CLINICAL DECISIONS
INTERACTIVE AT NEJM.ORG

Physician-Assisted Suicide

This interactive feature addresses the approach to a clinical case. A case vignette is followed by specific options, neither of which can be considered correct or incorrect. In short essays, experts in the field then argue for each of the options. Readers can participate in forming community opinion by choosing one of the options and, if they like, providing their reasons.

CASE VIGNETTE

John Wallace is a 72-year-old man with metastatic pancreatic cancer. At time of diagnosis, the cancer was metastatic to his regional lymph nodes and liver. He was treated with palliative chemotherapy, but the disease continued to progress. Recently he has become jaundiced, and he has very little appetite. He has been seeing a palliative care physician and a social worker on an ongoing basis. His abdominal pain is now well controlled with high-dose narcotics, but the narcotics have caused constipation. In addition to seeing the social worker, he has also been seeing a psychologist to help him to cope with his illness.

Mr. Wallace has been married to his wife, Joyce, for 51 years, and they have three children and six grandchildren. He and his wife have lived in Salem, Oregon, for the past 23 years, and most of his family lives nearby. He understands the prognosis of the disease, and he does not wish to spend his last days suffering or in an unresponsive state. He discusses his desire for euthanasia with his wife and family members, and they offer him their support. The next day, he calls his physician and asks for information about physician-assisted suicide.

Do you believe that Mr. Wallace should be able to receive life-terminating drugs from his physician? Which one of the following approaches to the broader issue do you find appropriate? Base your choice on the published literature, your own experience, and other sources of information.

Choose an option and comment on your choice at NEJM.org

1. **Physician-assisted suicide should not be permitted.**
2. **Physician-assisted suicide should be permitted.**

To aid in your decision making, each of these approaches is defended in the following short essays by experts in the field. Given your knowledge of the patient and the points made by the experts, which option would you choose? Make your choice and offer your comments at NEJM.org.

OPTION 1

Physician-Assisted Suicide Should Not Be Permitted

J. Donald Boudreau, M.D., and
Margaret A. Somerville, A.u.A. (pharm.), D.C.L.

We recognize that a patient in Mr. Wallace's situation is in a state of grief. We appreciate his desire to be of sound mind at the end of his life and not to have to suffer as death approaches. We also recognize the obligations of physicians to respect a patient's refusal of treatment, to relieve pain and suffering, and to provide palliative care. However, we believe that the art of healing should always remain at the core of medical practice, and the role of healer involves providing patients with hope and renewed aspirations, however tenuous and temporary. Within the realm of palliative care, there exists a well-recognized paradox that one can die healed.[1] Physicians have a duty to uphold the sacred healing space — not destroy it. Therefore, physicians must hear Mr. Wallace's request for death but never carry it out.

Supporters of physician-assisted suicide justify their position by placing the value of individual autonomy above all other values and ethical considerations. Giving individual autonomy absolute priority runs roughshod over competing values, protections, and needs and ignores the harmful effects on other people, societal institutions (the medical profession in particular), and the general community.

Permitting physician-assisted suicide creates a slippery slope that unavoidably leads to expanded access to assisted suicide interventions — and abuses. Advocates of euthanasia deny that slippery slopes exist, arguing that legal constraints and administrative safeguards are effective in preventing them. But the evidence is clearly to the contrary, as the High Court of Ireland recently affirmed. In upholding the constitutionality of the prohibition on assisted suicide, the justices wrote, ". . . the fact that the number of LAWER ('life-ending acts without explicit request') cases remains strikingly high in jurisdictions which have liberalised their law on assisted suicide . . . speaks for itself as to the risks involved."[2] Vulnerable communities in our societies — persons who are old and frail and those who are disabled or terminally ill — perceive themselves to be threatened.[3] Physicians must not be willfully blind to these serious dangers.

Many aspects of physician-assisted suicide breach physicians' long-standing ethical norms. For instance, the 2011 annual report on the Death with Dignity Act in Oregon shows that physicians were present at fewer than 10% of "assisted deaths."[4] Why might they want to disconnect themselves from what they have enabled? Perhaps they have a moral intuition that intentionally facilitating or inflicting death is wrong. Patients expect an empathic presence from their physicians, and authentic healers commit to accompanying patients throughout the illness trajectory.

Referring to physician-assisted suicide as "treatment" is a new rhetorical tool that is used by the advocates of euthanasia. The goal is to make assisted suicide seem less alarming to the public and to promote the idea that legalizing the practice is just another small step along a path already taken and ethically approved. By intentionally confusing physician-assisted suicide with legitimate palliative care, pro-euthanasia advocates hope that the public will conclude that it is a medically and ethically accepted end-of-life treatment.[5]

For palliative care to remain a healing intervention, it cannot include "therapeutic homicide."[6] Euthanizing and healing are intrinsically incompatible. Involvement of physicians in such interventions is unethical and harms the fundamental role of the doctor as healer.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Department of Medicine and Centre for Medical Education (J.D.B.), the Centre for Medicine, Ethics and Law (M.A.S.), and the Faculty of Medicine (J.D.B., M.A.S.), McGill University, Montreal.

OPTION 2

Physician-Assisted Suicide Should Be Permitted

Nikola Biller-Andorno, M.D., Ph.D.

To many of us — physicians and nonphysicians alike — death appears as a menace, as something we fear and want to avoid at all cost. At the same time, most of us know someone for whom death has come as a relief. These deaths were sometimes long-awaited or they were actively sought out, prepared for in secrecy, and endured alone. For those persons, the opportunity to ask a competent professional for assistance in ending their lives in a legally and socially accepted way would be a clear improvement. Mr. Wallace is fortunate that this is an option in the state in which he lives and that he can discuss it openly with his family and his physician.

The role of physicians is not simply to preserve life but also to apply expertise and skills to help improve their patients' health or alleviate their suffering. The latter includes providing comfort and support to dying patients. Such patients may, after careful consideration, come to the conclusion that in their particular situation, asking a physician for assistance in suicide best reflects their interests and preferences. Responding to such a carefully considered request can be compatible with the goals and ethos of medicine, as well as with a trusting patient–physician relationship.

There is broad consensus about the importance and desirability of palliative medicine and hospice care, and physician-assisted suicide is in no way a repudiation of those practices.[7] Yet in some cases, symptoms cannot be sufficiently controlled; in many other instances, what is at stake is a perceived loss of autonomy and dignity.[8] Some patients wish to proactively shape the end of their life; to those patients, taking action to end their life is better than passively waiting for death to occur.

Physician-assisted suicide is now legal in a number of states in the United States, including Oregon and Washington State, as well as in

Switzerland and in the Netherlands. The data from these places show that the implementation of physician-assisted suicide, when it is accompanied by certain safeguards (including comprehensive screening and informed consent processes), does not lead to uncontrolled expansion or abuse. In Switzerland, the number of assisted suicides has risen steadily over the past decade, but the total number of suicides has declined.[9] The data from Oregon and Washington show that the majority of persons who request physician-assisted suicide are white, educated men — not a population that would be considered particularly vulnerable. Also, only a minority of persons who inquire about suicide assistance actually complete the process; this indicates that the option is perceived as a choice that can be abandoned.[10]

Even in societies with broad public support for physician-assisted suicide, a certain uneasiness and ambivalence remain, particularly among physicians who have to carry the emotional burden and moral responsibility of having enabled someone to end his or her life.[11,12] The decision to provide suicide assistance cannot be forced on physicians but needs to be left to their individual conscience. However, if a physician is prepared to respond to a request for assistance in suicide, there are no compelling ethical reasons not to allow that physician to do so. In any case, careful regulation, comprehensive monitoring, and an ongoing critical debate are required to ensure that physician-assisted suicide remains a choice that is based on caring relationships among the patient, the family, and health care professionals.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Department of Health Policy and Management, Harvard School of Public Health, and the Division of Medical Ethics, Department of Global Health, and Social Medicine, Harvard Medical School, Boston; the Institute of Biomedical Ethics, University of Zurich, and Careum Foundation, Zurich, Switzerland; and the Harkness Fellowship Program, Commonwealth Fund, New York.

1. Mount B, Kearney M. Healing and palliative care: charting our way forward. Palliat Med 2003;17:657-8.
2. Fleming v. Ireland & Ors, (2013) IEHC 2 (Jan. 10, 2013).
3. Golden M, Zoanni T. Killing us softly: the dangers of legalizing assisted suicide. Disabil Health J 2010;3:16-30.
4. Oregon.gov. Death with Dignity Act (http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx).
5. Somerville MA. Death talk: the case against euthanasia and physician-assisted suicide. Montreal: McGill-Queen's University Press, 2001:218-30.
6. Flegel K, Fletcher J. Choosing when and how to die: are we ready to perform therapeutic homicide? CMAJ 2012;184:1227.
7. Quill TE. Physicians should "assist in suicide" when it is appropriate. J Law Med Ethics 2012;40:57-65.
8. Ganzini L, Goy ER, Dobscha SK. Oregonians' reasons for requesting physician aid in dying. Arch Intern Med 2009;169:489-92. [Erratum, Arch Intern Med 2009;169:571.]
9. Swiss Federal Statistical Office. Todesursachenstatistik 2009. Sterbehilfe (assistierter Suizid) und Suizid in der Schweiz. 2012 (http://www.bfs.admin.ch/bfs/portal/de/index/themen/14/02/04/dos/04.html).
10. Loggers ET, Starks H, Shannon-Dudley M, Back AL, Appelbaum FR, Stewart FM. Implementing a death with dignity program at a comprehensive cancer center. N Engl J Med 2013;368:1417-24.
11. Biller-Andorno N, Pfister E. Line, please. Hastings Cent Rep 2009;39:6.
12. Pfister E, Biller-Andorno N. Physician-assisted suicide: views of Swiss health care professionals. J Bioeth Inq 2010;7:283-5.

DOI: 10.1056/NEJMclde1302615