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34.3 Euthanasia and Physician-Assisted Suicide

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individuals have been convicted of euthanasia. Most physicians and medical groups in other parts of the world also oppose legalizing euthanasia. In the United Kingdom, for example, the British Medical Association believes that euthanasia is “alien to the traditional ethos and moral focus of medicine” and, if legalized, “would irrevocably change the context of health care for everyone, but especially for the most vulnerable.” The World Medical Association issued the following declaration on euthanasia in October 1987:

Euthanasia, that is, the act of deliberately ending the life of a patient, even at his own request or at the request of his close relatives, is unethical. This does not prevent the physician from respecting the will of a patient to allow the natural process of death to follow its course in the terminal phase of sickness. Again, in 2002, the World Medical Association reissued a resolution condemning euthanasia as “unethical” and urging all doctors and medical associations to refrain from the practice. Similarly, the New York State Committee on Bioethical Issues issued a statement declaring its opposition to euthanasia. The committee stated that the physician’s obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care, including providing effective palliative treatment, even though it may occasionally hasten death. Physicians, however, should not perform active euthanasia or participate in assisted suicide. The Committee believed that support, comfort, respect for patient autonomy, good communication, and adequate pain control would dramatically decrease the demand for euthanasia and assisted suicide. They argued that the societal risks of involving physicians in medical interventions to cause a patient’s death were too great to condone active euthanasia or physician-assisted suicide. In response to shifting public opinion and lobbying groups with different views, state laws that banned physician-assisted death in Washington State and New York were sent to the United States Supreme Court, challenging the constitutionality of these prohibitions. In June 1997, the Court unanimously held that terminally ill patients do not have the right to physician aid in dying. The ruling, however, left room for continuing debate and future policy initiatives at the state level. PHYSICIAN-ASSISTED SUICIDE In the United States, most of the debate centers on physician-assisted suicide rather than on euthanasia. Some have argued that physician-assisted suicide is a humane alternative to active euthanasia in that the patient maintains more autonomy, remains the actual agent of death, and may be less likely to be coerced. Others believe that the distinctions are capricious in that the intent in both cases is to bring about a patient’s death. Indeed, it may be difficult to justify providing a lethal dose of medication to a terminally ill patient (physician-assisted suicide) while ignoring the desperate pleas of another patient who may be even more ill and distressed but who cannot complete the act because of problems with swallowing, dexterity, or strength. Several degrees are seen to which a physician may assist the suicidal patient to end his or her life. Physician-assisted suicide can involve providing information on ways of committing suicide, supplying a prescription for a lethal dose of medication or a means of inhaling a lethal amount of carbon monoxide, or perhaps even providing a suicide device that the patient can operate. The controversy over physician-suicide came to national attention surrounding the activities of retired pathologist Jack Kevorkian, who, in 1989, provided his suicide machine to a 54-year-old woman with probable Alzheimer’s disease. After the woman

killed herself with his device, Kevorkian was charged with first-degree murder. The charges were later dismissed because Michigan had no law against physician-assisted suicide. Since that first case, Kevorkian assisted in several more suicides, often for persons he met on only a few occasions and frequently for persons who did not have a terminal illness. Claiming to have helped more than

130 people take their lives, Kevorkian was sent to prison in 1999, was released in 2006, and died in 2011. His attorneys and followers applauded his courage in easing pain and suffering; his detractors countered that he was a serial mercy killer. Opponents of Kevorkian's methods charged that, without safeguards, consultations, and thorough psychiatric evaluations, patients may search out suicide not because of terminal illness or intractable pain but because of untreated depressive disorders. They argued that suicide rarely occurs in the absence of psychiatric illness. Finding more effective treatments for pain and depression, rather than inventing more sophisticated devices to help desperate patients kill themselves, defines compassionate and effective physician care. In 1994, Oregon passed a ballot initiative legalizing physician-assisted suicide (Death with Dignity Act), making Oregon the first state in the United States to permit assisted suicides (Table 34.3-1). An assessment of the first 4 years revealed the following: Patients dying from physician-assisted suicide represent approximately eight of 10,000 deaths. The most common underlying illnesses were cancer, amyotrophic lateral sclerosis, and chronic lower respiratory disease. The three most common end-of-life concerns were loss of autonomy (85 percent), a decreasing ability to participate in activities that made life enjoyable (77 percent), and losing control of bodily functions (63 percent). Eighty percent of the patients were enrolled in hospice programs, and 91 percent died at home. The prescribing physician was present in 52 percent of the cases. Table 34.3-1 Oregon's Assisted Suicide Law

In 2001, Attorney General John Ashcroft attempted to prosecute Oregon doctors who helped terminally ill patients die, claiming that doctor-assisted suicide is not a legitimate medical purpose. The case was brought to the Supreme Court, which in 2006 supported the Oregon law and said the "authority claimed by the attorney general is both beyond his expertise and incongruous with the statutory purposes and design." Since 2001, three other states—Washington (2008), Montana (2009) and Vermont (2011)—have passed laws similar to the one in Oregon. Despite the abhorrence that many physicians and medical ethicists express regarding physician-assisted suicide, poll after poll shows that as many as two thirds of Americans favor the legalization of physician-assisted suicide in certain circumstances, and evidence even indicates that the formerly uniform opposition to physician-assisted suicide within the medical community has eroded. Consistent with their positions on active euthanasia, the AMA, APA, and American Bar Association, however, continue to oppose physician-assisted suicide. Recently, the American College of Physicians– American Society of Internal Medicine (ACP-ASIM) expressed its commitment to improving care for patients at the end of life while recommending against legalization of physician-assisted suicide. The ACP-ASIM believes physician-assisted suicide raises serious ethical concerns, undermines the physician–patient relationship and the trust necessary to sustain it, alters the medical profession's role in society, and endangers the values American society places on life, especially on the lives of disabled, incompetent, and vulnerable individuals. The American Association of Suicidology in its 1996 Report of the Committee on Physician-Assisted Suicide and Euthanasia concluded that involuntary euthanasia can never be condoned; the report also stated, however, that "intolerable, prolonged suffering of persons in extremis should never be insisted upon, against their wishes, in single-minded efforts to preserve life at all cost." This position acknowledges that

patients can die as a result of treatment given to them for the explicit purpose of relieving suffering, but death associated with palliative care differs greatly from physician-assisted suicide in that death is not the goal of treatment and is not intentional. How to Deal with Requests for Suicide

To help guide clinicians facing requests for physician-assisted suicide, the AMA's Institute for Ethics has proposed the following eight-step clinical protocol:

1. Evaluation of the patient for depression or other psychiatric conditions that could cause disordered thought
2. Evaluation of the patient's "decision-making competence"
3. Discussion with the patient about his or her goals for care
4. Evaluation and response to the patient's "physical, mental, social, and spiritual suffering"
5. Discussion with the patient about the full range of treatment and care options
6. Consultation by the attending physician with other professional colleagues
7. Assurance that care plans chosen by the patient are being followed, including removal of unwanted treatment and the provision of adequate pain and symptom relief
8. Discussion with the patient explaining why physician-assisted suicide is to be avoided and why it is not compatible with the principled nature of the care protocol Psychiatrists view suicide as an irrational act that is the product of mental illness, usually depression. In almost every case in which a patient asks to be put to death, a triad exists of depression associated with an incurable medical condition that causes the patient intolerable pain. In these instances, every effort should be made to provide antidepressants or psychostimulants for depression and opioids for pain. Psychotherapy, spiritual counseling, or both may also be needed. In addition, family therapy to help with the stress of dealing with a dying patient may be necessary. Family therapy is also useful because some patients may ask to be put to death because they do not wish to be a burden to their families; others may feel coerced by their families into believing that they are, or will be, a burden and may choose death as a result. Currently, no professional codes countenance euthanasia or assisted suicide in the United States. Therefore, psychiatrists must stand on the side of responsible rescue and treatment. A distinction also is needed between major depression and suffering. The nature of suffering has not been sufficiently studied by psychiatrists. It remains the province of theologians and philosophers. Suffering is a complex mix of spiritual, emotional, and physical factors that transcends pain and other symptoms of terminal illness. Physicians are more skilled at dealing with depression than with suffering. Anatole Broyard, who chronicled his own death in his book Intoxicated by My Illness, wrote the following:

I see no reason or need for my doctor to love me nor would I expect him to suffer with me. I wouldn't demand a lot of my doctor's time; I just wish he would brood on my situation for perhaps five minutes, that he would give me his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way. FUTURE DIRECTIONS Advances in technology bring more complex medical, legal, moral, and ethical controversies regarding life, death, euthanasia, and physician-assisted suicide. Some forms of euthanasia have found a place in modern medicine, and expansion of the boundaries of patients' rights and their ability to choose the way they live and die are inevitable. Both patients and physicians need to be better educated about depression, pain management, palliative care, and quality of life. Medical schools and residency training programs need to give the topics of death, dying, and palliative care the attention they deserve. Society must ensure that economics, ageism, and racism do not get in the way of adequate and humane management of patients with chronic terminal illnesses. Finally, national health care policy must provide adequate insurance coverage,

home care, and hospice services to all appropriate patients. If these mandates are followed, the argument for physician assistance in dying will lose much of its impact. REFERENCES Broeckaert B. Palliative sedation, physician-assisted suicide, and euthanasia: “Same, same but different”? Am J Bioethics. 2011;11:62. Canetto SS. Physician-assisted suicide in the United States: Issues, challenges, roles and implications for clinicians. In: Qualls SH, Kasl-Godley JE, eds. End-of-Life Issues, Grief, and Bereavement: What Clinicians Need to Know. Hoboken, NJ: John Wiley & Sons; 2011:263. Carvalho TB, Rady MY, Verheijde JL, JS Robert. Continuous deep sedation in end-of-life care: Disentangling palliation from physician-assisted death. Am J Bioethics. 2011;11:60. Deschepper R, Distelmans W, Bilsen J. Requests for euthanasia/physician-assisted suicide on the basis of mental suffering: vulnerable patients or vulnerable physicians? JAMA Psychiatry. 2014;71(6):617–618. Gamliel E. To end life or not to prolong life: The effect of message framing on attitudes towards euthanasia. J Health Psychol. 2013;18:693. Kimsma, Gerrit K. Physician-Assisted Death in Perspective. New York: Cambridge University Press; 2012. Kraemer F. Ontology or phenomenology? How the LVAD challenges the euthanasia debate. Bioethics. 2013;27:140. Perper JA, Cina SJ. Euthanasia, and assisted suicide: What would Hippocrates do? In: When Doctors Kill: Who, Why and How. New York: Springer Science+Business Media; 2010:159. Rady MY, Verheijde JL. Continuous deep sedation until death: Palliation or physician-assisted death? Am J Hospice Palliat Med. 2010;27:205. Raus K, Sterckx S, Mortier F. Is continuous sedation at the end of life an ethically preferable alternative to physicianassisted suicide? Am J Bioethics. 2011; 11:32. Rys S, Deschepper R, Mortier F, Deliens L, Atkinson D, Bilsen J. The moral difference or equivalence between continuous

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