Physician Assisted Suicide

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There has been a recent trend towards legislation to provide for physician assisted suicide. From a medical perspective the main reasons for opposing such legislation are.

1. Medically 'assisted dying' in any form undermines the trust in patient-doctor relationships.
2. It changes the role of physician from someone who heals and cares to someone who takes life, thereby corrupting the fundamental ethos of medicine and radically altering the nature and context of aged and palliative care.
3. It puts at risk the fate and wellbeing of our most vulnerable and dependent patients who already carry with them a deep concern of their burden on others.
4. It endangers the respect and value that society places on human life, especially for those who are sick, disabled and vulnerable and those who are near the end of life.

Virtually every national medical organization throughout the English-speaking world, including the World Medical Association, the Australian Medical Association, the British Medical Association, the Canadian Medical Association, the American Medical Association and the New Zealand Medical Association, are unanimous and unequivocal in their rejection of the concept and practice of Euthanasia and Physician Assisted Suicide/Dying as unethical and contrary to the ethos of medical care.

Their positions reflect a long tradition of wisdom and ethics in healthcare which recognises the dangers that any form of "medically-assisted dying" may pose to the vulnerable, the sick and the dying, as well as the risks of undermining the nature of the patient-doctor relationship and of corrupting the integrity medicine.

Such opposition is in keeping with the deeply held values and ideals that have informed the practice of healthcare in the West for almost 2,500 years dating back to the time of Hippocrates.

The Hippocratic Oath, which includes the first recorded statement of opposition to the concept of euthanasia as a practice that is contrary and alien to the fundamental ethics of medicine, states: "I will not give a lethal drug to anyone even if I am asked, nor will I advise such a plan" [1]. This simple statement has set the standard for the ethical care of the sick and the dying for millennia and continues to inform the almost universally accepted ethical norms of caring for the sick and dying and is reflected in the policy statements of almost every national medical association.

For example, the World Medical Association, which represents 82 countries, in its 'Statement on Physician Assisted Suicide" in May 2005 once again succinctly

[1] http://www.nlm.nih.gov/hmd/greek/greek_oath.html 1/6/2008 20.00

reiterated its position: “Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically.”[2]

Likewise the Australian Medical Association’s ‘Position Statement on the Role of the Medical Practitioner in End of Life Care’ which was published in 2007, stated the association’s opposition to Euthanasia and Physician Assisted Suicide and declared that “medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life.”[3]

The British Medical Association(BMA) in June 2006 voted with an overwhelmingly majority against the legalisation of Euthanasia and Physician Assisted Suicide in the United Kingdom, confirming its previously long-held opposition. This occurred soon after the rejection of Lord Joel Joffe’s ‘Assisted Dying Bill” by the House of Lords by a large majority in May 2006.

The subsequent policy statement of the British Medical Association declared that it:
"i) believes that the ongoing improvement in palliative care allows patients to die with dignity;
ii) insists that physician assisted suicide should not be made legal in the UK;
iii) insists that voluntary euthanasia should not be made legal in the UK;”

In it the BMA stated clearly its opposition to “all forms of assisted dying, remarking that “the primary goal of medicine is still seen as promoting welfare, protecting the vulnerable and giving all patients as good a quality of life as is possible” and rejected the possibility that this “should include deliberately shortening their lives” even “when terminally ill patients request that or when an individuals’ suffering cannot be fully alleviated”. It also confirmed: “Assisting patients to die prematurely is not part of the moral ethos or the primary goal of medicine and, if allowed, could impact detrimentally on how doctors relate to their own role and to their patients.” It also specifically rejected the ‘absolute autonomy’ argument for euthanasia stating “that there are limits to what patients can choose if their choice will inevitably impact on other people.” [4]

The BMA’s policy statement also recognizes the intrinsic risks and dangers that the “concept of ‘assisted dying’ poses to the vulnerable and the sick, with whom a doctor’s prime responsibilities lie”. “If assisted dying were an option, there would be pressure for all seriously ill people to consider it even if they would not otherwise entertain such an idea”. “Health professionals explaining options for the management of terminal illness would have to include assisted dying. Patients might feel obliged to choose it for the wrong reasons, such as if they were worried about being a burden or concerned about the financial implications of a long terminal illness.” It also recognised that it would seriously “risk undermining patients’ ability to trust their

[2] http://www.wma.net/e/policy/p13.htm

[3] http://www.ama.com.au/web.nsf/doc/WEEN-76S8CY

[4] http://www.bma.org.uk/ap.nsf/Content/assisteddying?OpenDocument&Highlight=2,euthanasia

doctors and the health care system. In particular, it could generate immense anxiety for vulnerable, elderly, disabled or very ill patients."

The New Zealand Medical Association in its policy statement 'Euthanasia and Doctor-Assisted Suicide' published in July 2005, states that "The NZMA is opposed to both the concept and practice of euthanasia and doctor assisted suicide. Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's request or at the request of close relatives, is unethical. Doctor-assisted suicide, like euthanasia, is unethical." Importantly it also states that "the NZMA position is not dependent on euthanasia and doctor-assisted suicide remaining unlawful. Even if they were to become legal, or decriminalised, the NZMA would continue to regard them as unethical."[5]

The Canadian Medical Association also states that it "does not support euthanasia or assisted suicide [and] urges its members to uphold the principles of palliative care."[6]

Finally, despite the unique circumstances of the state of Oregon in the United States, the American Medical Association continues to unequivocally reject all forms of euthanasia. Its policy statement states that: "Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks" and "would ultimately cause more harm than good." It also recognizes the very real risks posed by euthanasia to incompetent and vulnerable patients and recommends that "instead of engaging in euthanasia, 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."

The ethos and integrity medicine is rooted in the reverence for all human life and the basic respect for the intrinsic dignity of all members of the human family. This does not allow for a discriminatory approach to the treatment or care of any patient, especially those who are in most need of such help and support. To do otherwise, to mark out some people for "assisted dying", is to devalue the humanity of the sick and dying and to practice the abandonment of the most vulnerable. As a society we should never confuse 'caring' with 'killing', nor should we make some members of our society eligible to be considered 'beyond caring for'.

Rather than enabling choice, legalising physician assisted suicide for would increase the likelihood that the chronically ill and the frail elderly would feel that they were a burden and should take the option made available to put themselves out of their own misery and the misery of those around them. Their life would hang on the tenuous thread of their own desire to continue.

Rather than considering legalising physician assisted suicide, politicians would do better to concentrate on ensuring that there are adequate services available for the chronically ill and frail elderly, especially palliative care. The main function of

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[5] http://www.nzma.org.nz/news/policies/euthanasia.html

[6] http://policybase.cma.ca/dbtw-wpd/Policypdf/PD07-01.pdf

palliative care is to assist someone to live more fully during the dying process by relieving distress and, in a multi-disciplinary way, ensuring that their social and emotional needs are met also. Facilitating their suicide would in fact decrease the political pressure to ensure that there are adequate services available for the chronically and frail elderly and decrease their sense of worth.