

Assisted Suicide, Euthanasia or Better End-of-Life Care?



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Introduction

Physician-assisted suicide (PAS) has been in the news a lot lately, as many states have either entertained or passed legislation allowing what has been termed “aid in dying”.¹ At its heart, PAS is not just a legal issue nor a political issue. It is not even fundamentally a religious issue. It is a human issue. As such, it transcends political, legal and religious boundaries. Factors that lead to requests for aid in dying such as loss of a sense of control, loss of a sense of meaning and purpose, fear of being a burden on others, and uncontrolled physical pain or other severe bodily symptoms, lie at the heart of human dignity. Health care which addresses these fundamental concerns is an obligation we owe and wish to render to our most vulnerable patients. Proper

care for the dying is not the same as assisting them in suicide.

Discussion

Physician-assisted suicide is inherently unethical. This is so crucial since “Physicians are members of a profession with ethical responsibilities; they are moral agents, not merely providers of service”². It violates codes of ethics and fundamental principles of bioethics as well as the *Ethical and Religious Directives for Catholic Health Care Services*.³ A central tenet of the Hippocratic Oath states, “I will not give a lethal drug to anyone if I am asked.”⁴ The American Medical Association Code of Ethics states:

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. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.⁵

The American Nurses' Association Statement on Physician-Assisted Suicide states:

The American Nurses Association (ANA) prohibits nurses' participation in assisted suicide and euthanasia because these acts are in direct violation of the *Code of Ethics for Nurses with Interpretive Statements*, the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide humane, comprehensive, and compassionate care that respects the rights of patients and upholds the standards of the profession in the presence of chronic, debilitating illness and at end-of-life.⁶

More recently, the American College of Physicians (the enormous national organization of internal medicine

specialists) issued an updated statement against physician-assisted suicide.⁷

The Argument in Favor of Physician-Assisted Suicide: The Slippery Slope in Practice

Proponents of physician-assisted suicide often cite the experience of the Death with Dignity Act (DWDA) in Oregon, and many assert that the bill has improved overall care for the dying in that state. They cite a greater willingness on the part of physicians to discuss end-of-life issues with patients and to effectively pursue pain management. Yet discussions regarding goals of care and end-of-life issues and commitment to appropriate palliative care do not flow from the existence or legalization of physician-assisted suicide, but rather from the deep-seated desire of health care providers to enter into the experience of dying patients and to accompany them on this journey. Safeguards meant to prevent abuse are sometimes not observed. For example, in 2013 the state of Oregon reported that only “two of the 71 DWDA patients who died during 2013 were referred for formal psychiatric or psychological evaluation.”⁸ The rate of formal psychiatric consultation for DWDA patients in Oregon fell from 11 percent in the first decade of enactment—itsself an abysmally low level—to 3 percent in the second decade.⁹ Thus, overall only 5.9 percent of all patients who received life-ending medication were referred for psychiatric evaluation even though most practitioners are aware that “despite its prevalence among patients with serious illness, clinical depression is often unrecognized”¹⁰ and even though assessments of decision-making capacity, possible depression, and emotional stability are key elements of the Act.

Another issue is the role of the physician in prescribing and administering fatal medications. If it is true that in some cases, doctors prescribe but are not present at the time of administration, this seems to us to be a possible dereliction of duty. This is especially true if complications develop that the family or other caregiver cannot handle. There are also questions about whether other caregivers should be present at administration of the drug. While normally a medical professional would oversee administration of medication, presence of a Catholic nurse or a nurse supplied by a Catholic organization could easily be construed as moral complicity.

The risks of abuse and misapplication of physician-assisted suicide are real, and bear consideration. The Netherlands began with legalized active voluntary euthanasia and physician-assisted suicide. Like most current assisted-suicide legislation in individual American states, there was no mandated reporting of aid-in-dying by physicians. The Dutch government relied on physicians to self-report their use of aid-in-dying. The *Rommelink Report*¹¹ cites instances of physicians who participated in assisted-suicide and active voluntary euthanasia, which are legal in that country; but also reports instances in which they participated in non-voluntary euthanasia, (i.e., the patient did not request euthanasia but was euthanized), and even of involuntary euthanasia whereby the patient expressly rejected euthanasia but was euthanized anyway. A disproportionate number of the involuntarily euthanized were elderly, poor, disabled and mentally ill: the most vulnerable in society.

Those who support what they deem “compassionate aid in dying” legislation often adduce testimony from physicians and patients about personal experiences with terminal illness. These are often heart-wrenching stories of anguish, pain, other suffering, and loss. Our first response to these patients is, of course, one of empathy and utmost compassion. The main problem with legalized physician-assisted suicide is its potential to undermine or replace proper care for the dying. Studies indicate that, contrary to one’s intuition, physical pain is not the most significant factor in requests for physician-assisted suicide. It currently ranks fifth on the list of factors. Indeed, the National Cancer Institute states:

While unrelieved physical suffering may have been widespread in the past, modern medicine now has more knowledge and skills to relieve suffering than ever before. Today, specialists in palliative care believe that if all patients had access to careful assessment and optimal symptom control and supportive care, the suffering of most patients with life-threatening illnesses could be reduced sufficiently to eliminate their desire for hastened death. Even when the desire persists, avenues other than physician-assisted suicide or euthanasia are available to remedy suffering and still avoid prolonging life against the patient’s wishes.¹²

In fact, one study states that “pain alone was a motivator in 3 percent of requests [for physician-assisted suicide].”¹³ Patients cite loss of control, loss of a sense of

meaning and purpose, and the fear of being a burden on others as the most significant factors in requests for assisted suicide. These experiences are very real, and need to be addressed with compassion and a multidisciplinary approach to caring for the dying. We don't address these patient concerns by deliberately ending a life. Rather, we address them by caring for the person in crisis even when we cannot overcome or extirpate these profound and grave difficulties. This conclusion mirrors the prescient comments made by Dame Cicely Saunders, the founder of the modern hospice movement, in a review from 37 years ago that emphasized repeatedly evaluating intractable symptoms and seeking creative approaches to alleviate suffering when conventional means fail or are exhausted.¹⁴

A Holistic Approach to End-of-Life Care as an Alternative to Physician-Assisted Suicide

In order to most compassionately and effectively respond to the needs of the terminally ill and their families, we must address those factors that lead to requests for aid-in-dying. We can address the fear of loss of control by encouraging patients and their families to discuss goals of care and wishes for treatment early in the trajectory of illness.¹⁵ Hospitals, medical schools and residency programs need to provide better training for physicians, nurse practitioners and physician assistants so that they know how to initiate discussion of end-of-life care and concerns with patients and their families. It is absolutely indispensable that open discussions occur *before* chronic or terminal illness is present. Nor can conversations about advance directives be

outsourced: clinical social workers, nurses, palliative care practitioners are all superb facilitators for such discussions. However, without representation of the attending of record and other team members who possess primary responsibility for the patient and carry an immediacy, credibility and authority that can only derive therefrom, such discussions too often prove vague and unsatisfactory.

Advance directives in the form of a living will or appointment of a health care representative can be a useful tool in this discussion, but they do not supplant this discussion.¹⁶ An advance directive is an outcome of meaningful conversation, but not the only reason for the conversation. Advance directives give the gift of understanding and increased peace of mind to loved ones and patients. They also extend autonomy beyond what most physician-assisted suicide bills would do, since the scope of these bills is customarily limited to terminally ill patients who still have decision-making capacity. Advance directives allow for autonomy to be established during competency and then to continue to guide care even after patients lose capacity. One does not have to be terminally ill to benefit from a health care proxy or other representative who advocates for and helps carry out one's wishes. Up to 85 percent of patients who have an advance directive, report feeling increased control and with it a better sense of being cared for by both their physician and family.¹⁷

Over treatment or inappropriate care is another major problem. Advance directives allow patients to refuse unwanted medical interventions such as artificial nutrition and hydration, mechanical ventilation, endotracheal intubation or CPR if they are no longer

beneficial, and/or overly burdensome. The right to reject such extraordinary care is supported by Catholic medical ethics and the *Ethical and Religious Directives for Catholic Health Care Services*. It was confirmed in the Supreme Court's ruling in the *Cruzan* decision, and upheld in the two assisted-suicide cases, *Washington vs. Glucksberg* and *Vacco vs. Quill*.¹⁸ These cases also affirmed that physician-assisted suicide is not a fundamental constitutional right, and that withholding or withdrawing extraordinary medical care is fundamentally different from physician-assisted suicide. Current legislation in Connecticut regarding the pilot program for MOLST is expected to enhance patient autonomy, assuming that the ethical principles of beneficence, nonmaleficence and justice remain in action.

The Importance of Palliative Care

Meticulous pain and physical symptom management¹⁹ are necessary but not sufficient: Proper care for the dying also requires psychological, emotional, spiritual and social support. Palliative care is designed to provide such a holistic approach for both patient and family. However, palliative care is poorly understood and significantly underutilized in North America. When fully matured in a health care system, palliative care forms an intrinsic part of the continuum of care from earliest treatment, and is routinely provided alongside curative treatment as well as later in the course of disease. Palliation and cure, contrary to the pervasive stereotype, are not mutually exclusive. The Palliative Care Advisory Committee convened in Connecticut – which ranks in the bottom 2 percent in the United States regarding the timeliness of hospice referral – is

optimistic about change and feasibility. However, a lot of work remains to be done. While hospice is not identical to palliative care, the two services are aligned, and parallel image problems beset both. Referrals to hospice are supposed to occur when a patient has six months or less to live as judged by a physician. On average in Connecticut, patients are referred to hospice with less than *two weeks* to live.²⁰ This does not allow for adequate time to address the physical, emotional, spiritual and psychological needs of patient and family. We can and must do better.

Every hospital and nursing home needs an active, vigorous multidisciplinary palliative care/end of life committee, with active rather than nominal physician leadership and participation. Meaningful training in advance directive conversations needs to be mandated for maintenance of clinical privileges—the antithesis of a checkbox that a question was asked about whether an advance directive exists: the extant tick-box is a sham of pseudo-compliance. The failure to obtain palliative care consultation in a patient who is terminal and has uncontrolled symptoms must be treated as medical error, with sanctions and re-education. Funding must be secured, now and going forward, to support palliative care teams, since collectable billings do not match the high cost of providing this human-resource-intensive service (though avoidance of futile expenditures ultimately makes the service financially sound as well as morally indispensable).

Conclusions

Physician-assisted suicide sends a message to the dying, however much we wish it wouldn't, that they are expendable and

disposable. It allows health care providers and even family to avoid the strenuous work of acting with utmost creativity and responsibility in caring for the dying. Too often we have seen that patients who can no longer be cured are then, intentionally or otherwise, more or less completely ignored. The end of curing is never, in the practice of any merciful human being, the end of caring. We tend to avoid what we cannot fix, but if we push through to accompany the dying on their journey, we can encounter many blessings on the journey, and help them to do the same. It is a gift and a responsibility.

Fundamentally, providing “compassionate aid in dying” means helping the terminally ill to see that they are cherished in their personhood, however frail, however diminished, and that they are not disposable. The dying have so much to teach the rest of us about the preciousness and joy of ordinary daily life, if we only choose to listen and learn from them. We promote compassionate care for the most vulnerable among us when we affirm their existence, listen to and acknowledge their fears skillfully; when we tirelessly and creatively manage their symptom burden including pain, and thus help them alleviate their spiritual and existential suffering. Assisting them with suicide does not belong on this list of comfort and aid to the most vulnerable.

¹ Mark Pattison. “More states are considering legalizing assisted suicide,” last modified April 17, 2017. <https://www.americamagazine.org/politics-society/2017/04/17/more-states-are-considering-legalizing-assisted-suicide>

² Y. Tony Yang, and Farr A. Curlin. “Why physicians should oppose assisted suicide.” *JAMA* 315, no. 3 (2016): 247-248, quoted in Snyder, Sulmasy and P. S. Mueller. “Ethics, Professionalism and Human Rights Committee of the American College of Physicians. Ethics and the legalization of physician-assisted suicide: an

American College of Physicians position paper.” *Annals of Internal Medicine* 167 (2017), 577.

³ *Ethical and Religious Directives for Catholic Health Care Services*. Washington, D.C.: United States Conference of Catholic Bishops, 2001. See in particular Directive 60.

⁴ “Hippocratic Oath,” *United States National Library of Medicine*, accessed December 28, 2017. https://www.nlm.nih.gov/hmd/greek/greek_oath.html.

⁵ “AMA Code of Ethics, Opinion 2.211 I, IV,” *The American Medical Association*, accessed December 28, 2017. <https://www.ama-assn.org/delivering-care/ama-code-medical-ethics>.

⁶ “American Nurses Association Position Statement on Assisted Suicide,” *Trends Health Care Law Ethics* 10, no1-2 (1995): 125-127.

⁷ Snyder, Sulmasy and P. S. Mueller. “Ethics, Professionalism and Human Rights Committee of the American College of Physicians. Ethics and the legalization of physician-assisted suicide: an American College of Physicians position paper.” *Annals of Internal Medicine* 167 (2017), 576-578 and with it three thoughtful commentaries: Katrina Hedberg and Craig New. “Oregon’s Death With Dignity Act: 20 Years of Experience to Inform the Debate.” *Annals of Internal Medicine* 167, no. 8 (2017): 579-583.; William G. Kussmaul. “The Slippery Slope of Legalization of Physician-Assisted Suicide,” *Annals of Internal Medicine* 167, no. 8 (2017): 595-596.; Timothy E. Quill, Robert M. Arnold, and Stuart J. Youngner. “Physician-Assisted Suicide: Finding a Path Forward in a Changing Legal Environment.” *Annals of Internal Medicine* 167, no. 8 (2017): 597-598.

⁸ “Death with Dignity Act Annual Report,” accessed December 28, 2017.

<http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>

⁹ Katrina Hedberg and Craig New. “Oregon’s Death With Dignity Act: 20 Years of Experience to Inform the Debate.” *Annals of Internal Medicine* 167, no. 8 (2017): 579-583.

¹⁰ *Education in Palliative and End of Life Care for Oncology*, produced by the National Cancer Institute (2006), Multimedia.

¹¹ Francis N. Netherlands—2015 euthanasia report card. Dying for Choice Web site. Cited by Snyder and Sulmasy at

www.dyingforchoice.com/resources/fact-files/netherlands-2015-euthanasia-report-card-on-Aug-18, 2017. See also P.J. van der Maas et. al. *Euthanasia and Other Medical Decisions Concerning the*

End of Life: An Investigation Performed upon the Request of the Commission of Inquiry into the Medical Practice Concerning Euthanasia (Amsterdam, Netherlands: Elsevier Press). Health Policy vol. 22, no. 1-2. and Richard Doerflinger, "Conclusion: Shaky Foundations and Slippery Slopes," *Duquesne Law Review* vol. 35, no. 1 (Fall, 1996): 523-531.

¹² *Education in Palliative and End of Life Care for Oncology*, produced by the National Cancer Institute (2006), Multimedia.

¹³ Elizabeth Mayfield Arnold. "Factors that influence consideration of hastening death among people with life-threatening illnesses." *Health & Social Work* 29, no. 1 (2004): 17-26.

¹⁴ Dame Cicely Saunders. "The hospice: its meaning to patients and their physicians." *Hospital Practice* 16, no. 6 (1981): 93-108.

¹⁵ See for example, Rachelle E. Bernacki and Susan D. Block. "Communication about serious illness care goals: a review and synthesis of best practices." *JAMA Internal Medicine* 174, no. 12 (2014): 1994-2003. and Kirsty Boyd and Scott A. Murray. "Why is talking about dying such a challenge?" (2014): g3699.

¹⁶ The Conversation Project (www.theconversationproject.org) was founded by a group of organizations specifically to encourage the conversation. Their website provides a wide range of resources for families, patients and clergy designed to get these conversations started. They note that while the vast majority of us say we want to have such a conversation, only about a quarter of us actually do.

¹⁷ See for example, Norman L. Cantor. "Making advance directives meaningful." *Psychology, Public Policy, and Law* 4, no. 3 (1998): 629. Alasdair R. Maclean. "Advance directives, future selves and decision-making." *Medical Law Review* 14, no. 3 (2006): 291-320.; Rebecca Dresser. "Substituting authenticity for autonomy." *The Hastings Center Report* 39, no. 2 (2009): 3. and Marilyn Mitchell. "An analysis of common arguments against Advance Directives." *Nursing Ethics* 19, no. 2 (2012): 245-251.

¹⁸ *Vacco v Quill* (117 S.Ct.2293); and *Washington v Glucksberg* (117 S.Ct. 2258).

¹⁹ See Mary E. Bretscher and Edward T. Creagan. "Understanding suffering: What palliative medicine teaches us." In *Mayo Clinic Proceedings*, vol. 72, no. 8, p. 785. Mayo Foundation for Medical Education and Research, 1997.

²⁰ See L. Chedekel, "Connecticut lags in key home health care measures, rankings show," *New Haven Register* (New Haven, CT), Apr. 3, 2012.