

Physician-assisted Suicide: The Wrong Approach to End of Life Care

By F. Michael Gloth, III, M.D.

The nation's largest and most influential medical organizations, the American Medical Association and the American College of Physicians, as well as many smaller physicians' groups, are on record as opposing physician-assisted suicide. Yet, despite the strong and widespread opposition of the medical community, last year physicians in Oregon wrote prescriptions to help 38 of their patients kill themselves. The 38 deaths represent a disturbing reversal in the decline in physician-assisted suicides in the prior year: from 27 in 2000 to 21 in 2001. Why has Oregon accepted a practice strongly opposed by organized medicine?

The answer is in large part due to clever media campaigns waged by advocates of physician-assisted suicide, and the willingness of these groups to distort medical facts and disseminate myths with the help of an uninformed or biased media. Advocates of physician-assisted suicide try to obscure its real nature by avoiding references to euthanasia, suicide, and homicide. Yet, the arguments supporting physician-assisted suicide apply equally to suicide without a physician's assistance, as well as to euthanasia and homicide. Adding the term "physician-assisted" makes it no less suicide, and no less murder — although admittedly it sounds more benign.

The confusion engendered by the lack of clear and accurate media reporting is not the only reason, of course. Many today measure the value of life in strictly utilitarian terms. Seeing diminished value in lives that are no longer robust, they conclude that physician-assisted suicide is a rational choice.

This article provides information on physician-assisted suicide drawn from clinical and public policy experience. It will be shown that as a matter of morality, medicine and public policy, physician-assisted suicide is the wrong approach to end of life care.

What is physician-assisted suicide?

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and information to enable the patient to perform a life-ending act — for example the physician provides a potentially lethal medication and information about the lethal dose and how to administer it,

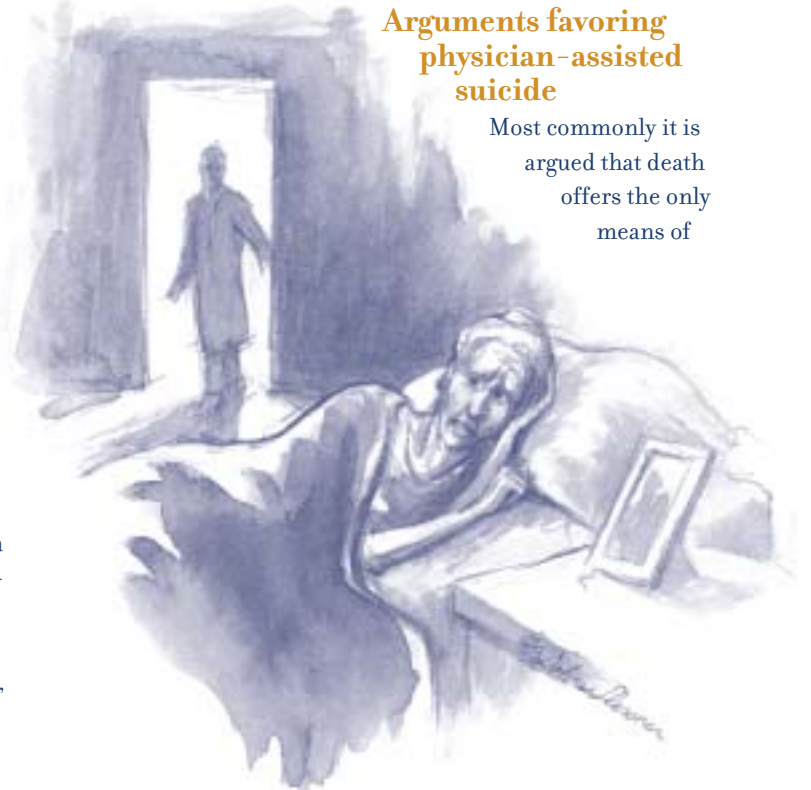
aware that the patient may commit suicide. Most laws against physician-assisted suicide require evidence that the physician intended to assist suicide. Under Maryland's law for example, physicians who provide medication to relieve pain are not prosecuted even if the dosage could increase the risk of death — unless they acted with an intent to assist a suicide. Physician-assisted suicide is distinct from active euthanasia where the physician himself directly acts to cause death.

Oregon stands as an anomaly

Physician-assisted suicide is a crime in forty-five states, by statute in 39 states and by common law in the remaining six. Hawaii, Nevada, Utah, and Wyoming have no controlling law. In the Spring of 2002, an effort to authorize the practice in Hawaii was defeated. In addition to Oregon, four states — Michigan, Washington, California, and Maine — have put the issue of physician-assisted suicide to a referendum. In all but Oregon, the practice was rejected by voters.

Arguments favoring physician-assisted suicide

Most commonly it is argued that death offers the only means of



attaining comfort or dignity for patients in extreme duress, such as those suffering from a terminal, painful, debilitating illness. Advocates of euthanasia and physician-assisted suicide produce data showing that inadequate pain control is given to patients who are dying with painful conditions. A physician's expertise is supposed to increase the likelihood of a success and make the act "cleaner" — both literally and politically.

Arguments concerning loss of autonomy and impaired quality of life are also offered to justify physician-assisted suicide. Advocates add that systemic changes to medical care, such as improved palliative care, won't benefit the individual currently dying in discomfort. They believe that immediate death is preferable to suffering with pain or "lack of dignity" in the last days, weeks or months of life.

Another argument in favor of assisted suicide is to prevent a "botched" suicide. Suicide by self-administered drugs is not always easy to accomplish. Failed attempts can cause greater trauma for the patient and caregivers than the natural course of the disease itself. In such circumstances, patients may beg caregivers to complete their failed attempt to die.

Reasons to oppose physician-assisted suicide

Catholic teaching condemns physician-assisted suicide because it, like murder, involves taking an innocent human life:

Suicide is always as morally objectionable as murder. The Church's tradition has always rejected it as a gravely evil choice. To concur with the intention of another person to commit suicide and to help in carrying it out through so-called "assisted suicide" means to cooperate in, and at times to be the actual perpetrator of, an injustice which can never be excused, even if it is requested. In a remarkably relevant passage Saint Augustine writes that "it is never licit to kill another: even if he should wish it, indeed if he request it, ... nor is it licit even when a sick person is no longer able to live" (The Gospel of Life, no. 66).

Policy makers and the public are not always receptive to appeals to Catholic moral teaching. Fortunately, well-established principles of medicine and bioethics provide sound and abundant grounds for opposing physician-assisted suicide.

In fact, the chief argument — that assisted suicide is needed to avoid the excruciating pain and suffering that may accompany a terminal illness — is based on a fallacy. Advances in pain management now make it possible to control pain effectively in dying patients; only rarely is it necessary to induce sleep to relieve pain or distress in the final stage of dying. Many physicians, however, don't provide adequate pain relief and changes in health care are required to better train and prepare physicians for pain control, and to better understand and provide end of life care. In 2002 the American Geriatrics Society released guidelines emphasizing the availability of treatment for pain in older adults.

Although untreated pain is an argument that sways many in the general public to support physician-assisted suicide, it is not among the top reasons why patients request it, as Lois Snyder, Esq., Director of the Center for Ethics and Professionalism for the American College of Physicians, has noted:

The more compelling arguments for physician-assisted suicide — about avoiding great pain and suffering — do not seem to be motivating requests ... in Oregon. Based on current evidence, people ... are more often concerned about loss of autonomy and control. We question whether it is medicine's role to give patients control over the timing and manner of death.

This finding is supported by a report from the Oregon Health Division's *Fifth Annual Report on Oregon's Death with Dignity Act*, indicating that the dominant reasons for requesting physician-assisted suicide were loss of autonomy (84%), decreasing ability to participate in activities that make life enjoyable (84%), and losing control of bodily functions (47%).

Federal Law

The federal government has also tried to address this issue. The Pain Relief Promotion Act passed the House of Representatives in 2000, but was not brought to a vote in the Senate. The bill promoted pain management and palliative care through the education and training of health care providers. It also banned dispensing federally-controlled drugs with the intent to assist in a patient's suicide. It provided a safe haven for physicians who dispense pain control medications in accordance with the federal Controlled Substances Act.

Opponents broadcast their "fears" that physicians would misunderstand the bill, that this would have a "chilling effect" on physicians prescribing medication for pain, and, thus, that pain relief efforts would be impeded. Ultimately the strategy was effective and even persuaded some well-recognized experts in palliative care to oppose the Pain Relief Promotion Act.

When a bill bans physician-assisted suicide but affirms and protects physicians using controlled drugs for pain management, does that have a chilling effect on patient care? Experience with state legislation shows the opposite is true. Maryland, for example, banned physician-assisted suicide in 1999. Now that the law has been in effect for a few years it is clear that such legislation has not had a "chilling effect" on pharmaceutical prescribing. To the contrary, Drug Enforcement Administration records from 1992-2000 show that in Maryland, as in every state that passed a similar law in that time period, there has been an increase in the per capita use of opioids, like morphine, used for pain control (see figure 1).

Other arguments — for example, that physicians fear government intervention and oversight, or that assisted suicide is a "states' rights" issue — are specious. The real agenda of many

groups organized against bans on physician-assisted suicide is to promote legalized euthanasia.

The Federal Courts

In 1997, the U.S. Supreme Court ruled that state laws that criminalize physician-assisted suicide are not unconstitutional. That ruling did not make physician-assisted suicide a crime. It simply declared that criminalizing physician-assisted suicide is a matter that each state may decide for itself.

But the court will likely consider the issue again. In November 2001, U. S. Attorney General John Ashcroft issued a directive entitled "Dispensing of Controlled Substances to Assist Suicide" (the "Ashcroft Directive"). The directive concludes that assisted suicide is not "a legitimate medical purpose" for drugs controlled by the federal government under the Controlled Substances Act. Under the directive, doctors who use these drugs to assist suicide are subject to having their federal narcotics prescribing licenses suspended or revoked.

Opponents of the directive have again raised the unfounded fear of a "chilling effect" on pain relief. In April 2002, U.S. District Judge Robert Jones permanently restrained the Ashcroft Directive, stating that the U.S. Attorney General had "overstepped the authority of the federal Controlled Substances Act when he declared that physician-assisted suicide was not a 'legitimate medical purpose.'" The Attorney General has appealed Judge Jones' decision and the case is pending before the 9th Circuit Court of Appeals as of this writing.

The role of physicians

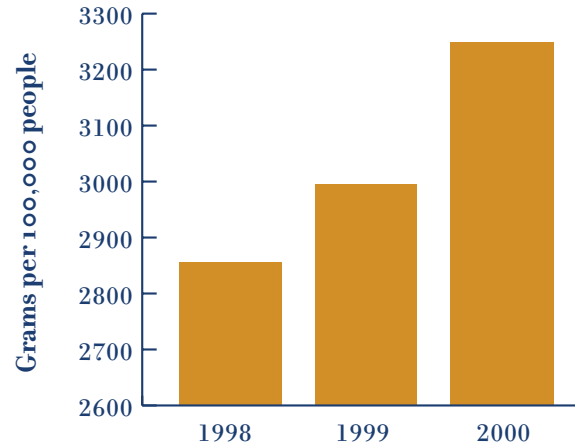
The American College of Physicians oppose physician-assisted suicide as a matter of principle. It has also expressed concerns about effectively regulating the practice and protecting vulnerable populations, as well as the potential for abuse. The College is concerned that research shows physicians and other clinicians are often not well trained in end of life care. If physician-assisted suicide were accepted as standard practice, the College believes it would undermine the physician-patient relationship as well as improvements in end of life care.

The American Medical Association (AMA) states that allowing physicians to participate in assisted suicide would cause more harm than good. The AMA maintains that physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. The American Medical Association's 156-year-old *Code of Medical Ethics* prohibits physician-assisted suicide in the same strong language it uses to prohibit physician involvement in euthanasia.

Legalizing physician-assisted suicide would bring subtle and not-so-subtle pressure to bear on terminally ill patients who fear their illness is physically, emotionally, or financially burdensome to families or caretakers. The legal option to commit suicide with a

FIGURE 1

Change in Morphine Consumption for Maryland Since 1998 Ban on Physician-Assisted Suicide



physician's help would be perceived as an obligation by many terminally ill patients concerned about being a burden to loved ones.

Instead of participating in assisted suicide, physicians should respond aggressively to the needs of patients at the end of life. Multidisciplinary interventions should be sought, including specialty consultation, hospice care, spiritual support, family counseling and other assistance. Patients near the end of life deserve to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

For physicians, the issue transcends state legislation. Doctors must not be forced to participate in physician-assisted suicide, abortion, capital punishment or other practices that run counter to professional ethics or personal beliefs. And physician-assisted suicide raises other medical dilemmas as well. Accurate diagnosis and prognosis cannot always be assured. Autopsies revealed that some patients who died from physician-assisted suicide did not have a terminal illness! The impact such an error has on survivors (not to mention the patient) can only be imagined.

Distinguishing between actively ending a life and allowing the natural progression of events is an integral part of discussions of physician-assisted suicide. Honoring a person's wishes regarding burdensome interventions, such as cardiopulmonary resuscitation (CPR) or ventilatory support neither hastens death nor prolongs life. But oftentimes medical interventions may actually cause more suffering and even unintentionally hasten death. It is important that physicians maintain the patient-physician relationship no matter what course the patient finally chooses, short of participating in suicide. Withdrawing or withholding treatments, e.g. respirators, CPR, and even hydration or nutrition at the request of a terminally ill patient or the patient's surrogate can be consistent with professional principles and are supported by the American Medical Association's *Code of Medical Ethics*.

There is, of course, a final reason given for physician-assisted suicide: it is cheaper to kill a person than to provide care. Yet a physician's first obligation is to "Do No Harm." Until that is replaced with "Save more money," it will be difficult to support physician-assisted suicide.

PROGRAM MODELS

Sign up to be a RESPITE volunteer! RESPITE, supported by The National Family Caregiver Support Program, provides assistance to the primary family caregiver, by providing supplementary care arrangements for the dependent relative on a needed basis. This may include care in the home, an adult day-care center, or a weekend in a nursing home or assisted living facility. The National Council of Catholic Women produces resources to aid volunteers: RESPITE Manual, 2nd Edition, \$11.95; RESPITE Video, \$24.95 (purchase), \$8.00 (loan); brochure, \$0.25 each (10-99 copies); Information for Caregivers brochure, \$0.25 each (10-99 copies); RESPITE pin \$4.00. Call NCCW's national office

at 202-682-00334, ext. 108 to order your materials.

Become a Parish Nurse — The parish nurse focuses on the spiritual, emotional and physical dimensions of persons, in their parish, as they strive to achieve wellness and to manage their illness. They function as an educator, a counselor, a referral agent and an advocate. There are currently over 6,000 parish nurses throughout the United States. Marquette University College of Nursing hosts an institute open to registered nurses with several years of experience to take part in an eight day educational program. This institute is held in various locations around the country. The second phase of this institute is a nine-month

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optional program offering five seminars and ongoing support to the nurse. Contact the Marquette University College of Nursing at nursing@marquette.edu, or at (414) 288-3809.

Start a YOUNG AT HEART group for the senior citizen community in your parish. This group can be used for fellowship and social events. Plan short trips, special Masses, or meals out at a local restaurant.

Begin a Bereavement group in your parish to work one-on-one with church members who have lost a loved one. Set up a system to assign a volunteer to meet with the bereaved parishioner for one year after the death of a loved one. Skills needed: compassionate, caring, loving and a good listener.

Encourage your local hospital to offer a Grief Recovery Program. Providence Hospital in Washington, D.C. sponsors a weekly five-session program that provides a forum for sharing an individual's concerns and feelings over the loss of a loved one. The program covers the topics of understanding grief, remembering the loved one, feelings and stress, holidays and anniversaries, and role changes and support systems that may be available. For more information on such a program, contact Gail Aaron or John Kelly of Providence Hospital at 202-269-7051. Providence Hospital, 1150 Varnum St., NE, Washington, DC 20017-3120.

RESOURCES

Teaching Documents

The Dignity of Dying People. Pontifical Academy for Life, 1999. Reprinted in *Origins*, Vol. 28, No. 41 (\$2.95 to download).

Declaration on Euthanasia. Sacred Congregation for the Doctrine of the Faith, 1980. Available from Secretariat for Pro-Life Activities (50 cents).

Guidelines for Legislation on Life-Sustaining Treatment. NCCB Committee for Pro-Life Activities, 1984. Secretariat for Pro-Life Activities (60 cents).

Nutrition and Hydration: Moral and Pastoral Reflections. NCCB Committee for Pro-Life Activities, 1992. Secretariat for Pro-Life Activities (\$1.95).

On the Christian Meaning of Human Suffering. Pope John Paul II, 1984. Washington, D.C.: USCCB (\$3.95).

Statement on Euthanasia. NCCB Administrative Committee, 1991. Secretariat for Pro-Life Activities (\$7/100; \$65/1,000).

Print

A Catholic Guide to End-of-Life Decisions. Brighton, Mass.: The National Catholic Bioethics Center, 1998 (\$2; quantity discounts).

The Case against Assisted Suicide: For the Right to End-of-Life Care. Kathleen Foley, M.D. and Herbert Hendin, M.D. (eds). Baltimore: The Johns Hopkins University Press, 2002 (\$49.95)

Euthanasia and Physician Assisted Suicide: Killing or Caring? Rev. Michael Manning, M.D. Mahwah, N.J.: Paulist Press, 1998 (\$8.95).

Handbook for Mortals: Guidance for People Facing Serious Illness. Joanne Lynn, M.D. and Joan Harrold, M.D. New York: Oxford University Press, 1999 (\$25).

Last Rites: Assisted Suicide and Euthanasia Debated. Michael M. Uhlmann (ed). Grand Rapids, Mich.: Wm. B. Eerdmans, 1998 (\$35).

Lessons from the School of Suffering: A Young Priest with Cancer Teaches us how to Live. Rev. Jim Willig and Tammy Bundy. Cincinnati, Ohio: St. Anthony Messenger Press, 2001 (\$6.95).

Life's Worth: The Case against Assisted Suicide. Arthur J. Dyck. Grand Rapids, Mich.: Wm. B. Eerdmans Publishing Co., 2002 (\$20.00).

Power over Pain: How to get the pain control you need. Eric M. Chevlen, M.D. and Wesley J. Smith. Steubenville, Ohio: International Task Force in Euthanasia, 2002 (\$12.95).

Right to Die versus Sacredness of Life. Kalman J. Kaplan (ed.). Amityville, N.Y.: Baywood Publishing Co., 2000 (\$31.95).

Stations of the Cross for the Sick. Catalina Ryan McDonough. Bloomington, In.: Our Sunday Visitor, Inc. (\$4.95) May be ordered from www.osv.com.

When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context. Report of the New York State Task Force on Life and the Law (updated, 1999). Albany, NY: Health Education Services (\$10).

Newsletters, Pamphlets, Reprints

Life at Risk. Acclaimed bimonthly newsletter tracks euthanasia trends in America. USCCB Secretariat for Pro-Life Activities (free; donations gratefully accepted).

Euthanasia. . . When the Doctor Kills the Patient. John Willke, M.D., pamphlet. Cincinnati: Hayes Pub. (\$15/100; \$65/500).

The Gift of Life . . . in the Face of Death. Secretariat for Pro-Life Activities, 1998, pamphlet (\$9/100; \$80/1,000).

Hope for the Journey: Meaningful Support for the Terminally Ill. Kathy Kalina, RN, CRNH. Secretariat for Pro-Life Activities, reprint, 2001 (#0101-KAL; 40 cents; 10-49 copies, 30 cents ea.; 50+ copies, 25 cents ea.).

Killing the Pain, Not the Patient: Palliative Care vs. Assisted Suicide. Richard M. Doerflinger & Carlos Gomez, M.D. Secretariat for Pro-Life Activities, reprint, 1998 (#9801-DOE; 40 cents; 10-49 copies, 30 cents ea., 50+ copies, 25 cents ea.).

Audiovisual

Euthanasia: False Light. Steubenville, OH: Intl Anti-Euthanasia Task Force, 1995. Excellent discussion featuring physician, hospice nurse, and three patients who survived "terminal illness" (\$24.95).

Final Blessing. Washington, D.C.: USCCB, 1997. Thought-provoking documentary on the spiritual dimensions of the lives of terminally ill persons (\$29.95).

Life at Risk: A Closer Look at Assisted Suicide. Twelve audiotapes of 1997 symposium of international experts at Catholic University of America, co-sponsored by the NCCB, The Catholic University of America and the Center for Jewish and Christian Values. Available from Donehey & Associates (\$50 per set in an album; individual tapes available at \$5 ea.).

Internet

www.acponline.org/journals/news/sep198/suicide.htm (American College of Physicians)

www.ama-assn.org/ama/pub/category/8288.html (American Medical Assoc. Code of Ethics)

www.cathmed.org (Catholic Medical Assn.)

www.healthinaging.org/public_education/pain (American Geriatrics Society Foundation for Health in Aging)

www.iaetf.org (Intl. Anti-Euthanasia Task Force)

www.kofc.org/faith/cis/028/sacredlife.cfm (Knights of Columbus Catholic Information Service)

www.ncbcenter.org (Nat'l Catholic Bioethics Center)

www.nrlc.org (Nat'l Right to Life Committee)

www.nursesforlife.org (Nat'l Assn. of Pro-Life Nurses)

www.seniorhealthcare.org (Senior Health Care Organization)

www.usccb.org/prolife