The Missing Link: The Physician and Assisted Suicide

by Amir Halevy

Since the time of Hippocrates, physicians have chosen the role of healer while rejecting that of killer. However, proponents of assisted suicide charge that competent patients should have the right to control their own fates and to ask for physician help to hasten their deaths if faced with intolerable pain and suffering. This essay argues that if the patient's desire for death can be attained without the help of a physician, then the healing-killing distinction would not be blurred, and we would avoid potential negative implications for professional integrity and public policy.

Traditionally, physicians have been charged with two goals: relieving suffering and preserving life. Occasionally, however, care and cure are in conflict. An attempt to prolong the life of a dying patient may result in extending suffering. Palliative care can shorten the patient's life even though the intent is to relieve suffering and not to cause death. The question of intent is important in law and medicine: is the goal of the intervention to provide care or to kill? Since the time of Hippocrates, who admonished physicians to "neither give a deadly drug to anybody if asked for it, nor . . . make a suggestion to this effect," physicians have chosen the role of healer while rejecting that of killer. However, efforts of right-to-die groups, such as the Hemlock Society and Compassion in Dying in the lay community and Drs. Kevorkian and Quill in the medical community, have made the physician's role in assisting death a topic for discussion in medical journals and in public forums. In light of the profession's long-held distinction between healing and killing, I allege that the sharp line between the two should not be weakened by linking the physician to assisted suicide, regardless of one's views about rational suicides.

Neither advocates nor opponents of physician-assisted suicide argue that either an absolute right to die or an absolute prohibition against killing exists. Supporters of physician-assisted suicide, at least publicly, limit the option to competent, rational individuals capable of ending their own lives. Opponents of physician-assisted suicide agree that while killing is prohibited by society, exceptions are made for state sanctioned execution, self-defense and "just" war. In situations where an absolute rule does not exist, exceptions are determined by a balance between desired positive outcomes and acceptable negative ones.

Such is the case with the debate on physician-assisted suicide. If we would legitimize physician-assisted suicide, then we must consider the benefits of this act against the negative impacts on professional integrity and on the socially perceived role of the physician, as well as on public policy. Opponents of assisted suicide are concerned about the possibility of a slippery slope whereby sanctioning physician assistance in the voluntary suicide of a competent individual will result in physician participation in the involuntary deaths of incompetent patients. A thorough discussion of all arguments in favor of and against physician-assisted suicide is beyond the scope of this paper. Rather, I propose that if the patient's desire for death can be attained without the help of a physician, then the healing-killing distinction would not be blurred, and we would avoid potential negative implications for professional integrity and public policy. Additionally, I argue that many patients may desire something other than a lethal cocktail when they request assisted suicide.

Proponents of physician-assisted suicide contend that patients should have the right to control their own fates and to hasten their deaths if they are faced with intolerable pain and suffering. Nearly all proposals regarding physician-assisted suicide require that the patient be competent, rational and not suffering from depression or psychoses. The physician would determine the patient's competence to make such a decision and then provide the means for a "good death."

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Both anecdotally and from the limited available literature, it appears that only a small minority of terminally-ill patients request assistance in suicide. One study questions whether such patients are actually suffering from major depression and therefore would not satisfy the requirement of competency.[1] However, even if there are a few cases justifying rational suicide, advocates of physician-assisted suicide have not offered a compelling reason to involve physicians.

Why is the physician needed to assist the patient in committing suicide? Individuals have been committing suicide for as long as recorded history. Suicide is currently the eighth leading cause of death in this country, accounting for more than 30,000 deaths per year. Without belaboring the obvious, there are countless ways for an individual to commit suicide. Guns, knives, ropes and razors are all available without prescriptions, as are many potentially lethal over-the-counter medications and toxins. Those who favor physician-assisted suicide counter with arguments for painless, easy death. Dr. Kevorkian's recent method of choice, for instance, is inhalation of carbon monoxide via face mask. However, physician assistance in such a suicide is unnecessary because cars and garages are readily available. Others argue that the physician's skill is required to create a prescription drug cocktail that will bring relief to the suicidal individual. But why does it have to be medication by prescription? There are many over-the-counter preparations that if taken inappropriately will result in death. If lack of knowledge about how to commit suicide is the issue, a simpler solution, which would not affect physician integrity and not significantly alter public policy, would be to provide the necessary information in a text for the lay public. The Hemlock Society has published how-to manuals, and there is recent evidence that *Final Exit* has guided a number of individuals in successfully committing suicide.[2]

Since anyone can commit suicide, then why do a small number of patients with terminal illnesses seek a physician's assistance? I would propose that there are two main reasons. The first is a cry for help and the other is a desire for a "stamp of approval."

Much has been written about individuals without terminal illnesses seeking medical attention for what was initially believed to be an unrelated somatic complaint prior to committing suicide.[3] The majority had seen a physician in the month before their deaths. Most consulted physicians about vague physical complaints; in retrospect, many were probably seeking attention and may have been helped if an underlying depression were properly diagnosed. Terminally-ill patients requesting assisted suicide may actually be expressing apprehension about the future and asking for help dealing with their fears rather than for ending their lives. Fears about pain, suffering, abandonment and dying may be among a patient's reasons for requesting suicide. Since an individual could commit suicide without going to the physician, he or she is likely exploring options and voicing concerns. Moreover,

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uncertainty about one's diagnosis is apparently more difficult for some people to live with than a confirmed bad outcome. Data from a controlled psychological autopsy study indicates that in a small series of suicide cases, the patient's belief that he had cancer played a major role in the decision to die; in fact more people committed suicide in anticipation of a diagnosis of cancer than with the actual diagnosis.[4]

Proponents of physician-assisted suicide contend that patients should have the right to die with some perceived control, free of pain and suffering. However, fear of pain and pain itself are not the same. Various narcotics can control the physical pain of a terminally-ill patient. And the doctrine of double effect (which, applied to this case, suggests that if death is not intended but nevertheless results from increasing narcotic levels to subdue pain, then no moral transgression has occurred) can be a comforting response to ethical concerns raised by patients, families and providers. That is not to say that all patients are treated appropriately; one of the failings of medicine, as evidenced by reports in the medical literature and patients' stories, has been inadequate pain control. Many physicians are not comfortable or familiar with preparations and dosages used by hospice physicians. Physicians should be better trained in pain management and symptom control, and there are educational programs striving to correct this problem. However, failure to control pain should not be a justification for suicide. If a patient is in pain or in fear of pain, the proper response of the health care professional should be to alleviate the pain or reassure the patient that there are options for pain control.

Non-physical suffering is often cited as the reason for requesting physician-assisted suicide. Again, there is a significant difference between fear of suf-

fering and suffering. Physicians should listen empathetically to their patients and openly confront suffering; such caring is a desirable professional virtue. If a patient fears a lingering death in the impersonal environment of the intensive care unit, he or she should be reassured that current law allows, and many medical ethicists support, the withholding or

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withdrawing of medical care including artificial hydration and nutrition, and that artificial life support, if not desired, will not be used. A goal of the Patient Self-Determination Act is to inform patients of their options regarding refusal of care and to encourage an open dialogue with their physicians. All patients admitted to a long-term care facility or hospital must be provided with information regarding statutory laws on advance directives and be given the opportunity to complete an advance directive document. The law also requires community education to inform the public of choices before a crisis occurs. As with inadequate pain management, it is ironic that physician failure to care in some cases is the justification for redefining the concept of care to include killing.

Another reason a terminally-ill patient may request physician assistance in a suicide is to receive the approval of a trusted friend or an authority. The physician is in a difficult position. In the current medical-legal climate, patient autonomy takes precedence over nearly all other values. If physician-assisted suicide were the legal and ethical norm, its proponents could argue that a physician's rejection of the practice would violate a patient's right of self-determination.

On the other hand, if the physician supported assisted suicide, the patient may perceive approval of suicide as a desirable option. If the patient decided not to commit suicide, how confident would he or she be of the judgment of the physician who responded sympathetically to the initial suggestion? A more disturbing scenario occurs if the patient does not change his or her mind. How independent would the final decision actually be if the physician agreed to assist? A lesson from current Do Not Resuscitate policies, which require patient or surrogate consent but are often initiated by physician discussion, may be applicable. While surveys indicate that only 5 percent of the population has an advance directive, the majority of hospital deaths involve an order to limit care.[5] We expect physicians to offer advice to patients regarding withholding and withdrawing treatment and that advice is often heeded. Is there any compelling reason to believe that patients would not be affected by a physician's endorsement of a suicide plan?

There are no absolutes in the current discussion on physician-assisted suicide; we must balance the arguments on both sides of the debate to reach an acceptable conclusion. I believe that the benefits of extending the right of self-determination can be attained without adversely affecting the medical profession and without a perilous descent down a slippery slope. For the patient whose thinking is not clouded by depression and whose pain and suffering cannot be appropriately managed, options exist for a "rational" suicide independent of the physician. Such patients should not be the reason we blur the sharp distinction between healers and killers.

References

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