need to be sedated to the point of unconsciousness. Ongoing discussions with the patient, if possible, or with the patient's family or surrogate decision maker will be helpful in identifying the level of pain control necessary to relieve the patient's suffering in accordance with the patient's treatment goals. Techniques of patient controlled analgesia (PCA) enhance the sense of control of terminally ill patients, and, for this reason, are particularly effective. Often, it is the loss of control, rather than physical pain, that causes the most suffering for dying patients.

The first priority for the care of patients facing severe pain as a result of a terminal illness or chronic condition should be the relief of their pain. Fear of addiction to pain medications should not be a barrier to the adequate relief of pain. Nor should physicians be concerned about legal repercussions or sanctions by licensing boards. The courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. Indeed, it is well accepted both ethically and legally that pain medications may be administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of causing addiction or of causing death through respiratory depression.¹

Relieving the patient's psychosocial and other suffering is as important as relieving the patient's pain. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. Patients in these circumstances must be managed "in a setting of [the patient's] own choosing, as free as possible from pain and other burdensome symptoms, and with the optimal psychological and spiritual support of family and friends."¹² Because the loss of control may be the greatest fear of dying patients, all efforts should be made to maximize the patient's sense of control.

Accomplishing these goals requires renewed efforts from physicians, nurses, family members and other sources of psychological and spiritual support. Often, the patient's despair with his or her quality of life can be relieved by psychiatric intervention.¹³ Seriously ill patients contemplating suicide may develop a renewed desire to live as a result of counseling and/ or anti-depressant medications. When requests for assisted suicide occur, it is important to provide the patient with an evaluation by a health professional with expertise in psychiatric aspects of terminal illness.

The hospice movement has made great strides in providing comfort care to patients at the end of life. In hospice care, the patient's symptoms, including pain, are aggressively treated to make the patient as comfortable as possible, but efforts to extend the patient's life are usually not pursued.¹⁴⁻¹⁶ Hospice patients are often cared for at home, or, if their condition requires care to be delivered in an institutional

setting, intrusive medical technology is kept to a minimum. The provision of a humane, low technology environment in which to spend their final days can go far in alleviating patients' fears of an undignified, lonely, technologically dependent death.

Physicians must not abandon or neglect the needs of their terminally ill patients. Indeed, the desire for suicide is a signal to the physician that more intensive efforts to comfort and care for the patient are needed. Physicians, family and friends can help patients near the end of life by their presence and by their loving support. Patients may feel obligated to die in order to spare their families the emotional and financial burden of their care or to spare limited societal resources for other health care needs. While patients may rationally and reasonably be concerned about the burden on others, physicians and family members must reassure patients that they are under no obligation to end their lives prematurely because of such concerns.

In some cases, terminally ill patients voluntarily refuse food or oral fluids. In such cases, patient autonomy must be respected and forced feeding or aggressive parenteral rehydration should not be employed. Emphasis should be placed on renewed efforts at pain control, sedation and other comfort care for the associated discomfort.

"Slippery slope" concerns

Permitting assisted suicide opens the door to policies that carry far greater risks. For example, if assisted suicide is permitted, then there is a strong argument for allowing euthanasia. It would be arbitrary to permit patients who have the physical ability to take a pill to end their lives, but not let similarly suffering patients die if they require the lethal drug to be administered by another person. Once euthanasia is permitted, however, there is a serious risk of involuntary deaths. Given the acceptance of withdrawal of life-sustaining treatment by proxies for incompetent patients, it would be easy for society to permit euthanasia for incompetent patients by proxy.

The Dutch experience with euthanasia demonstrates the risks of sanctioning physician-assisted suicide. In the Netherlands, there are strict criteria for the use of euthanasia that are similar to the criteria proposed for assisted suicide in the United States. In the leading study of euthanasia in the Netherlands,¹⁷ however, researchers found that, in about 28% of cases of euthanasia or physician-assisted suicide, the strict criteria were not fulfilled, suggesting that some patients' lives were ended prematurely or involuntarily. In a number of cases, the decision to end the patient's life was made by a surrogate decision maker since the patient had lost decision-making capacity by the time the decision to employ euthanasia was made.

RECOMMENDATIONS

1. Physician assisted suicide is fundamentally inconsistent with the physician's professional role.
2. It is critical that the medical profession redoubles its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
3. Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.

4. Requests for physician-assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.

5. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

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