

# Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper

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Calls to legalize physician-assisted suicide have increased and public interest in the subject has grown in recent years despite ethical prohibitions. Many people have concerns about how they will die and the emphasis by medicine and society on intervention and cure has sometimes come at the expense of good end-of-life care. Some have advocated strongly, on the basis of autonomy, that physician-assisted suicide should be a legal option at the end of life. As a proponent of patient-centered care, the American College of Physicians (ACP) is attentive to all voices, including those who speak of the desire to control when and how life will end. However, the ACP believes that the ethical arguments against legalizing physician-assisted suicide remain the most compelling. On the basis of substantive ethics, clinical practice, policy, and other concerns articulated in this position paper, the ACP does not support legalization of physician-assisted suicide. It is problematic given the nature of the patient-

physician relationship, affects trust in the relationship and in the profession, and fundamentally alters the medical profession's role in society. Furthermore, the principles at stake in this debate also underlie medicine's responsibilities regarding other issues and the physician's duties to provide care based on clinical judgment, evidence, and ethics. Society's focus at the end of life should be on efforts to address suffering and the needs of patients and families, including improving access to effective hospice and palliative care. The ACP remains committed to improving care for patients throughout and at the end of life.

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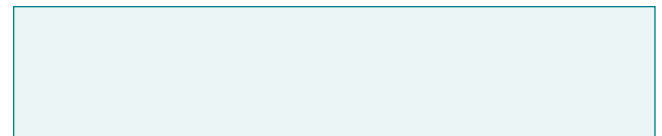
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**H**ow we die, live, and are cared for at the end of life is important, with implications for individuals, their families, and society. The 1997 report *At the End of Life*, by the Institute of Medicine (IOM), documented inadequate end-of-life care in the United States (1). The investigators of SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment; 2000) agreed (2, 3). The emphasis by medicine and society on intervention and cure has sometimes come at the expense of good end-of-life care. Inappropriate treatment at the end of life may be harmful and draining—physically, emotionally, and financially—for patients and their families. Many people have concerns about death. At the end of life, some patients receive unwanted care; others do not receive needed care (4–6). Some end-of-life concerns are outside of medicine's scope and should be addressed in other ways. Although medicine now has an unprecedented capacity to treat illness and ease the dying process, the right care in the right place at the right time has not been achieved.

Medicine and society still struggle with getting it right for all patients. Although progress has been made, the principles and practices of hospice and palliative medicine have not been fully realized (4). Revis-



ity of this issue. This executive summary is a synopsis of the ACP's position. See the [ACP Position Paper](#) for definitions and the [ACP Position Paper](#) for the full position paper.

**E D**

This position paper was developed from September 2015 to March 2017 on behalf of the ACP Ethics, Professionalism and Human Rights Committee (EPHRC). Committee members abide by the ACP's conflict-of-interest policy and procedures ([www.acponline.org/about-acp/who-we-are/acp-conflict-of-interest-policy-and-procedures](http://www.acponline.org/about-acp/who-we-are/acp-conflict-of-interest-policy-and-procedures)), and appointment to and procedures of the EPHRC are governed by the ACP's bylaws ([www.acponline.org/about-acp/who-we-are/acp-bylaws](http://www.acponline.org/about-acp/who-we-are/acp-bylaws)). After an environmental assessment to determine the scope of issues and literature reviews, the EPHRC evaluated and discussed several drafts of the paper; the paper was then reviewed by members of the ACP Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, Council of Subspecialty Societies, Patient Partnership in Healthcare Center and Advisory Board, and other committees and experts. The paper was revised on the basis of comments from the aforementioned groups and individuals, reviewed again by the full leadership, and then revised further. Finally, the ACP Board of Regents reviewed the paper and approved it on 27 March 2017. Financial support for this project is exclusively from the ACP operating budget.

**BAC G ED AND B EF A EA E**

In 2001, the ACP published a position paper opposing legalization of physician-assisted suicide (8). This issue also has been considered every few years in the *Annals of Internal Medicine*, including the current edition (9). Given recent changes in the legal landscape, public interest in the topic, and continuing barriers to palliative and hospice care, an updated position paper is presented here. Within a framework that considers clinical practice, ethics, law, and policy, this paper provides background, discusses the role of palliative and hospice care, explores the nature of the patient-physician relationship and the distinction between refusal of life-sustaining treatment and physician-assisted suicide, and provides recommendations for responding to patient requests for physician-assisted suicide.

Medical ethics establishes the duties of physicians to patients and society, sometimes to a greater extent than the law (9). Physicians have duties to patients on the basis of the ethical principles of beneficence (that is, acting in the patient's best interest), nonmaleficence (avoiding or minimizing harm), respect for patient autonomy, and promotion of fairness and social justice (9). Medical ethics and the law strongly support a patient's right to refuse treatment, including life-sustaining treatment. The intent is to avoid or withdraw treatment that the patient judges to be inconsistent with his or her goals and preferences. Death follows


naturally, after the refusal, as a result of the underlying disease (9).

Ethical arguments in support of physician-assisted suicide highlight the principle of respect for patient autonomy and a broad interpretation of a physician's duty to relieve suffering (10). Proponents view physician-assisted suicide as an act of compassion that respects patient choice and fulfills an obligation of nonabandonment (11). Opponents maintain that the profession's most consistent ethical traditions emphasize care and comfort, that physicians should not participate in intentionally ending a person's life, and that physician-assisted suicide requires physicians to breach specific prohibitions as well as the general duties of beneficence and nonmaleficence. Such breaches are viewed as inconsistent with the physician's role as healer and comforter (12, 13).

Both sides agree that patient autonomy is critical and must be respected, but they also recognize that it is not absolute and must be balanced with other ethical principles (9, 14). To do otherwise jeopardizes the physician's ability to practice high-value care in the best interests of the patient, in a true patient-physician partnership. Only by this balancing of ethical principles can physicians fulfill their duties, including those in more everyday encounters, such as when a physician advises against tests requested by a patient that are not medically indicated, declines to write an illegal prescription, or breaches confidentiality to protect public health. It also undergirds the physician's duty not to engage in futile care (such as care based on requests for nonindicated cardiopulmonary resuscitation or end-of-life treatment of brain-dead patients under an expansive view of patient autonomy). Physicians are members of a profession with ethical responsibilities; they are moral agents, not merely providers of services (15).

The suffering of dying patients may be great and is caused by somatic symptoms, such as pain and nausea; psychological conditions, such as depression and anxiety; interpersonal suffering due to dependency or unresolved conflict; or existential suffering based in hopelessness, indignity, or the belief that one's life has ended in a biographical sense but has not yet ended biologically. For some patients, a sense of control over the manner and timing of death brings comfort. However, is it reasonable to ask medicine to relieve all human suffering? Just as medicine cannot eliminate death, medicine cannot relieve all human suffering. Both proponents and opponents of physician-assisted suicide wish to alleviate suffering of dying patients, and physicians have an ethical duty to provide competent palliative and hospice care (9). However, is physician-assisted suicide a type of control over suffering and the dying process that is within the goals and scope of medicine?

Balancing respect for patient autonomy against other principles reflects ethical arguments about the nature of the patient-physician relationship—a relationship that is inherently unequal because of power differentials and the vulnerability of illness—physicians' duties, and the role of the medical profession in society. A fuller consideration of this ethical balance, intent and

causation in acts near the end of life, medicalization versus personalization of death, and the ethics and implications of physician-assisted suicide are presented in the A .

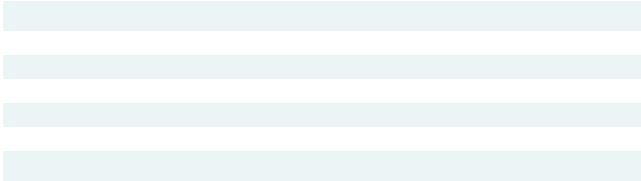
#### A E

The ACP affirms a professional responsibility to improve the care of dying patients and their families.

The ACP does not support the legalization of physician-assisted suicide, the practice of which raises ethical, clinical, and other concerns. The ACP and its members, including those who might lawfully participate in the practice, should ensure that all patients can

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## ALL WILL DIE. HOW WE DIE—AND LIVE AT THE END OF LIFE—IS IMPORTANT, WITH IMPLICATIONS FOR INDIVIDUALS, THEIR FAMILIES, AND SOCIETY. HOW WE ARE CARED FOR AT THE END OF LIFE MATTERS.

The groundbreaking 1997 report *Assessing the Quality of End-of-Life Care*, by the IOM, documented inadequate end-of-life care in the United States (1). In 2000, the SUPPORT investigators agreed (2, 3). Although the cultural norm of fighting disease aggressively is the right approach in many cases, the

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(13). Pronouncements against physician-assisted suicide date back to Hippocrates.

Opponents agree that patient autonomy is critical and must be respected but recognize that it is not absolute and must be balanced with other ethical principles (9, 14). To do otherwise jeopardizes the physician's ability to practice high-value care in the best interests of the patient, in a true patient-physician partnership. Only by such a balance of ethical principles can physicians fulfill their duties, including those in more everyday encounters, such as when a physician advises against tests requested by a patient that are not medically indicated, declines to write illegal prescriptions, or breaches confidentiality to protect public health. It also undergirds the duty that physicians not engage in futile care (for example, care based on requests for nonindicated cardiopulmonary resuscitation or end-of-life treatment of brain-dead patients under an expansive view of patient autonomy). Physicians are members of a profession with ethical responsibilities; they are moral agents, not merely providers of services (15).

Death certificate requirements under physician-assisted suicide laws ask physicians to list the cause of death as the underlying illness, not the new pathology caused by ingestion of a lethal dose of medicine (24), which seems inconsistent with the physician's duty of honesty. Moreover, although individual physicians may decline to participate, conscientious objection to physician-assisted suicide does not address the fundamental ethical objections to it.

The suffering of dying patients may be great; it is caused by somatic symptoms, such as pain and nausea; psychological conditions, such as depression and anxiety; interpersonal suffering due to dependency or unresolved conflict; or existential suffering based in hopelessness, indignity, or the belief that one's life has ended in a biographical sense but has not yet ended biologically. For some patients, a sense of control over the manner and timing of death brings comfort. However, is it reasonable to ask medicine to relieve all human suffering? Just as medicine cannot eliminate death, medicine cannot relieve all human suffering; attempting to do so ultimately leads to bad medical care (25). Good medicine demands compassion for the dying, but compassion also needs reason (26). Both proponents and opponents wish to alleviate suffering of dying patients, and physicians have an ethical duty to provide competent palliative and hospice care (9). However, is physician-assisted suicide a type of control over suffering and the dying process that is within the goals and scope of medicine?

Balancing respect for patient autonomy against other ethical principles reflects arguments about the nature of the patient-physician relationship, physicians' duties, and the role of the medical profession in soci-

ety. In fact, one may argue that making physicians arbiters of assisted suicide is a return to paternalism and not a power physicians should want (27), that "the legalization of physician-assisted suicide does not empower patients; it empowers physicians" (28).

Legalization of physician-assisted suicide also raises social justice issues. Society and the medical profession have duties to safeguard the patient-physician relationship and human dignity. These duties apply especially to the most vulnerable members of society: the sick, the elderly, children, the disabled, the poor, minorities, and others. Some individuals might view themselves as unproductive or burdensome and, on that basis, as candidates for assisted suicide, especially if a physician raises it or validates a request. Physician-assisted suicide laws have been associated with a 6% increase in total suicides (15% in those older than 65 years) in the states where physician-assisted suicide is legal, controlling for state-specific time trends (29, 30). Although a recent study did not find vulnerable groups being pressured to accept physician-assisted suicide, it did raise questions about a lack of data on complications and on how many physicians may have assisted without reporting (31). Vulnerable communities and individuals raise strong concerns that legalization leads to attitudinal changes, subtle biases about quality of life, and judgments that some lives are not worth living (32, 33). National disability groups are opposed to physician-assisted suicide (32, 34). One article reported various opinions among focus group participants (35). Finally, advocating for physician-assisted suicide where there is no general right to health care and access to hospice and palliative care services is limited, especially in an era of health care cost containment, is ironic (8).

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The ACP's main concerns in this debate are ethical ones. The patient-physician relationship is inherently unequal. Physicians have specialized medical knowledge, training, experience, and prescribing powers that patients do not. Illness makes patients vulnerable (including physicians who are patients [36, 37]). Patients disrobe, are examined, and disclose intimate information to their physicians. The physician must earn the patient's trust, preserve his or her confidentiality, and act as a fiduciary. Physicians publicly profess that they will act for the benefit of their patients, putting patients' welfare and best interests first and helping them cope with illness, disability, suffering, and death. The physician has a duty to respect the dignity and the cultural and spiritual uniqueness and traditions of every patient (9).

Physician-assisted suicide and euthanasia were common during the time of Hippocrates, leading to

their specific prohibition in the Hippocratic Oath (38). Together with the prohibition of sexual relationships between physicians and patients and the duty to maintain patient confidentiality, the Oath provides a context for a therapeutic alliance to prevent the exploitation of patient relationships.

The Hippocratic Oath, of course, is not followed word for word today; however, it has been analyzed and applied over time in light of its fundamental principles. Acting in the best interests of the patient and recognizing the special nature of the patient-physician relationship, principles and prohibitions set ethical boundaries to prevent misunderstandings and misuse of medical authority. These boundaries encourage patients to be open and honest regarding intimate health matters in a safe space, in the context of a trusted relationship.

Physicians can influence patients, even in ways physicians may not appreciate. Patients seeking physician-assisted suicide may seek validation to end their lives. Indeed, studies have shown that socially isolated, vulnerable persons seek social support and contact through visits with their physicians (16). Physicians may influence patients based on their own fears of death and disability (39). Evidence also suggests that many physicians who participate in physician-assisted suicide are adversely affected by the experience (40). Some commentators question whether assisted suicide needs to be physician assisted and whether others might provide assistance instead (41).

they both are acts that lead to the patient's death. However, commission (doing something) versus omission (not doing something) is not alone determinative. Withdrawing ventilator support is an act, but the act merely removes an intervention that prevented a preexisting illness from running its course. The aim of the act is not to terminate the patient's life (47). Intent and causation are critical factors in distinguishing physician-assisted suicide from withdrawal of life-sustaining treatment.

Death may be accelerated if a patient requests withdrawal of a life-sustaining treatment and that request is carried out. However, the patient could have refused the treatment when it was originally offered; therefore, he or she may request its withdrawal after it is started. If not for the intervention to which the patient consented, death would have occurred as a result of the underlying disease. As the International Association for Hospice and Palliative Care, citing the European Association for Palliative Care, stated, "Withholding or withdrawing ineffective, futile, burdensome, and unnecessary life-prolonging procedures or treatments does not constitute euthanasia or PAS [physician-assisted suicide] because it is not intended to hasten death, but rather indicate the acceptance of death as a natural consequence of the underlying disease progression" (48).

The intent of treatment refusal is freedom from an unwanted intervention. A natural death follows due to

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For decades, the consensus has been that after a careful weighing of patient autonomy, beneficence, nonmaleficence, and societal interests, a patient may forgo life-sustaining treatment. Although Hippocratic writings explicitly proscribe euthanasia and physician-assisted suicide, they deem treatment abatement ethically appropriate in patients who are "overmastered by disease" (42). Although some lower courts have questioned the importance of this distinction (43), the U.S. Supreme Court has distinguished the refusal of treatment from suicide (44, 45). Withdrawal of treatment based on patient wishes respects the patient's bodily integrity and right to be free of unwanted treatment. Physician-assisted suicide and euthanasia are interventions done with the intent to end the patient's life (46, 47). This distinction is ethically and legally important (9).

Some argue that withdrawing treatment on the basis of patient wishes—an omission, such as forgoing a mechanical ventilator in a patient with respiratory failure—and prescribing a lethal dose of medicine for the patient's use—a commission—are equivalent, because





requests increased from 55% in 2007 to 77% in 2013 (61). An editorial said these trends were “worrisome” and “require that [the slippery-slope concern] be taken very seriously” (62).

A recent review found that safeguards and controls in jurisdictions where physician-assisted suicide and euthanasia are legal are not always followed (63), and concerns have been raised about underreporting (31). Subtle long-term changes in attitudes are difficult to detect. For example, although only a small number of persons have requested physician-assisted suicide in Oregon, as noted earlier, questions arise regarding whether that fact lessens these and other concerns.

Limiting physician-assisted suicide to the terminally ill is said to be a safeguard, but prognostication raises practical concerns. Laws such as Oregon’s require a consultation from a second physician to confirm the diagnosis and prognosis. However, predicting how long a terminally ill patient will live or to what extent cognitive capacity will be impaired by disease or injury often is difficult. In addition, many patients do not have longstanding relationships with physicians who know them well. Furthermore, current safeguards are likely to be challenged. Restricting physician-assisted suicide to terminally ill adults with decision-making capacity raises legal concerns about arbitrary discrimination (64). Fairness, it may be argued, would require granting access to decisionally incapable and non-terminally ill persons. Also, because some patients cannot take pills, arbitrary discrimination could be asserted, unless the practice is broadened from physician-assisted suicide to euthanasia.

... aimed to integrate palliative care and spiritual care into critical care practice. Eliciting and honoring wishes fostered a community of caring, promoting patient- and family-

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Is a medicalized death a good death? Have we already gone too far down a path in which dying patients receive unwanted technology in the intensive care unit while their family members are regarded as “visitors”? Is the solution medicalization of death through medication overdose? Physician-assisted suicide is not a therapy. It runs counter to the goal of the patient rights movement to empower patients to experience a more natural death.

Medicalizing death does not address the needs of dying patients and their families. What is needed is care that emphasizes, in the last phase of life, facilitating a natural dying process, and humanizing institutions that are used only when those settings are unavoidable. The 3 Wishes Project shows how even simple, nontechnologic approaches in the hospital intensive care unit can improve care, ease dying, enhance dignity, and give voice to patients and families while deepening the sense of vocation among clinicians (65). The 3 Wishes researchers said the project



resents a personal failure. In hindsight, acknowledging the impending loss enabled appropriate palliation for the patient and timely pastoral care for her husband . . . " (80).

The need to ensure the central role of families in care; provision of consistent, high-quality care; and education, training, and support of physicians were identified as overarching themes in a series of reports on end-of-life care recently issued by the British Medical Association (81). The British Medical Association and Australian Medical Association both reaffirmed opposition to legalization of physician-assisted suicide and euthanasia in 2016.

## C

The art of medicine is arguably most needed as patients live out the last phase of life. Society's goal should be to make dying less, not more, medical. The ACP affirms a professional responsibility to improve the care of dying patients and their families.

The ACP does not support the legalization of physician-assisted suicide, the practice of which raises ethical, clinical, and other concerns. The ACP and its members, including those who might lawfully participate in the practice, should ensure that all persons can rely on high-quality care through to the end of life, with prevention or relief of suffering insofar as possible, a commitment to human dignity and the management of pain and other symptoms, and support for family. Physicians and patients must continue to search together for answers to the challenges posed by living with serious illness before death (9).

Control over the manner and timing of a person's death has not been and should not be a goal of medicine. However, through high-quality care, effective communication, compassionate support, and the right resources, physicians can help patients control many aspects of how they live out life's last chapter. Throughout patients' lives, including as they face death, medicine must strive to give patients the care, respect, and comfort they deserve.

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