

Physician-Assisted Suicide

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Medical professional codes have long prohibited physician involvement in assisting a patient's suicide. However, despite ethical and legal prohibitions, calls for the liberalization of this ban have grown in recent years.

The medical profession should articulate its views on the arguments for and against changes in public policy and decide whether changes are prudent. In addressing such a contentious issue, physicians, policymakers, and society must fully consider the needs of patients, the vulnerability of particular patient groups, issues of trust and professionalism, and the complexities of end-of-life health care. Physician-assisted suicide is prominent among the issues that define our professional norms and codes of ethics.

The American College of Physicians–American Society of Internal Medicine (ACP–ASIM) does not support the legalization of physician-assisted suicide. The routine practice of physician-assisted suicide raises serious ethical and other concerns. Legalization would undermine the patient–physician relationship and the trust necessary to sustain it; alter the medical profession's role in society; and endanger the value our society places on life, especially on the lives of disabled, incompetent, and vulnerable individuals. The ACP–ASIM remains thoroughly committed to improving care for patients at the end of life.

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Is physician-assisted suicide the answer? This may depend on the question. Is it an issue of patient rights? Of medicine's limitations? Of trust? Of fear and control for patients? Is it a legal issue? An ethical or moral issue? An individual issue? A societal issue? It is all of these. Many have theorized about the merits or dangers of physician-assisted suicide. But whether it should be legally sanctioned is a question with no easy answers.

Physician-assisted suicide is only one of many clinically and ethically distinguishable practices in end-of-life care. Most commonly, life-sustaining treatments are withheld or withdrawn when patients refuse such treatment. The ethical and legal consensus about such practices is well established. Physician-assisted suicide, however, is a different type of act, and is far more controversial. In physician-assisted suicide, medical help is provided to enable a patient to perform an act that is specifically intended to take his or her own life, for example, overdosing on pills as prescribed by the physician for that purpose. Physician-assisted suicide should be distinguished from euthanasia, in which the physician performs an act that is specifically intended to take the patient's life, through, for example, lethal injection (1). Our use of these terms throughout this paper is based on these definitions. Terms such as "aid-in-dying" or "phy-

sician-assisted death," which lump together categories, can obscure the ethics of what is at stake.

Recent voter initiatives and court decisions have reflected public interest in physician-assisted suicide. Many people fear a painful and protracted death or desire more control over the dying process. Some fears have been justified. Our societal emphasis on "cure" and the medical emphasis on intervention have sometimes been at the expense of good end-of-life care. We have been slow to embrace the practice and principles of hospice, and dissemination of state-of-the-art palliative care, especially pain control techniques, has been incomplete. Reimbursement disincentives for comfort care have exacerbated the problem, and cost-control pressures that discourage expensive long-term care loom large over care at the end of life.

Most individuals who contemplate or succeed at suicide are depressed or have other psychiatric comorbid conditions (2–6). Among terminally ill patients who desire death, the wish fluctuates significantly over time (7, 8). Others are not receiving effective pain and symptom control, are not experiencing caring and compassion from their health care providers (or family or friends), or live in fear that they will not receive these when needed (9, 10). Some are concerned about finances or being a burden on their family. Some fear loss of control and

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self-image or the prospect of being in a long-term care or other facility. Some are alone, or are vulnerable in other ways.

The Institute of Medicine's report, "Approaching Death: Improving Care at the End of Life," found end-of-life care in the United States to be lacking in many ways (11), as did the \$28 million Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (12, 13). The cultural norm of medicine and of hospital life is to fight hard to preserve life, and in most cases this is the right thing to do. However, inappropriate aggressive care at the end of life can be emotionally, physically, and financially detrimental to patients, their families, and health care providers.

CLINICAL DUTIES: REACHING CONSENSUS ON PALLIATIVE CARE

Traditionally, the decision to forgo life-sustaining treatment has been ethically, legally, and clinically distinguished from a request for physician assistance with suicide or euthanasia (14–16). Although the Hippocratic Oath proscribes euthanasia and assisted suicide (17), abating treatment has been considered appropriate when patients are "overmastered by disease" (18). Some lower-court decisions have questioned the importance of this distinction (19), but the U.S. Supreme Court has consistently distinguished the refusal of treatment from suicide (20, 21). The withdrawal of treatment based on patient wishes respects a patient's right to be free of unwanted medical treatment, while physician-assisted suicide and euthanasia invoke a right to have the physician provide a new intervention for the patient (22). The American College of Physicians–American Society of Internal Medicine (ACP–ASIM) continues to believe that this distinction is important (23).

Patients have a firmly established legal right to refuse unwanted medical treatment. Physicians should not refrain from withholding or withdrawing medical interventions according to now well-established ethical and clinical standards. Patients might otherwise feel pressured to refuse a trial of life-sustaining treatment, or even to request assisted suicide or active euthanasia, in order to avoid what they fear might become prolonged use of life support.

Patients often fear the prospect of unrelieved pain. Many patients with terminal illness are, in fact, under-

medicated (24–27). Some physicians withhold pain medication because of largely ungrounded fears that terminally ill patients will become tolerant of or addicted to the medication or will abuse medications (24). When patients select palliation as their highest goal, physicians should make relief of suffering the highest priority (23). Some physicians withhold palliative doses of opioids because they fear that the required higher doses may hasten death through respiratory suppression. Usually, adequate pain relief does not hasten death (28). Even if life may be shortened, there is strong support for increasing medications for terminally ill patients to levels that relieve pain (23, 29, 30).

THE QUESTION OF PHYSICIAN-ASSISTED SUICIDE

For years, the consensus has been that, after a careful weighing of patient autonomy, medical beneficence, and societal interests, a patient may forgo life-sustaining treatment. Some now argue that physician-assisted suicide is the logical next step.

Suicide and attempted suicide have been decriminalized in the United States. They are now subjects of mental health law, not criminal law. Society does, however, seek to prevent suicide by allowing others to intervene to prevent acts of self-destruction and involuntary hospitalization and by criminalizing the aiding of a suicide.

Our society and the medical profession are divided on the issue of legalizing physician-assisted suicide and euthanasia for patients at the end of life. In the past, the ACP–ASIM and others have questioned whether a blanket condemnation of physician-assisted suicide, with no other comment, misses an opportunity to improve the care of dying patients (23, 31–34). Polls show significant public support (35, 36), and many physicians, while reluctant to perform assisted suicide or euthanasia themselves, support the legalization of assisted suicide (37–42). Nonetheless, assisting a suicide remains a specific statutory offense in most states (2). Euthanasia is illegal everywhere in the United States.

One state—Oregon—has legalized physician-assisted suicide (43–45). In other states, recent referenda and bills to legalize assisted suicide have been defeated (46–49), and 15 states newly criminalized it between 1986 and 1999 (50, 51). Other countries have experimented with physician-assisted suicide and euthanasia. In the

Netherlands, both practices had been illegal but tolerated under detailed guidelines. Recently, these practices were legalized (52). Euthanasia was briefly legalized, from July 1996 to March 1997, in the Northern Territory of Australia (53).

THE U.S. SUPREME COURT DECISIONS ON ASSISTED SUICIDE

In landmark decisions in July 1997, the U.S. Supreme Court ruled that there is no constitutional right to assisted suicide (21, 54). Given the lack of consensus in this country on legalization, the uncertainties about whether regulation could confine the practice to competent terminally or irreversibly ill persons, the current inadequate provision of palliative care, and the collective failure of our society to assure universal access to health care, the finding of a new constitutional right to physician-assisted suicide would have foreclosed debate.

A ruling by one of the lower courts—the Ninth U.S. Circuit Court of Appeals—in *Compassion in Dying v. Washington* (55), was the first federal appellate court decision on physician-assisted suicide. In this case, it was held that individuals have a right to choose how and when they die. As applied to the limited circumstance of the competent, terminally ill adult who wants a physician's prescription for a lethal dose of medication, the Washington State criminal statute banning physician-assisted suicide was found unconstitutional as a violation of the Due Process Clause of the 14th Amendment. That clause says a state may not “deprive any person of life, liberty, or property without due process of law.”

By contrast, in recognition of previous decisions by the Supreme Court, the Second Circuit had said it specifically declined to “identify a new fundamental right in the absence of a clear direction from the Court whose precedents we are bound to follow.” Instead, in *Quill v. Vacco* (19), the Second Circuit found a New York law to be unconstitutional on much narrower grounds. The Equal Protection Clause of the 14th Amendment says that no state shall “deny to any person within its jurisdiction the equal protection of the laws.” The law was found to violate that clause because competent patients at the end of life were being treated differently: Some patients could refuse life-sustaining treatment and thereby hasten death, but others were prohibited from seeking prescriptions from physicians to hasten death.

The U.S. Supreme Court did not find either of the

lower-court decisions persuasive. Instead, the Supreme Court specifically distinguished refusal of treatment from physician-assisted suicide. Refusal of treatment, the Court concluded, is about being free of the bodily invasion of unwanted medical treatment, not a right to something. This can be seen as a “negative right”—a form of right of which Americans have many—and differs from a positive right to secure assistance to kill oneself and control the manner and timing of death (56). While the U.S. Supreme Court ruled that there is no constitutional right to assisted suicide and that states may prohibit it, the Court also left open the possibility that individual states could legalize it, as Oregon has done in limited circumstances.

ARGUMENTS FOR LEGALIZING PHYSICIAN-ASSISTED SUICIDE

Providing more and better palliative and other care will undoubtedly help quell the demand for assisted suicide (10, 57). This includes measures such as increasing access to hospice care, improving physician training in the principles and clinical science of palliative care, improving hospital and nursing home capabilities in palliative care, financing for palliative care, and creating openness to discussions about the end of life between physicians and patients. These and other measures could reduce public anxiety and fear about death and the desire for physician-assisted suicide but will not eliminate all requests.

In the first 56 cases of physician-assisted suicide that occurred since the implementation of the Oregon assisted suicide law, the decision to seek physician-assisted suicide was more often associated with concerns about loss of autonomy and control, not fear of pain or suffering (58, 59). In the Netherlands, loss of control and “tiredness of life” were much more commonly reported than pain as the reasons for requesting euthanasia (60).

Arguments supporting physician-assisted suicide highlight the duty to relieve patient suffering or stem from a vigorous understanding of the duty to respect patient autonomy (61). The suffering of patients at the end of life can be great. It includes the suffering occasioned by somatic symptoms, such as pain and nausea, or psychological conditions, such as depression and anxiety. It encompasses interpersonal suffering (due to dependency on other persons or to unresolved interpersonal conflicts) or existential suffering (based on a sense

of hopelessness, indignity, or the belief that one's life has ended in a biographical sense but not yet ended biologically). In certain clinical situations, some aspects of suffering cannot be satisfactorily controlled with standard pharmacologic or surgical interventions. Many proponents of assisted suicide have argued that trust is eroded when physician-assisted suicide is not an option, or an option for discussion, in these circumstances. Physician-assisted suicide is, in this view, an act of compassion that respects patient choice and fulfills an obligation of non-abandonment (62–64).

Positions in favor of legalizing physician-assisted suicide are related to the contemporary trend toward emphasizing patient autonomy in bioethics and law. It is argued that the decision to end one's life is intensely personal and private, harms no one else, and ought not be prohibited by the government or the medical profession (65, 66).

ARGUMENTS AGAINST LEGALIZING PHYSICIAN-ASSISTED SUICIDE: THE ACP-ASIM'S POSITION

The arguments in favor of legalizing physician-assisted suicide are weighty, and compelling individual cases of suffering are distressing. However, after carefully considering all the arguments, the ACP-ASIM is opposed to the legalization of physician-assisted suicide, even in limited circumstances.

First, one can raise serious questions about whether medicine should arrogate to itself the task of relieving all human suffering, even near the end of life. Our culture's goal of eliminating death is a false goal. Likewise, the medical profession might better serve patients by acknowledging that the elimination of all human suffering is also a false goal that, if pursued, will ultimately lead to bad medical care (67). Good medicine demands compassion for the dying, but compassion needs reason too (68).

Physicians ought to use their skills to eliminate or alleviate the medical conditions that cause suffering at the end of life. This includes the palliation of both somatic symptoms, such as pain and nausea, and psychological conditions, such as depression and anxiety. But the feeling of helplessness shared by both patient and physician when the patient continues to suffer despite the power of contemporary medical palliative technology is not sufficient to justify assistance with suicide.

Etymologically, to be *compassionate* means to “suffer with” another person. The physician who remains with the dying patient but has not participated in assisted suicide on the patient's request has not acted without compassion, nor has she or he abandoned the patient (67, 69, 70). When patients continue to suffer from physical symptoms or psychiatric syndromes despite the best efforts at palliation, physicians should vigorously pursue the alleviation of these symptoms, even at the risk of unintentionally hastening death (23, 71). But when the patient's suffering is interpersonal, existential, or spiritual, the tasks of the physician are to remain present, to “suffer with” the patient in compassion, and to enlist the support of clergy, social workers, family, and friends in healing the aspects of suffering that are beyond the legitimate scope of medical care.

The profession's most consistent ethical traditions have always emphasized healing and comfort and have demurred at the idea that a physician should intentionally bring about the death of any patient (72, 73). Pronouncements against euthanasia and assisted suicide date back to the Hippocratic Oath (17) and have formed the ethical backbone for professional opposition to the practice of physician-assisted suicide (71). While a professional ethic is not an absolute and does not trump all other claims, “its balancing weight is not simply the force of present arguments or powers, but derives from the way the norms have been constructed in the history of the profession” (74). Assisting in suicide carries with it the danger of compromising the patient-physician relationship and the trust necessary to sustain it (75). It also undermines the integrity of the profession and diverts attention from the real issues in the care of the dying, subverting the social role of the physician as healer, and altering the meaning of beneficence in medical practice (76).

Nor is respect for patient autonomy and privacy so absolute that these values are sufficient to justify assistance with suicide (77). Respect for personal autonomy is important, but autonomy is not self-justifying. Just as society can direct that no one has the “right” to sell himself or herself into slavery, so too can society direct that no one has a “right” to assistance with suicide (78).

Both society in general and the medical profession in particular have important duties to safeguard the value of human life. This duty applies especially to the most vulnerable members of society—the sick, the

elderly, the disabled, the poor, ethnic minorities, and other vulnerable persons. In the long run, such persons might come to be further discounted by society, or even to view themselves as unproductive and burdensome, and on that basis, “appropriate” candidates for assistance with suicide (2, 57, 79). The troublesome idea that euthanasia or assisted suicide might become civic or moral duties for such persons, once satirized by Trollope (80), has already been seriously proposed in the context of the U.S. debate over these issues (81).

If physician-assisted suicide is legally permitted yet restricted to the terminally ill adult with full decision-making capacity, it will inevitably raise legal concerns about arbitrary discrimination (82). The practice therefore will probably broaden to include nonconsenting and non-terminally ill persons. And because some patients cannot take pills or push buttons, they will also appear to be victims of arbitrary discrimination unless the practice is broadened from assisted suicide to euthanasia, in which the physician will perform the life-ending act for the patient.

Finally, the power to prescribe assisted suicide carries a profound potential for misuse and abuse (61, 83). The creation of a formal role for physicians to assist patients with suicide in an era of health care cost containment is especially troublesome (84). A broad right to physician-assisted suicide in a country with no general right to health care would be, at best, ironic.

Some have proposed guidelines and regulatory safeguards (85–88). A task force in Oregon produced a guidebook for health care providers implementing the Oregon Death with Dignity Act (89). But other observers question whether proposed guidelines have been (90) or can ever be (16, 91) effective. It also remains far from clear that any array of regulations can adequately function to oversee this practice and protect the vulnerable, as the Dutch experience with physician-assisted suicide and euthanasia seems to indicate. Euthanasia undertaken without an explicit request by the patient (92–94) in part prompted a re-examination of Dutch guidelines and more restrictive rules (95). Serial surveys of the experiences of patients in the Netherlands and Oregon will not settle disputes about the possibility of abuse. The data themselves are subject to conflicting interpretation (96–99), and concerns about subtle long-term changes in attitudes and practices are unlikely to be detected by simple surveys.

Further, while limiting the practice to the terminally ill has been proposed as a safeguard, prognostication raises serious practical concerns (100, 101). Often it is impossible to predict exactly how long a terminally ill patient has to live or to what extent cognitive capacity will be damaged or impaired by disease or injury. In addition, many patients do not have a long-standing relationship with a physician who knows them well, an obvious prerequisite to any meaningful discussion of voluntary informed choice about assistance with suicide. When a sound relationship does exist, it is difficult to see how law, regulations, and bureaucracy will not imperil the very trust that allows the best end-of-life care to flourish. Moreover, it would seem that detailed regulation undermines the extraordinarily personal nature at the essence of the right that is sought.

RESPONDING TO PATIENT REQUESTS FOR ASSISTED SUICIDE OR EUTHANASIA

Some patients now request active physician assistance with suicide, and will continue to do so. The first duty of physicians must be to optimize their skills in assessing and treating pain, assessing and optimizing function, identifying depression, coordinating the efforts of other members of the health care team, and using community-based services and hospice care to decrease the typically enormous financial and emotional burdens on the patient’s home life and caregivers (23). For the patient who directly or indirectly requests assisted suicide, the physician should first reassess how well the treatment plan is meeting the patient’s medical, social, psychological, and spiritual needs and fears. The physician should explore the reasons for the request, try to understand its meaning, keep dialogue open, and affirm that he or she will not abandon the patient (102). Modern medicine at the end of life, with its daunting technological complexities, its potential for prolonging suffering, and its enormous costs to loved ones (103), adds to the complexity of these problems.

CONCLUSION: MEDICINE’S ROLE IN A SOCIETAL DECISION

All of the moral and other questions raised by the broader issue of suicide cannot be answered here, nor should medicine be the only voice that rightfully speaks

to public policy on assisted suicide. It is, however, medicine's responsibility to take a position on physician-assisted suicide.

We recognize that the thoughtful arguments of those who support the legalization of physician-assisted suicide are weighty and that particular cases will remain medically and ethically challenging. However, they do not outweigh the other vital interests at stake, nor do they warrant the risks associated with the legalization of physician-assisted suicide. Therefore, the ACP-ASIM concludes that physician-assisted suicide should be legally prohibited.

To the extent that this is a dilemma partly due to the failings of medicine to adequately provide good care and comfort at the end of life, medicine can and should do better. We must solve the real and pressing problems of inadequate care, not avoid them through solutions such as physician-assisted suicide. A broad right to physician-assisted suicide could undermine efforts to marshal the needed resources, and the will, to ensure humane and dignified care for all persons facing terminal illness or severe disability.

The ACP-ASIM again affirms a professional ethic to improve the care of patients and families facing these issues (104). But physician-assisted suicide should not become standard medical care. The ramifications are too disturbing for the patient-physician relationship and the trust necessary to sustain it; for the medical profession's role in society; and for the value our society places on life, especially on the lives of disabled, incompetent, and vulnerable persons.

In summary, the ACP-ASIM does not support the legalization of physician-assisted suicide. Its practice would raise serious ethical and other concerns, as outlined above. Physicians cannot give to individuals the control over the manner and timing of death that some seek. But, throughout patients' lives, including as patients face death, medicine must strive to give patients the care, compassion, and comfort they need and deserve.

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