PHYSICIAN AID IN DYING: PROS AND CONS

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Physician-aid-id-dying (PAD) is among the most hotly debated bioethical issues of our time. Every reasonable person prefers that no patient ever contemplate hastening his own death – with or without assistance – and recent improvements in pain management have begun to reduce the number of patients seeking such assistance. However, there are some patients who experience terrible suffering that cannot be relieved by any of the therapeutic or palliative techniques that medicine and nursing have to offer and some of those patients desperately seek deliverance.

This is not about physicians killing their patients. It's about patients whose suffering we cannot relieve and about not turning away from them when they ask for help. Will there be physicians who feel they cannot do this? Of course, and they shouldn't be obliged to. But if other physicians consider it merciful to help such patients by writing a prescription, it is unreasonable to place them in jeopardy of criminal prosecution, loss of license or other penalty for doing so.

Many arguments are put forward for maintaining the prohibition against PAD, but I believe they are outweighed by two fundamental principles that support ending the prohibition. These two principles are **patient autonomy** – the right to control one's own body – and the **physician's duty to relieve suffering**.

Patient Autonomy: Society recognizes the competent patient's right to decide what will or will not be done to his or her body. There is almost universal agreement that a competent adult has the right to self-determination, including the right to have life-sustaining treatment withheld or withdrawn. Suicide, once illegal throughout the country**,** is no longer illegal in any part of the United States. Yet assisting a person to take his or her own life is prohibited in all but five states. If patients seek such help, it is cruel to leave them to fend for themselves, weighing options that are both traumatic and uncertain, when humane assistance could be made available.

Relief of Suffering: The physician's obligations are many but, when cure is impossible and palliation has failed to achieve its objectives, there is always a residual obligation to relieve suffering. Ultimately, if the physician has exhausted all reasonable palliative measures, it is the patient, and only the patient, who can judge whether death is harmful or is a good to be sought. Marcia Angell, former Executive Editor of The New England Journal of Medicine, has put it this way: "The highest ethical imperative of doctors should be to provide care in whatever way best serves patients' interests, in accord with each patient's wishes, not with a theoretical commitment to preserve life no matter what the cost in suffering ... The greatest harm we can do is to consign a desperate patient to unbearable suffering – or force the patient to seek out a stranger like Dr. Kevorkian."

Let's examine the key arguments made against PAD. **First**, much weight is placed on the Hippocratic injunction to do no harm. It has been asserted that sanctioning PAD "would give doctors a license to kill" and physicians who accede to such requests have been branded by some

as murderers. This is both illogical and inflammatory. Withdrawal of life-sustaining treatment (for example, disconnecting a ventilator at a patient's request) is accepted by society, yet this requires a more definitive act by a physician than prescribing a medication that a patient has requested and is free to take or not, as he or she sees fit. Why should the latter be perceived as doing harm when the former is not? Rather than characterizing this as "killing," we should see it as bringing the dying process to a merciful end. The physician who complies with a plea for final release from a patient facing death under unbearable conditions is doing good, not harm, and her or his actions are entirely consonant with the Hippocratic tradition.

Second, some physicians say that requests for PAD come largely from patients who have not received adequate pain control or who are clinically depressed and have not been properly diagnosed or treated. There is no question that proper management of such conditions would significantly reduce the number of patients who consider hastening death; any sanctioning of assistance should be contingent upon prior management of pain and depression. However, treatable pain is not the only reason, or even the most common reason, why patients seek to end their lives. Severe body wasting, intractable vomiting, urinary and bowel incontinence, immobility and total dependence are recognized as more important than pain in the desire for hastened death. There is a growing awareness that loss of dignity and of those attributes that we associate particularly with being human are the factors that most commonly reduce patients to a state of unrelieved misery and desperation.

Third, it is argued that permitting PAD would undermine the sense of trust that patients have in their doctors. This is curious reasoning; patients are not lying in bed wondering if their physicians are going to kill them – and permitting PAD should not create such fears, since the act of administering a fatal dose would be solely within the control of the patient. Rather than undermining a patient's trust, I would expect the legalization of PAD to enhance that trust. I have spoken with a great many people who feel that they would like to be able to trust their physicians to provide such help in the event of unrelieved suffering – and making that possible would give such patients a greater sense of security. Furthermore, some patients have taken their own lives at a relatively early stage of terminal illness precisely because they feared that progressively increasing disability, without anyone to assist them, would rob them of this option at a later time when they were truly desperate. A patient contemplating a hastened death would be much less likely to take such a step if he or she were confident of receiving assistance in the future if so desired.

Fourth, some insist that patients don't need assistance to hasten their deaths – they can manage it all by themselves. This seems both callous and unrealistic. Is a patient to shoot himself, jump from a window, starve herself to death or rig a pipe to the car exhaust? All of these methods have been used by patients in the final stages of desperation, but it is a hideous experience for both patient and survivor. Even patients who cannot contemplate such traumatic acts and instead manage to hoard a supply of lethal drugs may be too weak to complete the process without help and therefore face a high risk of failure, with dreadful consequences for themselves and their families.

Fifth, it is argued that requests for assistance in hastening death are not frequent enough to warrant changing the law. Interestingly, some physicians say they have rarely, if ever, received

such requests, while others say they have often received requests for this kind of help. This is a curious discrepancy but I think it can be explained: the patient who seeks help hastening his death will cautiously test a physician's receptivity to the idea, and simply won't approach a physician who is unreceptive. Thus, there are two subsets of physicians in this situation: those who are open to the idea of PAD and those who are not. Patients are likely to seek help from the former, but not from the latter.

Sixth, the objection is raised that once we open the door to physician-aid-in-dying we will find ourselves on a slippery slope leading to coercion and involuntary euthanasia of vulnerable patients. Why so? We have learned to grapple with many slippery slopes in medicine, such as DNR orders and withdrawal of life support. We do not deal with those slippery slopes by prohibition, but rather by adopting reasonable ground rules and setting appropriate limits.

The slippery slope argument discounts the real harm of failing to respond to the pleas of real people and considers only the potential harm that might be done to others at some future time and place. As in the case of other slippery slopes, theoretical future harm can be mitigated by establishing appropriate criteria that would have to be met before a patient could receive assistance. Such criteria have been outlined frequently. Stated briefly, they are:

1. The patient must have an incurable condition causing severe, unrelenting suffering.

2. The patient must understand his/her condition and prognosis, which must be verified by an independent second opinion.

3. All reasonable palliative measures must have been presented to and considered by the patient.

4. The patient must clearly and repeatedly request assistance in dying.

5. A psychiatric consultation must be held to establish if the patient is suffering from a treatable depression.

6. The prescribing physician, absent a close pre-existing relationship (which would be ideal), must get to know the patient well enough to understand the reasons for her/his request.

7. No physician should be expected to violate his/her own basic values. A physician who is unwilling to assist the patient should facilitate transfer to another physician who would be prepared to do so.

8. All of the foregoing must be clearly documented.

Application of the above criteria would substantially reduce the risk of abuse but could not guarantee that abuse would never occur. We must recognize, however, that abuses occur today – in part because we tolerate covert action that is subject to no safeguards at all. A more open process would, in the words of philosopher and ethicist Margaret Battin, "...prod us to develop

much stronger protections for the kinds of choices about death we already make in what are often quite casual, cavalier ways."

It seems improbable that PAD would pose a special danger to the elderly, infirm and disabled. To paraphrase John Maynard Keynes, in the long run we are all elderly, infirm or disabled and, since society well knows this, serious attention would surely be given to adequate protections against abuse. It is not my intention to dispose glibly of the fear that society would view vulnerable patients as a liability and would manipulate them to end their lives prematurely. Of course this concern must be respected, but the risk can be minimized by applying the criteria listed above. Furthermore, this argument assumes that termination of life is invariably an evil against which we must protect vulnerable patients who are poor or otherwise lacking in societal support. However, by definition, we are speaking of patients who desperately wish final release from unrelieved suffering, and poor and vulnerable patients are least able to secure aid in dying if they want it. The well-to-do patient may, with some effort and some good luck, find a physician who is willing to provide covert help; the poor and disenfranchised rarely have access to such assistance in today's world.

Seventh, at least one respected ethicist has asserted that a society that does not assure all its citizens the right to basic health care and protect them against catastrophic health costs has no business considering physician-aid-in-dying. I find this an astonishing argument. It says to every patient who seeks ultimate relief from severe suffering that his or her case will not be considered until all of us are assured basic health care and financial protection. These are certainly proper goals for any decent society, but they will not be attained in the United States until we become a more generous and responsible nation, and that day seems to be far off. Patients seeking deliverance from unrelieved suffering should not be held hostage pending hoped-for future developments that are not even visible on the distant horizon.

Finally, some have suggested that the status quo is acceptable, that a patient who is determined to end his or her life can find a sympathetic physician who will provide the necessary prescription and that physicians are virtually never prosecuted for such acts. There are at least four reasons to reject the status quo: (1) It forces patients and physicians to undertake a clandestine conspiracy to violate the law, thus compromising the integrity of patient, physician and family. (2) Such secret compacts, by their very nature, are subject to faulty implementation with a high risk of failure and consequent tragedy for both patient and family. (3) The assumption that a determined patient can find a sympathetic physician applies, at best, to middle- and upper-income persons who have ongoing relationships with their physicians; the poor, as I've already noted, rarely have such an opportunity. (4) Covert action places a physician in danger of criminal prosecution or loss of license and, although such penalties are assumed to be unlikely, that risk certainly inhibits some physicians from doing what they believe is proper to help their patients.

CONCLUDING COMMENTS

I believe that removing the prohibition against physician aid-in-dying, rather than opening the flood gates to ill-advised suicide, is likely to reduce any such pressures: patients who fear great suffering in the final stages of illness would have the assurance that help would be available if

needed and they would be more inclined to test their own abilities to withstand the trials that lie ahead.

Life is the most precious gift of all and no sane person wants to part with it, but there are some circumstances where life has lost its value. A competent person who has thoughtfully considered his or her own situation and finds that unrelieved suffering outweighs the value of continued life should not have to starve to death or find other drastic and violent solutions when more merciful means exist. Those physicians who wish to fulfill what they perceive to be their humane responsibilities to their patients should not be forced by legislative prohibition into covert actions.

There is no risk-free solution to these very sensitive problems. However, I believe that reasonable protections can be put in place that will minimize the risk of abuse and that the humanitarian benefits of legalizing physician-aid-in-dying outweigh that risk. All physicians are bound by the injunction to do no harm, but we must recognize that harm may result not only from the commission of a wrongful act, but also from the omission of an act of mercy. While not every physician will feel comfortable offering help in these tragic situations, many believe it is right to do so and our society should not criminalize such humanitarian acts.

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