7. Physician-Assisted Suicide

Charge

The VHA Bioethics Committee was charged to study the implications of permitting physician-assisted suicide (PAS) within the Veterans Health Administration (VHA), in anticipation of the future probability that PAS becomes legal in some jurisdictions.

Definitions[1]

Physician-assisted suicide is a physician's act of providing medical means for suicide, upon request, to a patient who is physically capable of committing suicide and who subsequently acts to carry out the suicide on his or her own using those means. In PAS, the physician's act is a necessary but not sufficient condition for the patient's suicide. An example of PAS is a physician prescribing an ample quantity of barbiturate capsules and instructing a patient on their dosage and route of administration to complete a successful suicide at a later date. Physicians who simply respond to patients' request for PAS by telling them books have been written on how to commit suicide are not performing PAS. Because this information is widely available, the physician's act is not a necessary component for the suicide. Similarly, physicians who warn patients that taking excessive amounts of a prescribed drug may be harmful are not performing PAS because providing cautionary information on drug overdosage is ordinary medical practice. PAS is distinguished from voluntary active euthanasia, withholding or withdrawing life-sustaining therapy that a patient has refused, and providing palliative care to a dying patient in the following ways.

Voluntary active euthanasia (VAE) is the physician's act to kill a patient, at the patient's request, by employing an action that is both necessary and sufficient for the patient's death. In VAE, the patient's underlying condition is not a necessary factor for the death. An example of VAE is a physician who administers a lethal injection to a patient at the patient's request immediately causing the patient's death. VAE is compassionate killing of the patient at the patient's request.

Withholding or withdrawing life-sustaining therapy that has been refused by a competent patient or the proxy of an incompetent patient in the past has been called "voluntary passive euthanasia." The latter term is misleading and should be abandoned. Withholding or withdrawing therapy at a patient's refusal is not euthanizing a patient because the patient is dying of the underlying disease. Withdrawing or withholding life-sustaining therapy refused by the patient has been termed more correctly "allowing to die." Here, in the absence of validly refused treatment, the patient's underlying disease is a necessary and sufficient cause of death.

Palliative care of the dying patient includes care directed toward the relief of pain and other causes of suffering.[2] Examples of palliative care are the judicious prescription of morphine and benzodiazepines to a dying patient. Physicians have a duty to provide dying patients palliative care to the best of their ability. If properly ordered and administered, palliative care unintentionally produces an acceleration of the moment of death, this "double effect" is not considered PAS or VAE. Rather, it is simply the price of providing adequate analgesia and comfort care.

Physician-aid-in-dying is a term that has been used to refer to the whole gamut of physician behaviors in the management of the dying patient. The term should be abandoned because it may encompass all of the above different acts and is inherently ambiguous and misleading.

Presumptions

Much of the public interest in legalizing PAS results from the common public perception that contemporary physicians fail to provide adequate comfort care to dying patients and that dying patients are suffering unnecessarily as a result. Many patients similarly fear that physicians will not respect patients' wishes to refuse treatment when they become unable to articulate them. Patients also fear a personally degrading and financially bankrupting prolonged terminal illness.[3] Patients request PAS because they feel they have no alternative if they want to maintain control over the time and circumstance of their death.

Competent patients have the moral and legal right to refuse life-prolonging medical therapies, including hydration and nutrition, even if their death will result. It is almost always rational for a patient dying of a terminal illness to wish to die sooner rather than later, in order to avoid suffering. Physicians have the responsibility to carefully counsel patients about their prognosis with and without therapy and with different types of therapy.[4]

However, patients do not have the correlative moral or legal right to request that physicians provide them with special therapies or acts, such as PAS or VAE, particularly if physicians judge that such requests are medically inappropriate. Physicians are neither morally nor legally required to respond to patients' requests that are not medically indicated, including some requests to withhold or withdraw life-sustaining therapy. Physicians should decide whether to accede to a patient's request depending upon the physician's judgment about the medical, moral, and legal appropriateness of the request.[5]

Terminally ill patients contemplating suicide do not necessarily wish to die, only to be relieved of their suffering. Often, they choose to commit suicide or to ask their physician to help them commit suicide because they believe death is the only solution to relieve their suffering. When faced with a terminally ill patient's request for PAS, the physician should attempt to provide optimum palliative care, thereby eliminating the need for the patient to commit suicide.

Most experienced clinicians can recall a few cases of suffering so profound and intractable that a coherent argument could be made that it would be morally justified for the physician to provide assistance to the patient's suicide. However, there is an important practical distinction between the theoretical moral permissibility of PAS in these rare, arguably justified cases, and the public policy decision to legalize PAS. The decision to legalize PAS produces an unavoidable series of negative consequences whose totality produces more harm than benefit. This conclusion was reached by the Council on Ethical and Judicial Affairs of the American Medical Association, which reaffirmed its opposition to legalizing PAS in 1992.[6]

Findings and Conclusions

PAS would rarely be necessary if physicians were appropriately trained in and willing to perform better palliative care of the terminally ill, including aggressive control of pain and other sources of suffering in dying patients.[7] However, because some sources of suffering in dying patients cannot be controlled adequately, even with optimum palliative treatment (e.g., loss of bowel control, unpleasant odors, bodily disfigurement, despair, shame, and isolation), there will remain a demand for PAS. Physicians can minimize this demand by improving their technical and interpersonal skills in providing terminal care.

The only potential benefit derived from permitting PAS in VAMCs in those jurisdictions that have legalized it is that certain patients may regard the VHA as caring and sensitive to the needs of dying patients. However, there are a number of serious public policy problems created by legalizing PAS that would be avoided by not doing so.

Of greatest relevance here is the potential for damage to the public and patient confidence in the VHA and its facilities and personnel if the veteran population believes that physicians are helping or encouraging patients to commit suicide to save the system money. In these days of budgetary constraints, the agency must be particularly sensitive to any public perception that the welfare of our patients is being jeopardized to save money. Accusations of this type already have been leveled

against our policy in *VA Manual M-2*, Chapter 31 to withhold and withdraw treatment. These accusations would be more difficult to defend if PAS were permitted in VHA.

On a more general level, legalization of PAS could cause the loss of public confidence in the medical profession if physicians were perceived as killers instead of healers. The goal of medicine is to heal, counsel, and comfort. Actively assisting patients' suicides crosses the line between healing and killing and violates the moral basis for the practice of medicine.[8]

Another risk of legalizing PAS is that dying patients may feel "the duty to die." Terminally ill patients may "request" PAS because of perceived pressure from family members to save money from a lengthy terminal hospitalization. Asking for PAS because of pressure from others subverts the concept of voluntariness.

Similarly, terminally ill patients could feel subtle or overt pressure from physicians to "request" PAS. Physicians may no longer feel it necessary to work hard to provide optimal palliative care to dying patients and, rather, could advocate directly or by inference that the patients could commit suicide. Patients may agree with this suggestion because they think the physician must know what is best for them.

Legalizing PAS would require the development of a bureaucracy of legal sanctions and permissions to prevent abuse. This bureaucracy could further compromise the relationship between the physician and the dying patient. Despite bureaucratic legislation intended to prevent abuse, it is likely that that abuses will occur.

How should VHA physicians respond to a terminally ill patient's request for PAS? First, the physician should investigate the reasons for the request. The physician should attempt to treat all sources of the patient's suffering to the fullest extent possible. If after the application of maximal palliative therapy, the patient continues to request PAS, the physician should notify him or her of the full right to refuse all life-prolonging therapies, including hydration and nutrition. Such patients can be educated that they may voluntarily refuse to receive life-

sustaining hydration and nutrition.[9] Patients who have refused hydration and nutrition should be educated that their decision is revocable should they change their mind. Reversible disorders, including depression, should be treated to the fullest extent reasonable.

Most terminally ill patients dying of lack of hydration and nutrition do not suffer if managed properly. Indeed, the forced hydration and nutrition of terminally ill patients can cause suffering from nausea and pulmonary edema. Physicians caring for patients who wish to die from refusal of hydration and nutrition have the duty to help maintain their comfort during the one to two week dying process. Physicians should be willing to order proper mouth care and use opiates and benzodiazepines to appropriately minimize any suffering during dying. This method of dying from dehydration has been used successfully in hospice patients.[10-12]

Refusal of hydration and nutrition has several public policy advantages over legalizing PAS. It is already legal and requires no change in the physician's role as healer, counselor, and caregiver. It maintains the proper emphasis on the physician's role of providing adequate terminal care to his dying patients. The one to two week dying period allows the patient time to discuss the decision with family members and to reconsider. Finally, refusal of hydration and nutrition is less likely to be abused than PAS. It is unlikely that a patient would feel pressure from family members or physicians to die of refusal of hydration and nutrition.

Recommendations

1. PAS should not be legalized in the VHA. If a state legalizes PAS in the future, the VAMC physicians should explain that PAS is not permitted within VHA hospitals and clinics. Neither should VHA pay for a patient's PAS in another hospital.
2. Physicians need to learn and practice optimal palliative care for their dying patients, thereby both to restore patients' faith that the medical profession can and is willing to prevent unnecessary suffering during dying, and to reduce the need for requests for PAS.

3. If maximal palliative care is insufficient to stop a terminally ill patient's request for PAS, the patient can be educated that he may refuse hydration and nutrition.
4. VHA should add a chapter to the *VA Manual* outlining a comprehensive policy on the management of the dying patient to include DNR orders, advance directives, hospice care, pain management, and other aspects of terminal palliative care.
5. A national educational effort should be mounted to instruct VHA physicians, other staff members, and the families of patients on the principles of excellence in the management of the terminally ill dying patient.

Notes

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