

Physician-Assisted Suicide: Why Neutrality by Organized Medicine Is Neither Neutral Nor Appropriate

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It has been proposed that medical organizations adopt neutrality with respect to physician-assisted suicide (PAS), given that the practice is legal in some jurisdictions and that membership is divided. We review developments in end-of-life care and the role of medical organizations with respect to the legalization of PAS since the 1990s. We argue that moving from opposition to neutrality is not ethically neutral, but a substantive shift from prohibited to optional. We argue that medical organizations already oppose many practices that are legal in many jurisdictions, and that unanimity among membership has not been required for any other clinical or ethical policy positions. Moreover, on an issue so central to the meaning of medical professionalism, it seems important for organized medicine to take a stand. We subsequently review the arguments in favor of PAS (arguments from autonomy and mercy, and against the distinction between killing and allowing to die (K/ATD)) and the arguments against legalization (the limits of autonomy, effects on the patient-physician relationship, the meaning of healing, the validity of the K/ATD distinction, the social nature of suicide, the availability of alternatives, the propensity for incremental extension, and the meaning of control). We conclude that organized medicine should continue its opposition to PAS.

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In 2015–2016, the medical societies of California, Colorado, and the District of Columbia adopted officially neutral stances regarding physician-assisted suicide (PAS), followed by the legalization of the practice in those jurisdictions.^{1–6} Declarations of neutrality by state medical organizations in advance of legalization also occurred in Oregon⁷ and Vermont,⁸ but not Washington.⁹ The Massachusetts Medical

Society adopted a neutral position in late 2017.¹⁰ Recently, both the American Medical Association and the World Medical Association have been asked by some members to consider revising their opposition to PAS.^{11,12} Some are now calling on official medical organizations to move beyond “neutrality” to “engaged neutrality” on the issue, providing advice to physicians who participate in the practice where it is legal.¹³

The US Supreme Court has ruled that PAS is not a constitutional right, but states may choose to legalize it.^{14,15} PAS is now legal in Oregon, Washington, Vermont, Montana, California, Colorado, and the District of Columbia. Over the last two decades, state referenda to legalize PAS have been defeated more often than they have passed. In 2017 alone, PAS bills were rejected in 27 US states.¹⁶ In 2016, the New Mexico Supreme Court overturned a lower court, ruling that there is no constitutional right to PAS in that state.¹⁷ New York also ruled there is no state constitutional right to PAS.¹⁸ The American Academy of Hospice and Palliative Medicine is neutral,¹⁹ while the National Hospice and Palliative Care Organization is opposed.²⁰ The American Medical Association,²¹ the American College of Physicians,²² the American Academy of Pediatrics,²³ the American Nurses Association,²⁴ and the World Medical Association²⁵ all remain opposed. The British Medical Association is also opposed and has explicitly rejected calls for neutrality.²⁶ Informal online polls of US physicians have produced conflicting results, while a national, scientific, stratified poll has shown a majority opposed to PAS and euthanasia.^{27–29}

WHY NEUTRALITY IS NOT NEUTRAL

In disagreements, a position of neutrality is sometimes proposed either as a compromise to accommodate diverse views or as an expression of uncertainty about an issue. This approach might seem reasonable were a position statement an internal document addressed exclusively to members. A position statement by a professional organization, however, is oriented externally, addressing the profession, state, and the public at large about an issue relevant to the practice of that profession.³⁰ The stance of bodies representing the medical profession on issues of medical ethics has social and political consequences, especially in the case of PAS because doctors

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are the intended implementers, making the profession's views central to the political debate.

Neutrality is not neutral. To change from opposition to neutrality represents a substantive shift in a professional, ethical, and political position, declaring a policy no longer morally unacceptable; the political effect is to give it a green light. Logically, neutrality implies, "We are not opposed."^{31,32} When the California Medical Society became neutral on PAS, the newspapers rightly reported, "California Physicians End Opposition to Aid-in-Dying Bill."³³

Some might argue that neutrality is necessary because there are jurisdictions in which members of medical organizations can prescribe PAS legally. But exceedingly few physicians engage in the practice even in jurisdictions where it is legal,³⁴ and the fact that some members do so does not require any professional body to be "neutral" with respect to that practice. As a logical counter-example (and not an analogy) to the thesis that professional neutrality is required if a medical practice is legal, consider the fact that physician participation in capital punishment is legal in 30 states. This fact does not affect the ethical opposition that the profession takes, nor has organized medicine felt compelled to give instructions on how to execute prisoners well for those few members who do this.

Disagreement among members does not require a position of neutrality. There certainly are members of medical organizations who are not opposed to physician participation in capital punishment even though their organizations oppose it. Similarly, there are members of medical organizations who disagree with their organizations' positions on mammogram screening and health care reform. Presumably, both sides have made their cases, but one side has prevailed.

>Nor is an organization that opposes the legalization of PAS logically or ethically required to discipline members who participate in the practice in jurisdictions where it is legal. For example, a medical organization opposed to single-payer systems is not required to discipline physicians who practice in states that adopt it and participate in its billing system. Restraint in disciplining members who legally engage in a practice that an organization opposes does not logically require organizational neutrality.

Moreover, professions have a positive ethical responsibility to take public stances on issues that are central to the meaning of their work. Neutrality on PAS, in this light, seems an abdication of professional responsibility. Each profession has a duty to define the ethical parameters of its practice within the public sphere, subject to the political limits necessary to sustain and promote the common good.

WHAT ARE THE ARGUMENTS IN FAVOR OF LEGALIZATION?

There are three main arguments in favor of legalization. Proponents argue foremost that PAS is justified by respect for patient autonomy.³⁵ Some patients want to control how and

when they die, and proponents argue that respect for patient self-determination requires that patients be given this option, since it is a private choice. Second, they argue that the primary duty of medicine is to relieve suffering, and that PAS is the ultimate, merciful medical means of ending suffering that patients deem intolerable.³⁶ Third, they argue that the distinction between forgoing life-sustaining treatment and suicide is arbitrary and sophistical, denying patients who are not being maintained on life-sustaining treatments an equal opportunity to end their lives.³⁷ They supplement these arguments by suggesting that there has been no evidence of a "slippery slope" where PAS has been legalized.³⁸

WHAT ARE THE ARGUMENTS IN FAVOR OF CONTINUED OPPOSITION?

The arguments against a permissive stance towards PAS are based on the meaning of medical practice, the importance of the patient-physician relationship, and respect for the common good.

Respect for Autonomy Is Not a Sufficient Justification

Autonomy cannot be considered in isolation from the entire framework of ethical principles in medicine and in society.³⁹ Patient autonomy is not the isolated exercise of will.⁴⁰ Autonomy is relational—the way one person behaves affects others. One person's autonomy must not undermine another's; it does not mean "I want, therefore I must get." Autonomy must be weighed against other professional principles such as beneficence, non-maleficence, the internal rationality of medicine, justice, and respect for the common good.⁴¹

Some claim that respect for autonomy in combination with the duty to relieve suffering jointly suffice to justify PAS.^{36,42} Yet this adds little to the argument that the duty to respect autonomy is what justifies PAS, since the suffering driving the demand for PAS is not occasioned by pain or other symptoms, but complaints such as loss of autonomy and fear of being a burden.^{43,44} This sort of suffering and its tolerability are subjective assessments by autonomous individuals. Thus, this argument becomes a restatement of the duty to respect autonomy, which, as we argue, is not sufficient to justify PAS. When patients report that their suffering is leading them to desire death, we suggest that physicians consider principles beyond autonomy and redouble their efforts to eliminate suffering, not the sufferer.

Physicians Are Not Qualified to Make the Judgments That PAS Laws Require

Many of the eligibility criteria in PAS laws are personal, interpersonal, and subjective rather than medical. Some suffering is amenable to direct medical intervention, but many experiences of suffering, such as loneliness and existential

distress, are not. It is beyond the ken and expertise of the physician to judge whether such suffering is adequate to fulfill the criteria for the provision of lethal drugs. Among the legal requirements is that a request for PAS must be voluntary and free of undue pressures. Yet most doctors have limited knowledge of their patients' lives beyond the examination room—for example, what family dynamics are at work or what internal pressures may exist. This problem is particularly acute because the majority of doctors refuse to participate so that requests are often considered by doctors who have no prior relationship with the patient. PAS laws have a medical aspect—verifying the diagnosis and likely course of disease—but the most important criteria are subjective, personal, or interpersonal rather than medical and beyond a doctor's sphere of professional competence. It is one thing to ask a doctor to provide a professional opinion on a requesting patient's medical state; quite another to load subjective, personal, and interpersonal judgments on the shoulders of doctors themselves.

The Facilitation of Suicide Is Not a Healing Act

Medicine's central task is to heal. Although healing is a much broader concept than curing, it makes no sense to claim that patients have been healed by having assisted them in ending their lives. Symptom relief heals, and forgoing treatment acknowledges the limits of healing, but PAS undermines the very meaning of medicine.^{22,45}

The Patient-Physician Relationship

Since the time of Hippocrates, the pledge not to kill is one among the minimal conditions of commitment and trust within the patient-physician relationship. Modern medical knowledge has enabled a vast array of interventions, however, giving physicians far greater power over the patient's life than in the past. Patients, made vulnerable by disease, need to trust a physician upon whose skills they depend. Countertransference and physicians' own discomfort with death and the limits of medicine further complicate matters.^{46,47} When the doctor is licensed to provide lethal drugs, patients could be inadvertently steered towards assisted suicide, especially those with low self-esteem or who are viewed negatively as weak, dependent, unproductive, unattractive, costly, and unworthy of the efforts of others. Some press reports detail such transactions occurring.^{48–51}

The Distinction Between Deliberately Ending Life and Accepting the End of Life

Commonsense suggests that there is a medical and ethical difference between forgoing a heart transplant and ingesting a poison. Yet, explaining the distinction requires simultaneous attention to logic, outcomes, intentions, and causes.⁵² Deliberately ending life means to create a new lethal pathophysiological state with the direct intention of making the patient

dead. This is what the patient does to herself in PAS, with the aid and consent of her physician. Allowing to die means to forgo an intervention that is thwarting the progression of a pre-existing lethal pathophysiological condition. It may be undertaken for good reasons, such as respect for a patient's judgment that the treatment is too burdensome or because the treatment has proven futile. Properly formulated, the distinction says that killing patients is never ethically justifiable, but allowing patients to die is often justifiable. A patient who requests cessation of life-prolonging treatment is not, either in law or medical ethics, expressing a suicide wish but an acceptance of death. The difference between forgoing treatment and PAS is the difference between accepting death and precipitating death.

Despite attacks on this commonsense distinction, US courts (including the Supreme Court) recognize the distinction between forgoing treatment and suicide.^{14,15,17,18}

Suicide Is Not a Purely Self-regarding Act

Suicide affects others. Assisted suicide can be traumatic for families.⁵³ Laws are more than mere regulatory instruments. They send social messages. A PAS law sends the message, however unintended, that if one is seriously ill, taking one's life is something to consider. Moreover, if it becomes socially acceptable for persons to commit suicide because they find loss of control and dependence on others intolerable, then the value of millions of other persons who are heavily dependent upon others is called into question. This is the chief reason that there is such widespread resistance to PAS in the disabled community^{54,55}—not that they will be disproportionately persuaded to undertake PAS, but that their dignity is deeply disrespected by the very fact that a society legally sanctions the notion that dependent persons like them can be considered better off dead. Those already undervalued by society understandably feel even more devalued.⁵⁶

Further, evidence suggests that publicity about PAS leads to suicide contagion,⁵⁷ and rates of suicide in the general population have increased faster in states that have legalized PAS relative to those that have not.⁵⁸

Approaching Death

The public sometimes falsely believes that, if terminally ill, they face a stark dilemma—either a gruesome death, strapped to machines, sickened by drugs, and stabbed with needles, or a peaceful death via a lethal prescription. Progress in symptom control, hospice, and palliative care belies this depiction of care at the end of life.^{59–67} Moreover, progress in medical ethics has made it routine for patients to refuse life-sustaining therapies such as ventilators, dialysis, feeding tubes, and cardiopulmonary resuscitation that they judge to be more burdensome than beneficial, and then to be supported in dying. Acceptance of the principle of double effect makes it possible for patients to consent to be treated with sufficient doses of medication to control their symptoms even at the risk

of unconsciousness or hastened death.⁶⁸ There should be no need for PAS for uncontrolled symptoms; the response of medicine should be to ensure that physicians become skilled in providing good care at the end of life and assuring that all patients have access to that care.

The Demand for PAS Is Very Small Until It Becomes Normalized

Popular support for PAS seems based on the fear that doctors will not adequately relieve symptoms, particularly pain. Evidence is emerging, however, that those who actually seek assisted suicide and die by lethal ingestion where it is legal do so not because of unrelieved symptoms, but because of perceptions of diminished autonomy or dignity or the fear of being burdensome to others.^{43,44} Those who receive lethal prescriptions tend to have a distinct but uncommon personality type, fixated on issues of control.⁶⁹ Focusing on PAS distracts from efforts to empower the vast majority of patients to seek and obtain the improved care at the end of life that they need and deserve.^{70,71} Good care gives patients substantial control over their dying without the need for them to express that control by precipitating their own deaths.

The Incremental Extension of PAS

Data from jurisdictions that have legalized PAS show year on year increases overall in the prescription of lethal drugs and in PAS deaths, suggesting a normalization of PAS as part of routine practice. Yet this is just the tip of the iceberg. Once PAS is legalized, on the strength of the argument that one must respect autonomy, it is a short step to say that those who are paralyzed and cannot self-administer drugs are being discriminated against on the basis of their handicaps, and that this requires a move from PAS to euthanasia.^{17,72–74} Moreover, since PAS can result in nausea and vomiting and the process can fail, legalizing PAS generates pressure to legalize euthanasia so that the process can be professionally controlled.

Similarly, those who are unable to speak for themselves (such as children, the demented, and severely retarded) would need to be eligible for euthanasia on the basis of surrogate judgments to avoid treating them unequally. Those suffering from refractory depression and autism, and others who are not terminally ill also become candidates for PAS in order not to discriminate against these classes of patients; the evidence from overseas shows how this happens.

In Belgium, 5% of all deaths (all causes) are now by euthanasia.⁷⁵ Quebec has witnessed a recent public outcry to permit euthanasia for those with dementia deemed ineligible for PAS.⁷⁶ A bill to allow surrogates to euthanize patients who have lost decisional capacity after receiving a PAS prescription was introduced in Oregon,⁷⁷ with proposals to extend the Death with Dignity Act to allow euthanasia for those incapacitated by dementia and those neurologically incapable of swallowing lethal drugs.⁷⁸ Opposition to these moves by pro-PAS groups appears

tactical, not principled, inasmuch as proponents realize that it might hurt their cause in other states.⁷⁸

Laws prohibiting PAS rest on a clear and rational principle—that doctors ought not involve themselves in deliberately bringing about the deaths of their patients. Once this principle is diluted by introducing exceptions, like terminal illness or suffering, it becomes clear that this is just an arbitrary line, one that is easily crossed and hard to defend. If it is an act of compassion to help usher out of this world someone who is expected to die in the near future, why is it not an act of compassion to give similar assistance to a chronically ill person with many years of discomfort ahead or to someone suffering severe mental anguish?

Control

Given that no one chooses to be ill, control can feel elusive to patients. Everyone who is dying wants some measure of control in the face of the overwhelming reality that no one can control—the fact of human mortality. They can exert substantial control over decisions such as whether to forgo life-sustaining treatments, how best to finalize their affairs in life, and how to maximize the time they have left. Dying nonetheless brings unavoidable uncertainties, such as the course of illness, response to interventions, and the response of others to one's illness. Doctors also face uncertainty. Prognostication, for instance, is fraught with error. PAS does not control these uncertainties at life's end.

Moreover, if it is argued that PAS is justified because respect for patient autonomy and control is the physician's *ultimate* duty, then professional judgment would be irrelevant and physicians mere functionaries. If autonomy always trumps other ethical considerations, there would be no principled way of withholding *any* requested treatments, including antibiotics for the common cold, or, ironically, requests for futile interventions at the end of life. Yet this seems absurd. Medical ethics requires the ability to decline some kinds of patient requests for the good of the individual or for the good of wider society.²²

CONCLUSION

There is more at stake in the debate over legalizing PAS than is at first apparent. Part of the concept of a profession is that it should define its ethics independently of the state, the market, and the vicissitudes of popular opinion.⁷⁹ Adopting a position of neutrality implies that organized medicine is avoiding taking responsibility for defining its fundamental ethical principles.

PAS is often presented to the medical community as “a matter for society,” implying that doctors should stand back and be neutral. It is inconsistent, however, to ask doctors to stand back from the question of whether PAS should be legalized, yet to require them to be the gate keepers in any legalized system. Many of the factors behind a request for PAS are

personal or interpersonal rather than medical and doctors are in no position to make knowledge-based judgements on them.

Medical organizations and the entire body politic must keep the bigger picture in focus. Doctors are not agents of the state and organized medicine cannot afford to be “neutral” on a topic that touches medicine at its very core.⁴⁵

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Compliance with Ethical Standards:

Conflict of Interest: Dr. Finlay is co-chair of Living and Dying Well, an independent, not-for-profit British think tank on end of life issues. Dr. Payne is a paid consultant for Vitas Hospice. Dr. Siegler is a paid board member of Ross Medical School. Drs. Fitzgerald, Foley, and Sulmasy have no conflicts to declare.

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