

Thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and well-considered perspectives about physician-assisted suicide. Nonetheless, at the core of public and professional debate about physician-assisted suicide is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs. Supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

Guidance in the AMA Code of Medical Ethics encompasses the irreducible moral tension at stake for physicians with respect to participating in assisted suicide. Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide. Opinion 1.1.7 articulates the thoughtful moral basis for those who support assisted suicide.



5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

- (a) Should not abandon a patient once it is determined that cure is impossible.
- (b) Must respect patient autonomy.
- (c) Must provide good communication and emotional support.
- (d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I, IV

1.1.7 Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation

that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

- (a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
- (b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
- (c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
- (d) Be mindful of the burden their actions may place on fellow professionals.
- (e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
- (f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
- (g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

AMA Principles of Medical Ethics: I, II, IV, VI, VIII, IX

Background report(s):

CEJA Report 2-A-19 Physician-assisted suicide

CEJA Report 8-I-93 Physician-assisted suicide

CEJA Report B-A-91 Decisions near the end of life

REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (2-A-19)
Physician-Assisted Suicide (Resolution 15-A-16 and Resolution 14-A-17)
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

The House of Delegates asked the Council on Ethical and Judicial Affairs (CEJA) to “study the issue of aid in dying with consideration of data collected from the states that currently authorize aid-in-dying, and input from some of the physicians who have provided medical aid-in-dying to qualified patients. CEJA was further asked to consider the need to distinguish between “physician-assisted suicide” and “aid in dying.”

In response to these requests, CEJA carried out an extensive review of relevant philosophical and empirical literature. Its deliberations have further been informed by an educational session at the 2016 Interim Meeting and consultations with stakeholders at the 2017 Annual and Interim meetings, as well as extensive correspondence from stakeholders within the medical community and the public at large. In addition, the council heard passionate testimony from both opponents and supporters of physician participation in assisted suicide at the 2018 Annual and Interim meetings.

Reflecting on this input, CEJA recognized that thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide. Importantly, the council found that despite deep differences, supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

CEJA interprets existing guidance in the AMA *Code of Medical Ethics* as encompassing the irreducible moral tension at stake for physicians with respect to participating in assisted suicide.

Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support assisted suicide, CEJA recommends that the *Code of Medical Ethics* not be amended.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-A-19

Subject: Physician-Assisted Suicide
(Resolution 15-A-16 and Resolution 14-A-17)

Presented by: James E. Sabin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(William C. Reha, MD, Chair)

1 At the 2016 Annual Meeting, the House of Delegates referred Resolution 15-A-16, “Study Aid-in-
2 Dying as End-of-Life Option,” presented by the Oregon Delegation, which asked:

3
4 That our American Medical Association (AMA) and its Council on Judicial and Ethical
5 Affairs (CEJA), study the issue of medical aid-in-dying with consideration of (1) data
6 collected from the states that currently authorize aid-in-dying, and (2) input from some of
7 the physicians who have provided medical aid-in-dying to qualified patients, and report
8 back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA
9 taking a neutral stance on physician “aid-in-dying.”

10
11 At the following Annual Meeting in June 2017, the House of Delegates similarly referred
12 Resolution 14-A-17, “The Need to Distinguish between ‘Physician-Assisted Suicide’ and ‘Aid in
13 Dying’” (presented by M. Zuhdi Jasser, MD), which asked that our AMA:

14
15 (1) as a matter of organizational policy, when referring to what it currently defines as
16 ‘*Physician Assisted Suicide*’ avoid any replacement with the phrase ‘*Aid in Dying*’ when
17 describing what has long been understood by the AMA to specifically be ‘*Physician Assisted*
18 *Suicide*’; (2) develop definitions and a clear distinction between what is meant when the AMA
19 uses the phrase ‘*Physician Assisted Suicide*’ and the phrase ‘*Aid in Dying*’; and (3) fully utilize
20 these definitions and distinctions in organizational policy, discussions, and position statements
21 regarding both ‘*Physician Assisted Suicide*’ and ‘*Aid in Dying*.’

22
23 This report by the Council on Ethical and Judicial Affairs addresses the concerns expressed in
24 Resolutions 15-A-16 and 14-A-17. In carrying out its review of issues in this area, CEJA reviewed
25 the philosophical and empirical literature, sought input from the House of Delegates through an I-
26 16 educational program on physician-assisted suicide, an informal “open house” at A-17, and its I-
27 17 Open Forum. The council wishes to express its sincere appreciation for participants’
28 contributions during these sessions and for additional written communications received from
29 multiple stakeholders, which have enhanced its deliberations.

30
31 The council observes that the ethical arguments advanced today supporting and opposing
32 “physician-assisted suicide” or “aid in dying” are fundamentally unchanged from those examined

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 in CEJA’s 1991 report on this topic [1]. The present report does not rehearse these arguments again
2 as such. Rather, it considers the implications of the legalization of assisted suicide in the United
3 States since the adoption of [Opinion E-5.7](#), “Physician-Assisted Suicide,” in 1994.

4
5 “ASSISTED SUICIDE,” “AID IN DYING,” OR “DEATH WITH DIGNITY”?

6
7 Not surprisingly, the terms stakeholders use to refer the practice of physicians prescribing lethal
8 medication to be self-administered by patients in many ways reflect the different ethical
9 perspectives that inform ongoing societal debate. Proponents of physician participation often use
10 language that casts the practice in a positive light. “Death with dignity” foregrounds patients’
11 values and goals, while “aid in dying” invokes physicians’ commitment to succor and support.
12 Such connotations are visible in the titles of relevant legislation in states that have legalized the
13 practice: “Death with Dignity” (Oregon, Washington, District of Columbia), “Patient Choice and
14 Control at the End of Life” (Vermont), “End of Life Options” (California, Colorado), “Our Care
15 Our Choice Act” (Hawaii), and in Canada’s “Medical Aid in Dying.”

16
17 Correspondingly, those who oppose physician provision of lethal medications refer to the practice
18 as “physician-assisted suicide,” with its negative connotations regarding patients’ psychological
19 state and its suggestion that physicians are complicit in something that, in other contexts, they
20 would seek to prevent. The language of dignity and aid, critics contend, are euphemisms [2]; their
21 use obscures or sanitizes the activity. In their view such language characterizes physicians’ role in
22 a way that risks construing an act that is ethically unacceptable as good medical practice [3]. Still
23 others, meanwhile, argue that the choice by terminally ill patients to take action to end their own
24 lives with the assistance of their physician is distinct from what is traditionally understood as
25 “suicide” [4].

26
27 The council recognizes that choosing one term of art over others can carry multiple, and not always
28 intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation
29 and debate is best served by using plainly descriptive language. In the council’s view, despite its
30 negative connotations [5], the term “physician assisted suicide” describes the practice with the
31 greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia [1]. The
32 terms “aid in dying” or “death with dignity” could be used to describe either euthanasia or
33 palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing
34 ethical guidance.

35 36 COMMON GROUND

37
38 Beneath the seemingly incommensurate perspectives that feature prominently in public and
39 professional debate about writing a prescription to provide patients with the means to end life if
40 they so choose, CEJA perceives a deeply and broadly shared vision of what matters at the end of
41 life. A vision that is characterized by hope for a death that preserves dignity, a sense of the
42 sacredness of ministering to a patient at the end of life, recognition of the relief of suffering as the
43 deepest aim of medicine, and fully voluntary participation on the part of both patient and physician
44 in decisions about how to approach the end of life.

45
46 Differences lie in the forms these deep commitments take in concrete decisions and actions. CEJA
47 believes that thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and
48 well-considered perspectives about physician-assisted suicide that govern how these shared
49 commitments are ultimately expressed. For one patient, dying “with dignity” may mean accepting
50 the end of life however it comes as gracefully as one can; for another, it may mean being able to
51 exercise some measure of control over the circumstances in which death occurs. For some

1 physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to
2 abandon the patient preclude the possibility of supporting patients in hastening their death. For
3 others, not to provide a prescription for lethal medication in response to a patient’s sincere request
4 violates that same commitment and duty. Both groups of physicians base their view of ethical
5 practice on the guidance of [Principle I](#) of the AMA *Principles of Medical Ethics*: “A physician
6 shall be dedicated to providing competent medical care, with compassion and respect for human
7 dignity and rights.”

8
9 So too, how physicians understand and act on the goals of relieving suffering, respecting
10 autonomy, and maintaining dignity at the end of life is directed by identity-conferring beliefs and
11 values that may not be commensurate. Where one physician understands providing the means to
12 hasten death to be an abrogation of the physician’s fundamental role as healer that forecloses any
13 possibility of offering care that respects dignity, another in equally good faith understands
14 supporting a patient’s request for aid in hastening a foreseen death to be an expression of care and
15 compassion.

16 17 IRREDUCIBLE DIFFERENCES IN MORAL PERSPECTIVES ON PHYSICIAN-ASSISTED 18 SUICIDE

19
20 How to respond when coherent, consistent, and deeply held beliefs yield irreducibly different
21 judgments about what is an ethically permissible course of action is profoundly challenging. With
22 respect to physician-assisted suicide, some professional organizations—for example, the American
23 Academy of Hospice and Palliative Medicine [6]—have adopted a position of “studied neutrality.”
24 Positions of studied neutrality neither endorse nor oppose the contested practice, but instead are
25 intended to respect that there are irreducible differences among the deeply held beliefs and values
26 that inform public and professional perspectives [6,7], and to leave space open for ongoing
27 discussion. Nonetheless, as a policy position, studied neutrality has been criticized as neither
28 neutral or appropriate for organized medicine [8], and as being open to unintended consequences,
29 including stifling the very debate it purports to encourage or being read as little more than
30 acquiescence with the contested practice [9].

31
32 CEJA approaches the condition of irreducible difference from a different direction. In its 2014
33 report on exercise of conscience, the Council noted that “health care professionals may hold very
34 different core beliefs and thus reach very different decisions based on those core beliefs, yet
35 equally act according to the dictates of conscience. For example, a physician who chooses to
36 provide abortions on the basis of a deeply held belief in protecting women’s autonomy makes the
37 same kind of moral claim to conscience as does a physician who refuses to provide abortion on the
38 basis of respect for the sanctity of life of the fetus” [10].

39
40 Importantly, decisions taken in conscience are not simply idiosyncratic; they do not rest on
41 intuition or emotion. Rather, such decisions are based on “substantive, coherent, and reasonably
42 stable” values and principles [10]. Physicians must be able to articulate how those values and
43 principles justify the action in question.

44
45 The ethical arguments offered for more than two decades by those who support and those who
46 oppose physician participation in assisted suicide reflect the diverging “substantive, coherent, and
47 reasonably stable” values and principles within the profession and the wider moral community.
48 While supporters and opponents of physician-assisted suicide share a common commitment to
49 “compassion and respect for human dignity and rights” (AMA [Principles of Medical Ethics](#), I),
50 they draw different moral conclusions from the underlying principle they share. As psychiatrist
51 Harvey Chochinov observed with respect to the stakeholders interviewed by Canadian Supreme

1 Court’s advisory panel on physician-assisted death, “neither those who are strongly supportive nor
2 those who are opposed hold a monopoly on integrity and a genuine concern for the well-being of
3 people contemplating end of life. Equally true: neither side is immune from impulses shaped more
4 by ideology than a deep and nuanced understanding of how to best honor and address the needs of
5 people who are suffering” [11].

6 7 THE RISK OF UNINTENDED CONSEQUENCES

8
9 From the earliest days of the debate, a prominent argument raised against permitting physician-
10 assisted suicide has been that doing so will have adverse consequences for individual patients, the
11 medical profession, and society at large. Scholars have cited the prospect that boundaries will be
12 eroded and practice will be extended beyond competent, terminally ill adult patients; to patients
13 with psychiatric disorders, children; or that criteria will be broadened beyond physical suffering to
14 encompass existential suffering; or that stigmatized or socioeconomically disadvantaged patients
15 will be coerced or encouraged to end their lives. Concerns have also been expressed that permitting
16 the practice will compromise the integrity of the profession, undermine trust, and harm the
17 physicians and other health care professionals who participate; and that forces outside medicine
18 will unduly influence decisions.

19
20 The question whether safeguards—which in the U.S. jurisdictions that permit assisted suicide,
21 restrict the practice to terminally ill adult patients who have decision-making capacity and who
22 voluntarily request assisted suicide, along with procedural and reporting requirements—can
23 actually protect patients and sustain the integrity of medicine remains deeply contested. Some
24 studies have “found no evidence to justify the grave and important concern often expressed about
25 the potential for abuse—namely, the fear that legalized physician-assisted dying will target the
26 vulnerable or pose the greatest risk to people in vulnerable groups” [12], others question whether
27 the available data can in fact support any such conclusions, finding the evidence cited variously
28 flawed [13], inadequate [14], or distorted [15].

29
30 Although cross-cultural comparisons are problematic [16], current evidence from Europe does tell
31 a cautionary tale. Recent findings from studies in Belgium and the Netherlands, both countries that
32 permit euthanasia as well as physician-assisted suicide, mitigate some fears but underscore others
33 [17]. For example, research in the Netherlands has found that “requests characterized by
34 psychological as opposed to physical suffering were more likely to be rejected, as were requests by
35 individuals who lived alone,” mitigating fears that “solitary, depressed individuals with potentially
36 reversible conditions might successfully end their lives.” At the same time, however, among
37 patients who obtained euthanasia or assisted suicide, nearly 4 percent “reported only psychological
38 suffering.” At the level of anecdote, a description of a case of euthanasia in Belgium elicited
39 widespread concern about the emergence of a “slippery slope” [18].

40
41 Studies have also raised questions about how effective retrospective review of decisions to provide
42 euthanasia/assisted suicide is in policing practice [19,20]. A qualitative analysis of cases that Dutch
43 regional euthanasia committees determined had not met legal “due care criteria” found that such
44 reviews focus on procedural considerations and do not “directly assess the actual eligibility” of the
45 patients who obtained euthanasia [19]. A separate study of cases in which psychiatric patients
46 obtained euthanasia found that physicians’ reports “stated that psychosis or depression did or did
47 not affect capacity but provided little explanation regarding their judgments” and that review
48 committees “generally accepted the judgment of the physician performing EAS [euthanasia or
49 physician-assisted suicide]” [20]. It remains an open question whether reviews that are not able to
50 assess physicians’ reasoning truly offer the protection they are intended to provide. To the extent

1 that reporting and data collection in states that permit physician-assisted suicide have similar
2 limitations, oversight of practice may not be adequate.

3
4 Medicine must learn from this experience. Where physician-assisted suicide is legalized,
5 safeguards can and should be improved—e.g., “[t]o increase safeguards, states could consider
6 introducing multidisciplinary panels to support patients through the entire process, including
7 verifying consent and capacity, ensuring appropriate psychosocial counseling, and discussing all
8 palliative and end-of-life options” [21]. Both the state and the medical profession have a
9 responsibility to monitor ongoing practice in a meaningful way and to address promptly
10 compromises in safeguards should any be discovered. It is equally important that strong practices
11 be identified and encouraged across all jurisdictions that permit physicians to assist suicide. Health
12 care organizations in California and Canada, for example, have shared richly descriptive reports of
13 practices adopted in response to the recent legalization of “aid in dying” in those jurisdictions that
14 seek to address concerns about quality of practice and data collection [22,23].

15
16 Medicine must also acknowledge, however, that evidence (no matter how robust) that there have
17 not yet been adverse consequences cannot guarantee that such consequences would not occur in the
18 future. As a recent commentary noted, “[p]art of the problem with the slippery slope is you never
19 know when you are on it” [17].

20 21 SAFEGUARDING DECISIONS AT THE END OF LIFE

22
23 CEJA has found that just as there are shared commitments behind deep differences regarding
24 physician-assisted suicide, there are also shared concerns about how to understand the available
25 evidence. For example, in the council’s recent Open Forum, both proponents and opponents of
26 physician-assisted suicide observed that in the U.S., debate occurs against the backdrop of a health
27 care system in which patients have uneven access to care, including access to high quality end-of-
28 life care. They also noted that patients and physicians too often still do not have the conversations
29 they should about death and dying, and that too few patients are aware of the range of options for
30 end-of-life care, raising concern that many patients may be led to request assisted suicide because
31 they don’t understand the degree of relief of suffering state-of-the-art palliative care can offer.
32 Participants who in other respects held very different views concurred as well that patients may be
33 vulnerable to coercion, particularly patients who are in other ways disadvantaged; and expressed
34 concern in common that forces external to medicine could adversely influence practice.

35
36 These are much the same concerns the Institute of Medicine identified in its 2015 report, *Dying in*
37 *America* [24]. They are concerns echoed in a February 2018 workshop on physician-assisted death
38 convened by the National Academies of Science, Engineering and Medicine [25]. They underscore
39 how important it is to understand *why* a patient requests assisted suicide as a starting point for care
40 [26].

41
42 Patient requests for assisted suicide invite physicians to have the kind of difficult conversations that
43 are too often avoided. They open opportunities to explore the patient’s goals and concerns, to learn
44 what about the situation the individual finds intolerable and to respond creatively to the patient’s
45 needs other than providing the means to end life—by such means as better managing symptoms,
46 arranging for psychosocial or spiritual support, treating depression, and helping the patient to
47 understand more clearly how the future is likely to unfold [5,27]. Medicine as a profession must
48 ensure that physicians are skillful in engaging in these difficult conversations and knowledgeable
49 about the options available to terminally ill patients [28]. The profession also has a responsibility to
50 advocate for adequate resources for end-of-life care [16,28], particularly for patients from

1 disadvantaged groups. The availability of assisted suicide where it is legal must not be allowed to
2 interfere with excellent care at the end of life.

3
4 CONCLUSION

5
6 At the core of public and professional debate, the council believes, is the aspiration that every
7 patient come to the end of life as free as possible from suffering that does not serve the patient's
8 deepest self-defining beliefs and in the presence of trusted companions, including where feasible
9 and when the patient desires, the presence of a trusted physician. As Timothy Quill noted more
10 than 20 years ago, "dying patients do not have the luxury of choosing not to undertake the journey,
11 or of separating their person from their disease" [27]. Decisions about how to approach the end of
12 life are among the most intimate that patients, families, and their physicians make. Respecting the
13 intimacy and the authenticity of those relationships is essential if our common ideal is to be
14 achieved.

15
16 While supporters and opponents of physician-assisted suicide share a common commitment to
17 "compassion and respect for human dignity and rights" ([AMA Principles of Medical Ethics](#), I),
18 they draw different moral conclusions from the underlying principle they share. Where one
19 physician understands providing the means to hasten death to be an abrogation of the physician's
20 fundamental role as healer that forecloses any possibility of offering care that respects dignity,
21 another in equally good faith understands supporting a patient's request for aid in hastening a
22 foreseen death to be an expression of care and compassion.

23
24 RECOMMENDATION

25
26 The Council on Ethical and Judicial Affairs has reviewed the literature and received thoughtful
27 input from numerous individuals and organizations to inform its deliberations, and is deeply
28 grateful to all who shared their insights. CEJA engaged in extensive, often passionate discussion
29 about how to interpret the *Code of Medical Ethics* in light of ongoing debate and the irreducible
30 differences in moral perspectives identified above. The council recognized that supporters and
31 opponents share a fundamental commitment to values of care, compassion, respect, and dignity, but
32 diverge in drawing different moral conclusions from those underlying values in equally good faith.
33 The council further recognized that medicine must learn from experience of physician-assisted
34 suicide, and must ensure that, where the practice is legal, safeguards are improved.

35
36 After careful consideration, CEJA concludes that in existing opinions on physician-assisted suicide
37 and the exercise of conscience, the *Code* offers guidance to support physicians and the patients
38 they serve in making well-considered, mutually respectful decisions about legally available options
39 for care at the end of life in the intimacy of a patient-physician relationship.

40
41 Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-
42 assisted suicide, and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support
43 assisted suicide, the Council on Ethical and Judicial Affairs recommends that the *Code of Medical*
44 *Ethics* not be amended, that Resolutions 15-A-16 and 14-A-17 not be adopted, and that the
45 remainder of the report be filed.¹

Fiscal Note: None.

¹ CEJA plans to present E-5.7 and E-1.1.7 in online and print versions of the *Code of Medical Ethics* as suggested in the Appendix.

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APPENDIX

Thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide. Nonetheless, at the core of public and professional debate about physician-assisted suicide is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs. Supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

Guidance in the AMA Code of Medical Ethics encompasses the irreducible moral tension at stake for physicians with respect to participating in assisted suicide. Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide. Opinion 1.1.7 articulates the thoughtful moral basis for those who support assisted suicide.

5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

- (a) Should not abandon a patient once it is determined that cure is impossible.
- (b) Must respect patient autonomy.
- (c) Must provide good communication and emotional support.
- (d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I, IV

1.1.7 Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and

committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

- (a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
- (b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
- (c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
- (d) Be mindful of the burden their actions may place on fellow professionals.
- (e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
- (f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.

- (g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

AMA Principles of Medical Ethics: I, II, IV, VI, VIII, IX

CEJA Report 8 – I-93 Physician-Assisted Suicide

INTRODUCTION

Physician-assisted suicide presents one of the greatest contemporary challenges to the medical profession's ethical responsibilities. Proposed as a means toward more humane care of the dying, assisted suicide threatens the very core of the medical profession's ethical integrity.

While the Council on Ethical and Judicial Affairs has long-standing policy opposing euthanasia, it did not expressly address the issue of assisted suicide until its June 1991 report, "Decisions "Near the End of Life."¹ In that report, the Council concluded that physician-assisted suicide is contrary to the professional role of physicians and that therefore physicians "must not...participate in assisted suicide."¹ Previously, the Council had issued reports rejecting the use of euthanasia. In June 1977, the Council stated that "mercy killing or euthanasia...is contrary to public policy, medical tradition, and the most fundamental measures of human value and worth."² Similarly, in June 1988, the Council reaffirmed "its strong opposition to 'mercy killing.'"³

Broad public debate of assisted suicide was sparked in June 1990, when Dr. Jack Kevorkian assisted in the suicide of Janet Adkins (NY Times, June 6, 1990:A1). The debate was advanced in March 1991 when Dr. Timothy Quill disclosed his assistance in the suicide of Diane Trumbull.⁴ Other public events quickly followed. Physician-assisted suicide, together with euthanasia, was placed on the public ballot in Washington State, in November 1991, and in California, in November 1992. Both times, voters turned down proposals to legalize physician-assisted dying (USA Today, August 9, 1993:13A). In September 1993, by a vote of 5-4, Canada's Supreme Court denied a woman's request to end her life by assisted suicide (NY Times, October 1, 1993:A8). In 1994, voters in Oregon will decide whether to legalize assisted suicide in their state.

Resolution 3, introduced at the 1993 Annual Meeting by the Medical Student Section and referred to the Board of Trustees by the House of Delegates, requested an ethical study of assisted suicide. In this report, the Council revisits the issue of physician-assisted suicide.

DEFINITIONS

Assisted suicide occurs when a physician provides a patient with the medical means and/ or the medical knowledge to commit suicide. For example, the physician could provide sleeping pills and information about the lethal dose, while aware that the patient is contemplating suicide. In physician-assisted suicide, the patient performs the life-ending act, whereas in euthanasia, the physician administers the death-causing drug or other agent.⁵

Assisted suicide and euthanasia should not be confused with the provision of a palliative treatment that may hasten the patient's death ("double effect"). The intent of the palliative treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a possible side effect of the treatment. It is ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death.¹

Assisted suicide also must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient's death occurs because the patient or the patient's proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its advantages and therefore that treatment is refused.¹

ETHICAL CONSIDERATIONS

Inappropriate extension of the right to refuse treatment

In granting patients the right to refuse life-sustaining medical treatment, society has acknowledged the right of patients to self-determination on matters of their medical care even if the exercise of that self-determination results in the patient's death. Because any medical treatment offers both benefits and detriments, and people attach different values to those benefits and detriments, only the patient can determine whether the advantages of treatment outweigh the disadvantages. As the Council has previously concluded, "[t]he principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity."¹

Although a patient's choice of suicide also represents an expression of self-determination, there is a fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment. The right of self-determination is a right to accept or refuse offered interventions, but not to decide what should be offered. The right to refuse life-sustaining treatment does not automatically entail a right to insist that others take action to bring on death.^{6(p.121)}

When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide, however, death is hastened by the taking of a lethal drug or other agent. Although a physician cannot force a patient to accept a treatment against the patient's will, even if the treatment is life-sustaining, it does not follow that a physician ought to provide a lethal agent to the patient. The inability of physicians to prevent death does not imply that physicians are free to help cause death.

For a number of reasons, the medical profession has rejected assisted suicide as fundamentally inconsistent with the professional role of physicians as healers. Indeed, according to the Hippocratic Oath, physicians shall "give no deadly drug to any, though it be asked of [them], nor will [they] counsel such." Physicians serve patients not because patients exercise self-determination but because patients are in need. Therefore, a patient may not insist on treatments that are inconsistent with sound medical practices. Rather, physicians provide treatments that are designed to make patients well, or as well as possible.⁷ The physician's role is to affirm life, not to hasten its demise.

Permitting assisted suicide would compromise the physician's professional role also because it would involve physicians in making inappropriate value judgments about the quality of life. Indeed, with the refusal of life-sustaining treatment, society does not limit the right to refuse treatment only to patients who meet a specific standard of suffering. With refusal of treatment, the state recognizes that the patient (or the patient's proxy) alone can decide that there no longer is a meaningful quality of life.

Objections to causing death also underlie religious views on assisted suicide. Most of the world's major religions oppose suicide in all forms and do not condone physician-assisted suicide even in cases of suffering or imminent death. In justification of their position, religions generally espouse common beliefs about the sanctity of human life, the appropriate interpretation of suffering, and the subordination of individual autonomy to a belief in God's will or sovereignty.⁸

The physician's role

The relief of suffering is an essential part of the physician's role as healer, and some patients seek assisted suicide because they are suffering greatly. Suffering is a complex process that may exist in one or several forms, including pain, loss of self-control and independence, a sense of futility, loss of dignity and fear of dying. It is incumbent upon physicians to discuss and identify the elements contributing to the patient's

suffering and address each appropriately. The patient, and family members as well, should participate with the physician to ensure that measures to provide comfort will be given the patient in a timely fashion.

One of the greatest concerns reported by patients facing a terminal illness or chronic debilitation is the fear that they will be unable to receive adequate relief for their pain.⁹ Though there is some basis for this fear in a small number of cases, for most patients pain can be adequately controlled.^{10,11} Inadequate pain relief is only rarely due to the unavailability of effective pain control medications; more often, it may be caused by reluctance on the part of physicians to use these medications aggressively enough to sufficiently alleviate the patient's pain. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area.

Pain control medications should be employed in whatever dose necessary, and by whatever route necessary, to fully relieve the patient's pain.⁹ The patient's treatment plan should be tailored to meet the particular patient's needs. Some patients will request less pain control in order to remain mentally lucid; others may need to be sedated to the point of unconsciousness. Ongoing discussions with the patient, if possible, or with the patient's family or surrogate decision maker will be helpful in identifying the level of pain control necessary to relieve the patient's suffering in accordance with the patient's treatment goals. Techniques of patient controlled analgesia (PCA) enhance the sense of control of terminally ill patients, and, for this reason, are particularly effective. Often, it is the loss of control, rather than physical pain, that causes the most suffering for dying patients.

The first priority for the care of patients facing severe pain as a result of a terminal illness or chronic condition should be the relief of their pain. Fear of addiction to pain medications should not be a barrier to the adequate relief of pain. Nor should physicians be concerned about legal repercussions or sanctions by licensing boards. The courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. Indeed, it is well accepted both ethically and legally that pain medications may be administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of causing addiction or of causing death through respiratory depression.¹

Relieving the patient's psychosocial and other suffering is as important as relieving the patient's pain. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. Patients in these circumstances must be managed "in a setting of [the patient's] own choosing, as free as possible from pain and other burdensome symptoms, and with the optimal psychological and spiritual support of family and friends."¹² Because the loss of control may be the greatest fear of dying patients, all efforts should be made to maximize the patient's sense of control.

Accomplishing these goals requires renewed efforts from physicians, nurses, family members and other sources of psychological and spiritual support. Often, the patient's despair with his or her quality of life can be relieved by psychiatric intervention.¹³ Seriously ill patients contemplating suicide may develop a renewed desire to live as a result of counseling and/ or anti-depressant medications. When requests for assisted suicide occur, it is important to provide the patient with an evaluation by a health professional with expertise in psychiatric aspects of terminal illness.

The hospice movement has made great strides in providing comfort care to patients at the end of life. In hospice care, the patient's symptoms, including pain, are aggressively treated to make the patient as comfortable as possible, but efforts to extend the patient's life are usually not pursued.¹⁴⁻¹⁶ Hospice patients are often cared for at home, or, if their condition requires care to be delivered in an institutional

setting, intrusive medical technology is kept to a minimum. The provision of a humane, low technology environment in which to spend their final days can go far in alleviating patients' fears of an undignified, lonely, technologically dependent death.

Physicians must not abandon or neglect the needs of their terminally ill patients. Indeed, the desire for suicide is a signal to the physician that more intensive efforts to comfort and care for the patient are needed. Physicians, family and friends can help patients near the end of life by their presence and by their loving support. Patients may feel obligated to die in order to spare their families the emotional and financial burden of their care or to spare limited societal resources for other health care needs. While patients may rationally and reasonably be concerned about the burden on others, physicians and family members must reassure patients that they are under no obligation to end their lives prematurely because of such concerns.

In some cases, terminally ill patients voluntarily refuse food or oral fluids. In such cases, patient autonomy must be respected and forced feeding or aggressive parenteral rehydration should not be employed. Emphasis should be placed on renewed efforts at pain control, sedation and other comfort care for the associated discomfort.

"Slippery slope" concerns

Permitting assisted suicide opens the door to policies that carry far greater risks. For example, if assisted suicide is permitted, then there is a strong argument for allowing euthanasia. It would be arbitrary to permit patients who have the physical ability to take a pill to end their lives, but not let similarly suffering patients die if they require the lethal drug to be administered by another person. Once euthanasia is permitted, however, there is a serious risk of involuntary deaths. Given the acceptance of withdrawal of life-sustaining treatment by proxies for incompetent patients, it would be easy for society to permit euthanasia for incompetent patients by proxy.

The Dutch experience with euthanasia demonstrates the risks of sanctioning physician-assisted suicide. In the Netherlands, there are strict criteria for the use of euthanasia that are similar to the criteria proposed for assisted suicide in the United States. In the leading study of euthanasia in the Netherlands,¹⁷ however, researchers found that, in about 28% of cases of euthanasia or physician-assisted suicide, the strict criteria were not fulfilled, suggesting that some patients' lives were ended prematurely or involuntarily. In a number of cases, the decision to end the patient's life was made by a surrogate decision maker since the patient had lost decision-making capacity by the time the decision to employ euthanasia was made.

RECOMMENDATIONS

1. Physician assisted suicide is fundamentally inconsistent with the physician's professional role.
2. It is critical that the medical profession redoubles its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
3. Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.

4. Requests for physician-assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.

5. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

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CEJA Report B – A-91 Decisions Near the End of Life

INTRODUCTION

There is a long-standing tradition in medicine that physicians must do everything medically possible to keep a patient alive. In recent years, the issue of allowing and even helping patients to die has been opened up to vigorous debate. At present do-not-resuscitate orders are commonplace.^{1,2} Courts have upheld the right of patients to refuse life-sustaining treatment in over 130 cases, and the U.S. Supreme Court recently indicated that a right to refuse life-sustaining treatment can be found in the U.S. Constitution.³ There is a surprising amount of support even for the proposition that physicians should be allowed to deliberately end a patient's life upon the patient's request. In one poll conducted in 1988 in New York City, 58% of the physicians responded that physicians should be lawfully able to end the life of terminally ill patients at the patients' request.¹⁴

Since the turn of the century, there has been a dramatic shift in the places where people die. Sixty years ago, the vast majority of deaths occurred at home. Now most people die in hospitals or long-term care facilities. Approximately 75% of all deaths in 1987 occurred in hospitals and long-term care institutions,⁵ up from 50% in 1949, 61% in 1958 and 70% in 1977.⁶ This move of the locale of death from the privacy of the home to medical institutions has increased public awareness and concern about medical decisions that lead to patients' deaths. "Since deaths which occur in institutions are more subject to scrutiny and official review, decisions for death made there are more likely to enter public consciousness."⁷

A related phenomenon, the advance of life-saving medical technologies, also has contributed to the increased attention to medical decisions that lead to the deaths of patients. These advances have resulted in a lengthening of the average life span, which has had the effect of increasing the proportion of deaths caused by chronic conditions. One study in 1968 found that half of all deaths are caused by an illness diagnosed at least 29 months earlier. Another study found that a chronic condition was the cause of 75% of all deaths in 1986.⁸ In addition, with the development of sophisticated life support technologies, medicine now has the capacity to intervene and forestall death for almost any case. The Office of Technology Assessment Task Force estimated in 1988 that 3775 to 6575 persons were dependent on mechanical ventilation and 1,404,500 persons were receiving artificial nutritional support.⁹ Bioethicist Alexander Capron has argued:

There is no such thing as a "natural" death. Somewhere along the way for just about every patient, death is forestalled by human choice and human action, or death is allowed to occur because of human choice. Life-support techniques make death a matter of human choice and hence a matter that provokes ethical concern.⁷

As a result, the public has become increasingly concerned about the prospect of protracted deaths marked by incapacitation, intolerable pain and indignity, and invasion by machines and tubes. In a public opinion poll 68% of respondents believed that "people dying of an incurable painful disease should be allowed to end their lives before the disease runs its course."^{1,10} A number of comparable surveys indicate similar public sentiment.¹

The Council has previously issued opinions on withdrawing and withholding life-prolonging treatment from patients who are terminally ill or permanently unconscious (2.20 and 2.21 in *Current Opinions*) and reports concerning do-not-resuscitate orders,^{11,12} euthanasia,¹³ and withdrawal of life-prolonging treatment from permanently unconscious patients.¹⁴

At the 1990 Annual Meeting of the AMA's House of Delegates, Resolution 267, "Suicide-Assisting Devices," was referred for decision. This report will examine the Council's existing positions and will expand the analysis to include physician-assisted suicide and withdrawing/withholding life-sustaining treatment for patients who are neither terminally ill nor permanently unconscious.

DEFINITIONS

The four categories of medical actions that can lead to the death of a patient are: withholding/withdrawing life-sustaining treatment, the provision of palliative treatment that may foreseeably hasten death, euthanasia, and assisted suicide.

Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics and artificial nutrition and hydration. At one time, the term "passive euthanasia" was commonly used to describe withholding or withdrawing life sustaining treatment. However, most experts now refrain from using the term "passive euthanasia."

The provision of a palliative treatment that may foreseeably hasten death is also described as "double effect euthanasia". The Intent of the treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a foreseeable side effect of the treatment. For example, a physician may gradually increase the morphine dosage for a patient to relieve severe cancer pain, realizing that large enough doses of morphine may depress respiration and cause death.

Since the term "euthanasia" has various meanings, it is important to specify the definition the Council intends in this report. In this country, euthanasia is commonly defined as the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy. In this report, the term "euthanasia" will signify the medical administration of a lethal agent to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

The terms "voluntary" and "nonvoluntary" will be used to modify euthanasia. Voluntary euthanasia is euthanasia which is provided to a competent person upon his or her informed request. Non-voluntary euthanasia is the provision of euthanasia to an incompetent person according to a surrogate's decision. Involuntary euthanasia, in theory, would be euthanasia performed against a person's will. However, the term "involuntary euthanasia" will not be used since it is difficult to imagine a merciful assistance to death ever occurring against a competent person's will.

Euthanasia and assisted suicide differ in the degree of physician participation. Euthanasia entails a physician performing the immediate life-ending action (e.g., administering a lethal injection). Assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/ or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient is intending to commit suicide).

Discussions about life-ending acts by physicians often refer to the patient's "competence" or "decision making capacity." The two terms are often used interchangeably. However, "competence" can refer to a *legal* determination of a person's soundness of mind. "Decision making capacity" is a more specific term that is not determined in the courts and signifies the ability to make a particular decision. The term "competence" for the purposes of this ethical analysis is intended to mean "decision making capacity."

The evaluation of a person's decision making capacity is an assessment of the person's capabilities for understanding, communicating and reasoning. Patients should not be determined to lack decision making

capacity based on the view that what they decide is unreasonable.¹⁵ For example, a considered refusal of a blood transfusion by a Jehovah's Witness should generally be respected even though it may be viewed as an unreasonable choice by most people. People are entitled to make decisions that others think are foolish as long as their choices pose no significant harm to others.

ETHICAL FRAMEWORK

Determining the ethical responsibilities of physicians when patients wish to die requires a close examination of the physician's role in society. Physicians are healers of disease and injury, preservers of life and relievers of suffering. Ethical judgments become complicated, however, when these duties conflict. The four instances discussed in this report in which physicians might act to hasten death or refrain from prolonging life involve conflicts between the duty to relieve suffering and the duty to preserve life.

The considerations that must be weighed in each case are 1) the principle of patient autonomy and the corresponding obligation of physicians to respect patients' choices, 2) whether what is offered by the physician is sound medical treatment, and 3) the potential consequences of a policy that permits physicians to act in a way that would lead to a patient's death.

PATIENT AUTONOMY

The principle of patient autonomy requires that patients who possess decision making capacity have the opportunity to choose among medically sound treatments and to refuse any unwanted treatment offered by their physicians. Absent countervailing obligations, physicians must respect patients' decisions. This ethical principle has been consistently upheld in the courts and is the basis of the doctrine of informed consent.¹⁶ Justice Cardozo pronounced in 1914, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his [*sic*] own body."¹⁷

Treatment decisions often involve personal value judgments and preferences in addition to objective medical considerations. We demonstrate respect for human dignity when we acknowledge "the freedom [of individuals] to make choices in accordance with their own values."¹⁸

SOUND MEDICAL TREATMENT

The physician's obligation to respect a patient's decision does not require a physician to provide a treatment that is not medically sound. Indeed, a physician is ethically prohibited from offering or providing medically unsound treatments. Sound medical treatment is defined as the use of medical knowledge or means to cure a medical disorder, relieve distressing symptoms, and/or prevent the occurrence of either.

This criterion of soundness arises from the well-established medical ethical principles of beneficence and nonmaleficence. The principle of nonmaleficence requires that physicians not use their medical knowledge nor skills to harm patients, while the principle of beneficence requires that medical knowledge and skills be used to benefit patients.

The criterion of soundness is particularly relevant to the discussion of physician participation in treatments, or non-treatments, that can lead to deaths of patients. Generally, a treatment that is likely to cause the death of a patient is considered unsound, and a failure to save a patient's life is negligent. However, the situations which will be examined in this report are extremely complicated because they involve the unique circumstance where the patient does not consider his or her death to be an undesirable outcome.

PRACTICAL CONSIDERATIONS

Policies governing the care of patients who wish to die must also be evaluated in terms of their practical consequences. The ethical acceptability of a policy depends upon the benefits and costs that result from the policy. In addition to the impact on individual cases {e.g., patients will die according to their decision to have life supports withdrawn), there are likely to be serious societal consequences from policies regarding physicians' responsibilities to dying patients. For example, while the withdrawal of artificial nutrition and hydration facilitates the relief of suffering, some commentators believe that it undermines society's commitment to feed those who cannot feed themselves.

WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENT

The principle of patient autonomy requires that physicians respect a competent patient's decision to forgo any medical treatment. This principle is not altered when the likely result of withholding or withdrawing a treatment is hastening the patient's death.⁶ The right of competent patients to forgo life-sustaining treatment has been upheld in the courts and is generally accepted by medical ethicists.¹⁹ The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research stated in 1983:

[t]he voluntary choice of a competent and informed patient should determine whether or not life sustaining therapy will be under taken, just as such choices provide the basis for other decisions about medical treatment. Health care institutions and professionals should *try* to enhance patients' abilities to make decisions on their own behalf and to promote understanding of the available treatment options.⁶

In part, the reasoning behind the right of competent patients to forgo life-sustaining treatment is that decisions which so profoundly affect a patient's well-being cannot be made independent of a patient's subjective preferences and values.²⁰ Many types of life-sustaining treatments are burdensome and invasive, so that the choice for the patient is not simply a choice between life and death.⁹ When a patient is dying of cancer, for example, a decision may have to be made whether to use a regimen of chemotherapy that might prolong life for several additional months but also would be painful, nauseating and debilitating. Similarly, when a patient is dying, there may be a choice between returning home to a natural death or remaining in the hospital, attached to machinery, where the patient's life might be prolonged a few more days or weeks. In both cases, individuals might weigh differently the value of additional life versus the burden of additional treatment.

The physician must ensure that the patient has the capacity to make medical decisions before carrying out the patient's decision to forgo (or receive) life-sustaining treatment. In particular, physicians need to be aware of the possibility that the patient's decision making capacity can be diminished by a misunderstanding of the medical prognosis and options or by a treatable state of depression.

The withdrawing or withholding of life-sustaining treatment is not contrary to the physician's obligation to provide only medically sound treatments. The physician is obligated only to offer treatment. Withdrawing or withholding are not treatments but the forgoing of treatments. Physicians are not entitled to impose treatment on patients who do not want them.

Some commentators argue that, if a physician has a strong moral objection to withdrawing or withholding life sustaining treatment, the physician may transfer the patient to another physician who is willing to comply with the patient's wishes. It is true that a physician does not have to provide a treatment, such as an abortion, that is contrary to his or her moral values. However, if a physician objects to withholding or withdrawing the treatment and forces unwanted treatment on a patient, the patient's

autonomy will be inappropriately violated even if it will take only a short time for the patient to be transferred to another physician.

Withdrawing or withholding some life-sustaining treatments may seem less acceptable than others. For example, some have objected to the right to refuse artificial nutrition and hydration, while accepting the right to refuse mechanical ventilation because food and water are considered basic patient care. The distinction between extraordinary and ordinary medical treatments has been proposed as a standard to determine whether a life sustaining treatment can be refused by a patient. The Council, along with most experts, believes that the difference between extraordinary and ordinary treatment is not a valid ethical distinction.⁶ If "ordinary" care is defined as treatment that provides a basic requirement of life regardless of the underlying condition, ventilators which provide oxygen to patients would also be "ordinary" care.

Moreover, the standard of extraordinary versus ordinary treatment implies that ordinary, unlike extraordinary life sustaining treatment is not burdensome to the patient. To the contrary, artificial nutrition and/or hydration immobilize the patient to a large degree, can be extremely uncomfortable (restraints are sometimes used to prevent patients from removing nasogastric tubes), and can entail serious risks (for example, surgical risks from insertion of a gastrostomy tube and the risk of aspiration pneumonia with a nasogastric tube).

The right to refuse artificial nutrition and hydration has also been contested by some because the provision of food and water has a symbolic significance as an expression of care and compassion. These commentators argue that withdrawing or withholding food and water is a form of abandonment and will cause the patient to die of starvation and/ or dehydration. However, it is far from evident that providing nutrients through an IV line to a patient for whom it is unwanted is comparable to the typical human ways of feeding those who are hungry.²¹ In addition, discomforting symptoms can be palliated so that a death that occurs after forgoing artificial nutrition and/ or hydration is not marked by substantial suffering.²² Such care requires constant attention to the patient and the patient's needs. Therefore, respecting a patient's decision to forgo artificial nutrition and hydration will not constitute an abandonment of the patient, symbolic or otherwise, when comfort care is maintained.

There is also no ethical distinction between withdrawing and withholding life-sustaining treatment. Withdrawing life support may seem ethically more difficult than withholding life support because the physician performs an action which hastens death. When life-sustaining treatment is withheld, on the other hand, death occurs because of an omission rather than an action. This action/omission distinction has been used to differentiate between killing and allowing to die. However, as most bioethicists now recognize, the action/omission distinction lacks ethical significance.⁶ First, the distinction is often meaningless. For example, if a physician fails to provide a tube feeding at the scheduled time, would it be a withholding or a withdrawing of treatment? Second, ethical relevance does not lie with the action/omission distinction, but on other factors such as the motivation and professional obligations of the physician. For example, refusing to start a ventilator despite the patient's need and request because the patient's heir has promised the physician a share of the inheritance is clearly ethically worse than stopping the ventilator for a patient who has decided to forgo it. Third, prohibiting the withdrawal of life support would inappropriately affect a patient's decision to initiate such treatment. If treatment cannot be stopped once it is initiated, patients and physicians may decide not to begin treatment.⁶

The practical benefit of respecting patients' choices is that decisions will maximize patient interest and well-being. Patients are in the best position to determine what is in their interests. In addition, if patients did not have control over decisions about life-sustaining treatment the principle of patient self-determination over health care would be eroded.

There are negative consequences of a policy to withhold or withdraw life support upon a patient's request.

First, deaths may occur as a result of uninformed decisions or from pain and suffering that could be relieved with measures that would not cause the patient's death. And second, there may exist pressures, whether subtle or overt, from family, physicians or society to forgo life-sustaining treatment, rendering the patient's choice less than free. These pressures could revolve around beliefs that such patients' lives no longer possess social worth and are an unjustifiable drain of limited health resources.

It is the responsibility of physicians to provide sufficient information to ensure patient understanding. It is also essential that all efforts be made to maximize the comfort and dignity of patients who are dependent on life-sustaining treatment and that patients be assured that these efforts will be made. With such assurances, patients will be less likely to forgo life support because of suffering or anticipated suffering that could be palliated.

The risks associated with potential pressures on patients to forgo life-sustaining treatments are an important concern. The Council believes that the medical profession must be vigilant against such tendencies, but that the greater policy risks are of undermining patient autonomy.

In summary, according to the principle of respect for patient autonomy, patients who possess an adequate decision making capacity have the right to forgo any life-sustaining treatment. Physicians must respect the decisions of patients, and they must ensure that patients both are well informed about their prognoses and treatment options and understand that comfort and dignity will be a top priority whether or not they decide to forgo life support.

PROVIDING PALLIATIVE TREATMENT WHICH MIGHT HASTEN DEATH

The Council stated in its 1988 report on "Euthanasia" that "the administration of a drug necessary to ease the pain of a patient who is terminally ill and suffering excruciating pain may be appropriate medical treatment even though the effect of the drug may shorten life."¹³ The Council maintains this position and further emphasizes that a patient possessing a decision making capacity must be the one who decides whether the relief of pain and suffering is worth the danger of hastening death. The principle of respect for patient autonomy and self-determination requires that patients decide about such treatment.

The ethical distinction between this situation and euthanasia lies in the difference between administering a medically sound pain relief treatment which will likely shorten the patient's life and providing a treatment to cause death as the means by which relief of suffering is achieved. The distinction is subtle because in both cases the action that causes death is performed with the purpose of relieving suffering, but the distinction is ethically significant. Most medical treatments entail some undesirable side effects. In general it should be the decision of the patient with the help of his or her physician to decide to either risk the side effects or forgo the treatment. A patient competent to make this decision has the right to weigh the risk of hastening death against the potential for relief of pain and suffering.

The concrete benefit of allowing physicians to provide palliative treatments is the relief of unrelenting and intolerable suffering. For many patients, relief may be worth even a great risk of death. An important concern is that patients who are not fully informed about their prognosis and options may make decisions that unnecessarily shorten their lives. In addition, severe pain might diminish the patient's capacity to decide whether to choose a treatment that risks death. Caution when determining decision-making capacity in this situation, therefore, must be exercised, and patients should be fully informed.

EUTHANASIA

Euthanasia is the medical administration of a lethal agent to a patient in order to relieve intolerable and untreatable suffering of the patient. The issue of whether or not a physician may use the skills or

knowledge of medicine to cause an "easy" death in a patient who requests such assistance has been debated since the time of Hippocrates. Recently, euthanasia has been gaining support from the public and some in the medical profession. In the Netherlands, for example, since 1984 euthanasia by physicians is not prosecuted when a case falls within certain established criteria.²³ These criteria include that (1) euthanasia is explicitly and repeatedly requested by the patient and there is no doubt that the patient wants to die; (2) the mental and physical suffering is severe with no prospect for relief; (3) the patient's decision is well informed, free and enduring; (4) all options for alternate care have been exhausted or refused by the patient and (5) the physician consults another physician.²⁴ Though currently there are no official statistics on the frequency of euthanasia in the Netherlands, it has been estimated to range from 2,000 to 10,000 persons per year.²³

In the United States there has been growing public support for legalized euthanasia. The Hemlock Society, an organization dedicated to legalizing voluntary euthanasia and physician-assisted suicide, has doubled its membership in the past five years to approximately 33,000.²⁵ Currently, an initiative in Washington state that would legalize euthanasia has gained 35,000 signatures over the 150,001 needed to put the initiative on the ballot this November.²⁶ This apparent increase in support for euthanasia poses a difficult question for the medical profession. What is the physician's role in treating patients who are suffering intolerably and are not dependent on life-sustaining treatment?

Though the principle of patient autonomy requires that patients who possess decision-making capacity be given the opportunity to choose among offered medical treatments and to forgo any treatment, it does not give patients the right to demand euthanasia. At issue is whether it is ever ethical for physicians to offer euthanasia in certain circumstances. On the other hand, there is an autonomy interest in directing one's death. But this interest does not override considerations of professional responsibility.

In the United States there is currently little data regarding the number of euthanasia or assisted suicide requests, the concerns behind the requests, the types and degree of intolerable and unrelievable suffering, or the number of requests that have been granted by health care providers. Before euthanasia can ever be considered a legitimate medical treatment in the United States, the needs behind the demand for physician-provided euthanasia must be examined more thoroughly and addressed more effectively. A thorough examination would require a more open discussion of euthanasia and the needs of patients who are requesting it. The existence of patients who find their situations so unbearable that they request help from their physicians to die must be acknowledged, and the concerns of these patients must be a primary focus of medicine. Instead of condoning physician-provided euthanasia, medicine must first respond by striving to identify and address the concerns and needs of dying patients.

There is evidence to suggest that most requests for euthanasia or assisted suicide would be eliminated if patients were guaranteed that their pain and suffering will be eased and their dignity and self-sufficiency promoted.²⁷ The success of the hospice movement illustrates the extent to which aggressive pain control and close attention to patient comfort and dignity can ease the transition to death.²⁸ Health care professionals have an ethical duty to provide optimal palliative care to dying patients. At the present, many physicians are not informed about the appropriate doses, the frequency of doses and alternate modalities of pain control for patients with severe chronic pain.²⁸ In particular, addiction should not be a concern when providing analgesia to these patients. Physicians should inform the patient and the family that concentrated efforts will be a priority in the care of the patient, since fear of pain is "one of the most pervasive causes of anxiety among patients, families and the public."¹

There may be cases, however, where a patient's pain and suffering is not reduced to a tolerable level and the patient requests a physician to help him or her die.^{1,28} If a physician cannot ease the pain and suffering of a patient, by means short of death, using medical expertise to aid an "easy" death may seem to be the humane and appropriate treatment for the patient.

There are, however, serious risks associated with condoning physician-performed euthanasia. The prohibition against medically killing patients is a strong and lasting tradition in medical ethics. This tradition is based upon a commitment that medicine is a profession dedicated to healing, and that its tools should not be used to kill patients. Weakening this prohibition against euthanasia, even in the most compelling situations, has troubling implications.^{29,30} Though the magnitude of such risks are impossible to predict accurately, the medical profession and society as a whole must not consider these risks lightly.

The prohibition of killing is an attempt to promote a solid basis for trust in the role of caring for patients and protecting them from harm. This prohibition is both instrumentally and symbolically important, and its removal would weaken a set of practices and restraints that we cannot easily replace.¹⁶

If euthanasia by physicians were to be condoned, the fact that physicians could offer death as a medical treatment might undermine public trust in medicine's dedication to preserving the life and health of patients.³¹ Some patients may fear the prospect of "involuntary" or nonvoluntary euthanasia if their lives are no longer deemed valuable as judged by physicians, their family, or society.³¹ Other patients who trust their doctors' judgments may not feel free to resist their physicians' suggestion that euthanasia may be appropriate for them.^{31,32,33}

Another risk is that physicians and other health care providers may be more reluctant to invest their energy and time serving patients whom they believe would benefit more from a quick and easy death. Caring for dying patients is taxing on physicians who in the process must face issues of their own mortality, and who often perceive such care as a reminder of their failure to cure these patients.^{6,18} In addition, the increasing pressure to reduce health costs may serve as another motivation to favor euthanasia over longer term palliative care.

Finally, allowing euthanasia to be a medical treatment for a limited group of patients who may truly benefit from it will present difficult line drawing problems for medicine and society. In specific cases it may be hard to distinguish which cases fit the criteria established for euthanasia. For example, if the existence of unbearable pain and suffering were one of the criteria for legitimate euthanasia, the definition of unbearable pain and suffering could be subject to different interpretations. Determining whether a patient will benefit from euthanasia requires an intimate understanding of the patient's concerns, values, and pressures that may be prompting the euthanasia request. In the Netherlands, where euthanasia seems to be fairly successful, physicians who provide euthanasia generally have a life-long relationship with the patient which enables the physician to have access to this vital information.³⁴ In the U.S., however, physicians rarely have the depth of knowledge about their patients that would be necessary for an appropriate evaluation of the patient's request for euthanasia.

More broadly, the line drawing necessary for the establishment of criteria for acceptable euthanasia is also problematic. If competent patients can receive euthanasia, can family members request euthanasia for an incompetent patient? Would it be acceptable for physicians to perform euthanasia on any competent individuals who come to them requesting it? Furthermore, since it will be physicians and the state who would decide which patients are eligible for euthanasia, value judgments about patients' lives will be made by another person or entity other than the patients.

Since it is unclear at this time where these lines should be drawn, the proposition of allowing euthanasia is particularly troublesome. A potential exists for a gradual distortion of the role of medicine into something which starkly contrasts with the current vision of a profession dedicated to healing and comforting. Before society can comfortably make exceptions to the prohibition against physicians deliberately intervening to cause the deaths of patients, more resources must be devoted to the study of the present situation of patients who request aid in dying.

PHYSICIAN-ASSISTED SUICIDE

Physician-assisted suicide has only recently become the focus of public attention. In particular, in June 1990, the Dr. Kevorkian case provoked strong responses on all sides of the issue. Dr. Kevorkian is a physician who assisted the death of a person with the use of a "suicide machine," which he invented. This case was an extreme example of assisted suicide and has been criticized by many for the irresponsible way in which it was carried out by the physician.²⁵ More recently, an article was published in the *New England Journal of Medicine* by a physician who described his role in providing the medication for a patient to commit suicide.³⁵ The care and compassion evidenced by the physician and the clearly reasoned decision-making process of the patient marked this account as truly compelling. Besides these two very public cases of physician-assisted suicide, there is reason to believe that it has been occurring for some time.¹

Some physicians, believing it to be the last act on a continuum of care provided for the hopelessly ill patient, do assist patients who request it, either by prescribing sleeping pills with knowledge of their intended use or by discussing the required doses and methods of administration with the patient.¹

There is an ethically relevant distinction between euthanasia and assisted suicide which makes assisted suicide a more attractive option. Physician-assisted suicide affords a patient a more autonomous way of ending his or her life than does euthanasia. As a result, if patients were to perform the life-ending act themselves, they would have the added protection of being able to change their minds and stop their suicides up until the last moment.

However, the ethical concerns about physician-assisted suicide are similar to those of euthanasia since both are essentially interventions intended to cause death. Physician-assisted suicide, like euthanasia, is contrary to the traditional prohibition against using the tools of medicine to cause a patient's death. Physician-assisted suicide also has most of the same societal risks as euthanasia, including the potential for coercive financial and societal pressures on patients to choose suicide. Further, determining the criteria for assisting a patient's suicide and determining whether a particular patient meets the criteria are as problematic as deciding who may receive euthanasia.

While in highly sympathetic cases physician-assisted suicide may seem appropriate, due to the likelihood of grave harm, the medical profession cannot condone physician-assisted suicide at this time. The medical profession instead must strive to identify the concerns behind patient's requests for assisted suicide, and make concerted efforts at finding ways to address these concerns short of assisting suicide, including providing more aggressive comfort care.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends the following: The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics and artificial nutrition and hydration.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great in this culture to condone euthanasia or physician- assisted suicide at this time.

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