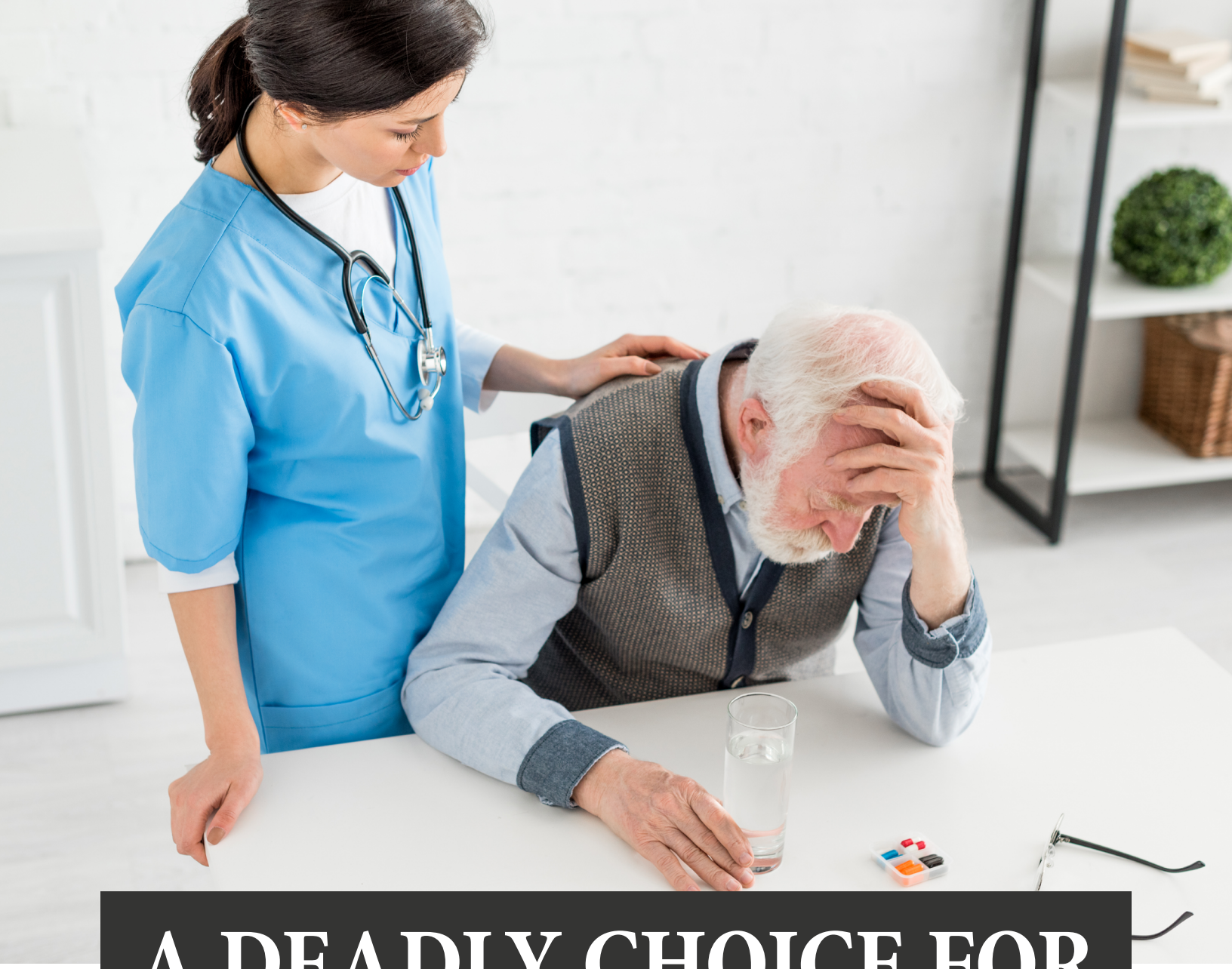

A DEADLY CHOICE FOR THE MEDICAL PROFESSION

Reflections on Physician-Assisted Suicide

Michel Accad, MD

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FOREWORD

Many physicians feel ambivalent about the rightness of helping patients end their lives. If the trend of the last decade continues, however, the number of doctors who offer a tacit or explicit endorsement of physician-assisted suicide will continue to rise, while those who oppose it will diminish in influence. In my opinion, this is a regrettable development. But I also recognize that the arguments in favor of assisted suicide—wrong as they may be—are compelling.

The following short articles were initially published on the blog "Alert and Oriented" in response to news items pertaining to the topic of physician-assisted suicide. This modest collection does not treat it in a comprehensive manner but attempts to attack it from a variety of angles. I believe that some of the perspective presented are original and provocative, and will hopefully spur in the reader a recognition of the falseness of assisted suicide.

Michel Accad, MD

A DEADLY CHOICE FOR THE MEDICAL PROFESSION

When a terminally ill but mentally competent patient wishes to die, should a physician be allowed to bring about such wish? The California legislature is considering that question, and physicians will soon be asked to weigh in on it. Until recently, so-called "physician-assisted dying" (PAD) garnered little support among doctors. Currently, however, enthusiasm in its favor is growing. What are the reasons given to justify this emerging practice? Do they truly warrant legal sanction? And do they justify an about-face from the medical profession's long-held stance on this matter?

Supporters of PAD claim to be motivated by compassion and respect for patient autonomy. Even under such pretexts, however, PAD contradicts the essential role of the physician and confuses the public about the goals and worthiness of the medical profession.

The Compassion Argument

To begin with, compassion is a willingness to suffer with patients, not to eliminate them. According to PAD's proponents, this practice constitutes neither homicide nor suicide, since the patient is predictably dying from a terminal disease. But if that is the case, isn't the disease, rather than the patient, benefiting from the doctor's assistance?

A physician may believe that PAD compassionately puts an end to the suffering of the terminally ill. Many people also believe in the possibility of an afterlife. Can the doctor involved in PAD assure the patient that wellbeing will ensue? Obviously not. Shouldn't this uncertainty, then, be part of the informed consent? Or, if that sounds absurd, isn't it wiser to leave the timing of death and its aftermath to nature and to one's God? Doing otherwise necessarily invites an overstepping of established professional boundaries.

At times, and with appeal to compassion, supporters of PAD call upon doctors to specifically effect a less agonizing death. There is precedent for this practice. For example, some physicians participate in capital punishment, allegedly to ensure that various lethal infusions are delivered in the least painful manner. But PAD amounts to merely prescribing an overdose of a sedative. Clinical training is unnecessary and physician engagement boils down to a basically legal, not medical, role.

The Autonomy Argument

To justify PAD under pretext of respect for autonomy is faulty as well. According to surveys, fear of losing control over one's mind and body, and fear of becoming a burden to others, are the main perceived indignities that prompt some terminally ill patients to seek PAD. But should the doctor agree with these despairing perceptions without applying a measure of objectivity?

Hospice care expert Ira Byock has shown that among the terminally ill, fear of burdening others is invariably short-sighted. Families and friends need to tend the dying person as a material expression of love. Burdensome as it may be, the care provided serves a therapeutic function in the grieving process and provides an unexpected opportunity to heal troubled relationships. Fear of burdening others is therefore subject to change, and the physician can play an effective role in alleviating the patient's apprehension.(2)

And whether terminally ill patients are supported by loved ones or not, the compassionate and socially constructive response to feelings of unworthiness is to do everything possible to dissipate those feelings. A physician who validates a patient's fear of losing control over mind and body implicitly devalues anyone with a serious disability—including the terminally ill.

Respect for patient autonomy is essential to a sound patient-doctor bond. It acknowledges that health and disease have a subjective dimension and tempers the prerogatives of physicians who, by necessity, are invested with social or legal authority. As an ethical principle, respect for autonomy has been explicitly promoted since the 1970's, in response to a then-common attitude of "paternalism" that disregarded the patient's right to choose. But has the pendulum swung too far?

PAD now fits an environment in which doctors tolerate the label of "provider" and patient care is increasingly conducted like a mere economic transaction. Under these conditions, "The customer is always right" naturally replaces "First do no harm" as the foremost expression of our professionalism. But when "Your body, your choice" finally rules the day, are there any principles left to be professed?

Conclusion

Providing death for the patient invites death for the medical profession. The wave of PAD legalization sweeping the country might well enact poetic justice, allowing the demise of patients who no longer value their lives and of physicians who no longer understand their role.

This article first appeared in the April 2015 issue of San Francisco Medicine, the magazine of the San Francisco Medical Society, along with a counterpoint article in favor of PAD. Both articles can be found in the original issue here.

AT THE TRIBUNAL OF JERRY BROWN'S CONSCIENCE

Assisted suicide and our peace of mind

When California Governor Edmund Gerald "Jerry" Brown, Jr. signed into law ABx2 15, legalizing assisted suicide in the state, he issued the following statement explaining the reasoning behind his decision:

OCT 5 2015

To the Members of the California State Assembly:

ABx2 15 is not an ordinary bill because it deals with life and death. The crux of the matter is whether the State of California should continue to make it a crime for a dying person to end his life, no matter how great his pain or suffering.

I have carefully read the thoughtful opposition materials presented by a number of doctors, religious leaders and those who champion disability rights. I have considered the theological and religious perspectives that any deliberate shortening of one's life is sinful.

I have also read the letters of those who support the bill, including heartfelt pleas from Brittany Maynard's family and Archbishop Desmond Tutu. In addition, I have discussed this matter with a Catholic Bishop, two of my own doctors and former classmates and friends who take varied, contradictory and nuanced positions.

In the end, I was left to reflect on what I would want in the face of my own death.

I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others.

Sincerely,

Edmund G. Brown Jr.

In his 1993, John Paul II had this to say about the kind of examination of conscience through which Governor Brown would become "certain" about the comfort that the law would provide him and others:

> *Certain currents of modern thought have gone so far as to exalt freedom to such an extent that it becomes an absolute, which would then be the source of values…The individual conscience is accorded the status of a supreme tribunal of moral judgment which hands down categorical and infallible decisions about good and evil. To the affirmation that one has a duty to follow one's conscience is unduly added the affirmation that one's moral judgment is true merely by the fact that it has its origin in the conscience. But in this way the inescapable claims of truth disappear, yielding their place to a criterion of sincerity, authenticity and "being at peace with oneself", so much so that some have come to adopt a radically subjectivistic conception of moral judgment* ***(Veritatis Splendor, no. 32)***

In the wake of Brown's decision stemming from his "being at peace with himself," no doubt some doctors will find it increasingly comforting to be able to adjudicate decisions regarding other people's lives from the tribunal of their own individual consciences.

THE SUICIDE ROBIN WILLIAMS WAS DENIED

The double standard of assisted dying laws

The autopsy performed after Robin Williams committed suicide showed that the actor had widespread Lewy body disease. His widow Susan just revealed that information and told reporters that depression was only a small part of the myriad of frightening and incomprehensible symptoms that beset him for more than a year before he took his life. As the disease progressed, he suffered from impaired movement, anxiety, paranoid thoughts, and depression.

Last month, Governor Jerry Brown signed into law a bill that allows doctors to prescribe a lethal medication to terminally ill patients who wish to end their lives. In the letter he issued as he signed the bill, he wrote: "I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others."

But apparently, Jerry Brown and those who support the law would deny "that right" to people who, like Robin Williams, suffer from Lewy body disease. Lewy body is a neurodegenerative disease whose cause is unknown and which leads inexorably to dementia and death, although it may take a while before the final outcome. Williams would have likely lived for a few more years if he had not taken his life.

The law Jerry Brown signed makes assisted suicide available only to patients expected to die withing six months. Those who contemplate a longer period of suffering are denied the medical procedure.

So are those who, like the mentally impaired or frankly demented, cannot express or may not be aware of their "indignity." So are the intractably depressed, who may have tried every trick in the book, yet remain under the siege of despair with no hope in sight.

So are those, now numerous enough to affect death statistics, who numb their hopelessness with recreational drugs and who, like Robin Williams, take their own lives with their own hands.

Should only those whose days are numbered and deemed in command of their mind by a "mental health specialist" be offered the comfort of the law, while the rest must struggle for a lifetime and be denied a peaceful exit into the unknown?

As the Netherlands testify, when a painless death is considered a right, any "safeguard" that limits that right is soon viewed as an injustice or a cruel double standard. Once the door of assisted suicide is opened, the slippery slope is unavoidable.

IS ASSISTED SUICIDE "MEDICALLY NECESSARY?"

Canada may soon debate the question

André Picard, one of Canada's foremost healthcare journalists, published an article today in which he analyzes the funding rationale for his country's healthcare system.

> *Canada has the most singularly bizarre health-funding model in the world. It is, to use the technical term, bifurcated – meaning there are two distinct categories.*
>
> *"Medically necessary" care, defined as hospital and physician services, is paid 100 per cent from the public purse. Selling these services privately is, with few exceptions, illegal or subject to punishing penalties…*
>
> *The rest of health care is, by default, not deemed medically necessary, but still gets varying degrees of public funding. Only about 6 per cent of dental care is paid publicly, as are almost half of prescription drug costs, and about two-thirds of long-term care costs.*

Given Canada's perennial healthcare budget deficits and notorious waiting lines for medical care, Picard adds:

> *Getting the mix of public and private care right means ensuring everyone has access to essential care in a cost-effective manner, and still allowing patients a modicum of choice, and the ability to supplement their publicly funded care with other services.*
>
> *At some point, we have to make some clear, coherent decisions to ensure that happens. Doing so begins with asking, and answering, the question: What is really "medically necessary"?*

The final question Picard asks couldn't come at a more opportune time.

Earlier this year, the Supreme Court of Canada struck down the ban on physician-assisted suicide (PAS) and gave the federal government one year to come up with legislation on the practice.

Will the government pay for the procedure, and if so, under what rationale?

To justify paying for PAS as a medically necessary service would rightly seem absurd. As Picard has noted, the concept of "medical necessity" is a correlate of licensing laws and derives from the fact that medical needs and care have an objective dimension. But the justification for PAS rests entirely on the principle of patient autonomy. There is no objective fact by which one can determine that a patient needs assisted suicide.

On the other hand, to pay for PAS while maintaining it is not medically necessary would imply that the state is cherry picking the kind of medical procedures it wishes to pay for. A willingness to selectively pay for the final exit of burdensome patients will naturally invite unpalatable conclusions.

I agree with Picard. "What is medical necessity?" is the question of the day.

May we realize that the answer is never entirely in the objectivity of the doctor's gaze nor completely in the subjectivity of the patient's mind.

SHOULD ASSISTED SUICIDE BE LEGAL IN A FREE SOCIETY?

Abigail Hall Blanco, a research fellow at the Independent Institute, recently wrote a piece entitled "Assisted suicide is a personal choice" in which she defends the position that assisted suicide should be legal in a free society.

Before discussing this piece, it is important to clarify what Blanco probably means when she asserts that assisted suicide is a "personal choice." After all, the statement may seem like a triviality: all humans are persons, and therefore all human choices are personal choices.

I suspect that what Blanco means to say is that assisted suicide should be legal because it is a free choice that only affects the person making it. In that sense, the subject and object of the choice are both the same person: The choice begins with the person and the effect ends in the same person.

Having made that clarification, let's examine the three arguments Blanco makes to support her position. These arguments are counterpoints to claims allegedly made by opponents of assisted suicide.

First, she argues correctly against a claim that suicide is irrational:

> *Suicide is a choice like any other. If a person believes that the costs of living outweigh the benefits, then choosing death is perfectly rational.*

Second, Blanco opposes the slippery slope argument and states that in places where assisted suicide is legal, there is no empirical evidence that the practice has reached "epidemic" proportions. Furthermore, she argues that assisted suicide and euthanasia are distinct, and that legalizing one does not entail encouraging the other.

Third, she argues that safeguards are in place to prevent "abuses of the law." For example, in most places, assisted suicide is available only to the terminally ill, and only to patients who have undergone psychological evaluation.

Blanco then concludes:

> *The idea of assisted suicide makes many of us uncomfortable. However, living in a free society means we must respect other people's choices. Part of living is dying. People should be free to choose.*

I think that Blanco is mistaken. Legalizing assisted suicide does not bring us closer to living in a free society.

Before I counter her conclusion, however, I would like to point out that none of Blanco's arguments actually support her final claim, even if those arguments are to be accepted at face value.

For example, whether assisted suicide is rational or not has no bearing on whether it is a personal choice that should be legalized. Many irrational choices are both personal and perfectly legal. If I choose to "knock on wood" to avoid tempting fate, that irrational choice starts and ends with me entirely. As far as I know, no one is arguing that knocking on wood should be made illegal.

Furthermore, whether the legalization of assisted suicide will increase the number of people seeking it or not also has no bearing on whether it is a personal choice that should be legalized. If assisted suicide is an acceptable personal choice for one person, there is no compelling reason to conclude that the number of eligible people seeking it should be small.[1]

The same goes for Blanco's point regarding safeguards in place to control the practice of assisted suicide. The existence of those safeguards has no bearing on whether assisted suicide should be legalized. In fact, as she points out parenthetically herself, "…we may argue that any adult should be allowed to end his or her life."[2] Indeed, once assisted suicide is deemed acceptable, there is no reason that it shouldn't be made available on demand to anyone.

Of course, Blanco may have done a poor job at building her case using straw man arguments, but she may still be correct in her conclusion. Should assisted suicide be legal in a free society?

I differ with Blanco on that position because Blanco overlooks the mechanism by which the legalization of assisted suicide takes place.

Assisted suicide is legalized as a medical practice in a context where medical care is regulated by the State. By virtue of this regulation, medical practices are permitted if and only if they intend to bring about a "good." That means that the legalization of assisted suicide implies that it is an objectively good practice, even if the specific language of the legislation emphasizes the subjectivity of the decision.

In other words, the fact that a licensed medical doctor is required to carry out assisted suicide sanctions the virtue of the choice, since the State ostensibly licenses doctors to help patients and not to harm them. The net effect is that assisted suicide is not simply a personal choice that begins and end with the person using a doctor as a mere instrument for the action. Assisted suicide affects the entire medical profession, including those physicians who personally oppose it.

An indication of that effect is seen in many jurisdiction where assisted suicide has been legalized: rights of conscientious objection of physicians and hospitals are being challenged. In Canada, for example, demands are being placed on hospitals and physicians to enable patients who seek assisted suicide to obtain it, even if the providers find the practice morally objectionable. In Belgium, hospitals and nursing homes have been fined for refusing to carry out euthanasia.

Note, also, that the procedure by which a doctor assists the suicide of a patient is entirely extraneous to the art or science of medicine. Clearly, no expertise is needed to provide someone with an overdose of barbiturates. There are ways, therefore, by which societies could assist the suicide of patients without involving the mediation of a licensed professional. For example, a state could provide patients access to an automatic dispenser of barbiturates and with specific instructions on how to use the "remedy." This underscores that the engagement of the physician in assisted suicide is primarily a legal, not medical role.

Of course, in a truly free society there would be no licensing of physicians by the State. And in such a society, the assisted suicide of a patient by an unlicensed doctor could not masquerade for anything other than what it really is: the direct or indirect consensual homicide of one person by another.

Footnotes:

1. I think Blanco is mistaken on the empirical evidence regarding the slippery slope. First of all, there are no mechanisms to accurately check the statistics since death certificates must state the terminal illness as the cause of death and may not in any way provide any indication that suicide or assisted suicide has taken plane. Secondly, there is also evidence that unassisted suicides have increased in the aftermath of assisted suicide legalization).

2. Blanco ignores the evidence from Belgium and the Netherlands where the so-called safeguards have greatly eroded over time.

THE BODY LANGUAGE OF ASSISTED SUICIDE

What the verbal request fails to reveal

Laws that allow assisted suicide restrict the provision of "aid-in-dying" drugs to patients whose mental status is not impaired and who are capable of sound judgment.

Medscape recently featured a video interview of Timothy Quill, the palliative care specialist and long-term assisted suicide activist. He is interviewed by the ethicist Arthur Caplan, and the two discuss the psychological evaluation of terminally ill patients who request physician-assisted suicide (PAS).

Several points made by Quill caught my attention.

For example, when it comes to the proper psychological evaluation of patients seeking PAS, Quill doesn't think that psychiatrists are up to the task. "There are not enough psychiatrists who are used to seeing patients this sick," he says. Quill notes that the physician must recognize "normal depression" (and, presumably, distinguish it from "abnormal" depression), but he is not explicit about why psychiatrists are ill-equipped to perform that task in patients with a terminal disease.

Quill recognizes, however, that there are cases where a psychiatric consultation is actually essential: along with patients who have a long-standing history of psychiatric illness, "people for whom [a PAS request] is completely out of character" should be seen by a psychiatrist.

But when is a request for PAS "out of character?" The only illustration Quill provides is the contrast between the deeply religious patient (whose request for PAS should be taken suspiciously) and the lifelong member of the Hemlock Society (whose request for PAS is presumably "in character"—although one wonders if Quill believes such a person should undergo psychiatric evaluation if he were to unexpectedly decline assisted suicide).

What about those who fall outside of these rare extremes? Quill does not elaborate, but he warns that primary care physicians are unlikely to be able to weigh in on a patient's request for PAS. Primary care physicians are too busy, Quill argues, so he recommends instead that the evaluation of a PAS request be carried out by the palliative care team who can decide on its "authenticity."

So, a palliative care specialist without prior familiarity with a terminally ill patient can apparently be brought in to evaluate him or her and, through careful listening, "make sure that [the request for PAS] is consistent with who they are as a person."

This is inconsistent with the main argument in favor of PAS: patient autonomy, or "trying to honor what they want," as Caplan puts it. After all, people can change. "Who they are" now does not need to match who they were in the past, and denying a person's request for being "out of character" with who they are seems plainly authoritarian.

At any rate, assisted suicide laws and their proponents assume that a distinction can be made between suicide that is "legitimate" and suicide that is not, but they seem rather vague as to how the distinction can be ascertained. Upon listening to this interview, it occurred to me that the difficulty arises because those who condone suicide focus exclusively on what patients explicitly verbalize, but ignore the other, less misleading form of communication: body language.

If we paid attention to body language, we would come to recognize that suicide always and necessarily betrays a deep-seated conflict: The man who ingests—and digests—a meal before jumping off a bridge is a man who is torn apart. The body manifests a desire to remain alive but the mind acts to destroy the person. There is an inherent contradiction between what the suicide does and what his body says that he wants. We easily recognize this inherent conflict, and that's why we rightly (and un-controversially) apply social resources to deter suicides from occurring.

A terminally ill patient who commits suicide by lethal ingestion, days or weeks before death would naturally occur, is expressing no less of a conflict than the person who jumps off a bridge. The patient is acting one way, his or her body another.

We should bear in mind that a person who coherently loses the will to live, i.e. loses it mentally and physically, will actually die in short order. She will lose her appetite, stop eating and drinking, and fall into a coma. She may even die suddenly. (The commonplace, non-medical explanation for why spouses die within a few months of each other is undoubtedly correct).

To consider suicide a potentially rational act betrays a dualist conception of the human person as a self/mind/soul substance "inhabiting" a material body. In the case of the terminally ill, the stance in favor of suicide implies that the self can rationally wish to separate itself from the failing body, despite the body's apparent willingness to continue to live.

But mind-body substance dualism is untenable. We are unitary beings. There is no "ghost in the machine" or "pilot of the ship" directing the material body. (Even the brain shouldn't be identified with the mind or the self although, as Professor Peter Hacker explains in this lecture, that misunderstanding is pervasive in the field of cognitive neuroscience).

It follows that the mental coherence of terminally ill patients at the time they make a formal request for PAS is irrelevant. When they commit suicide they demonstrate a profound inner conflict. It is a sad testimony to our psychological ignorance that we increasingly encourage suicide under the guise of compassion.

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