

# Professional Organizations' Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality

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Position statements opposing legalization of physician-assisted suicide by organizations such as the American College of Physicians–American Society of Internal Medicine rightly emphasize that palliative care should be the standard of care for the dying, and that the inadequacies that exist in its delivery should be remedied. But such position statements generally understate the limitations of palliative care to alleviate some end-of-life suffering, and they do not provide adequate guidance about how physicians should approach patients with intractable suffering who are prepared to die. In this manuscript, we briefly present data about severe suffering before death for terminally ill patients, including those enrolled in hospice programs. We also review some of what is known about requests and responses for physician-assisted suicide in Oregon and in the rest of the United States. Preliminary

data from Oregon suggest that legally sanctioned access to physician-assisted suicide is used by a very small number of patients and seems to be associated with improved delivery of hospice and palliative care. Physicians of good will, deep religious convictions, and considerable palliative care experience exist on both sides of the debate about legalization of physician-assisted suicide. In an effort to respect this diversity, and to encourage our profession to continue to struggle with the genuine dilemmas faced by some patients toward the end of their lives and by their families, we argue in favor of medical organizations' taking a position of studied neutrality on this contentious issue.

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The 2001 position statement by American College of Physicians–American Society of Internal Medicine (ACP–ASIM) on physician-assisted suicide (1) was clear about the arguments opposing legalization. We agree that excellent palliative care should be the standard of care for severely ill and dying patients, that the significant inadequacies in its delivery must be remedied, and that legalization has risks (2, 3). Yet the paper was less complete in its presentation of the arguments in favor of legalization, and it was not clear about physicians' responsibilities to address intractable suffering as part of their commitment not to abandon (4).

Simply prohibiting physician-assisted suicide without giving guidance about how to approach patients experiencing intolerable suffering despite excellent palliative care (5) has several potential adverse consequences: 1) It increases patients' fears about physicians' abandonment in the face of severe suffering (6); 2) it reinforces clinicians' tendencies not to acknowledge the intolerable suffering that some patients experience despite excellent palliative care; 3) it suggests falsely bright lines between physician-assisted suicide and other currently available end-of-life practices that do not resonate with beliefs of many patients, families, and clinicians (7, 8); 4) it may explain some of the variability in access to other last-resort practices; and 5) it may teach patients to be less than forthright with their physicians if they desire a hastened death (9).

People of good will, deep religious conviction, and considerable palliative care experience exist on both sides of the debate about legalization of physician-assisted suicide. As members of ACP–ASIM who believe the position statement (1) was not a balanced description of the clinical and moral issues involved, we write to 1) present clinical data not adequately considered in the article and 2) make a case for organizations to take a position of studied neutrality

unless they have empirical knowledge of the views of their members.

## INTRACTABLE SUFFERING, REQUESTS, AND PRACTICES Does Intractable Suffering Exist Despite Excellent Palliative Care?

Terminally ill patients frequently have symptoms such as weakness (39% to 91% of patients), pain (49% to 82%), anorexia (8% to 76%), dyspnea (17% to 51%), nausea and vomiting (9% to 44%), confusion (9% to 24%), and pressure sores (14%) (10, 11). Most experts in pain management believe that they can relieve 95% to 98% of pain using modern methods (12, 13), although other physical symptoms (for example, nausea, vomiting, dyspnea, and open wounds) are more difficult to address. In the last week of life, 2% to 35% of hospice patients report their pain as "severe" or "intolerable" (10, 14, 15), and 35% report their shortness of breath as "unbearable" (16). Survey data from death certificate informants suggest that up to 17% of such patients would have wanted physician-assisted suicide (17). These data speak to a more complex reality of dying patients, even those in hospice, than is ordinarily acknowledged (18).

## Are Patients Who Request Physician-Assisted Suicide Depressed?

We must distinguish among contemplations, wishes, general explorations, and explicit requests. For those who receive lethal medication, we must distinguish between those who take it to hasten death and those who still die of their underlying disease (19). Thoughts and wishes about ending one's life are common in terminally ill patients and may fluctuate over time (20, 21). About half of patients with a persistent desire for physician-assisted suicide have some evidence of clinical depression, but the other half do

not (22). Furthermore, many symptoms used to diagnose depression (fatigue, sleep disturbance, thoughts about death) are also symptoms of terminal illness. Without adjusting for such symptoms, depression is diagnosed in 26.1% of terminally ill; with modification for these symptoms, the rate is 13% (22, 23). Some patients with clinical depression retain the mental capacity to make medical decisions, yet determining this ability can be subtle and complex (24).

### How Many Physicians Participate in Physician-Assisted Suicide Outside of Oregon?

The illegality of physician-assisted suicide makes estimation of its frequency difficult. Two well-done studies about the secret practice of physician-assisted suicide report a lifetime physician participation rate of about 5% (25, 26). Subgroups, such as AIDS physicians in San Francisco, California, show participation rates as high as 50% (27).

### How Are Other “Last-Resort” Practices Handled?

Supreme Court amicus briefs opposing physician-assisted suicide argued that the practice was not needed because other effective ways can respond to the most challenging cases (28, 29). Patients receiving life-sustaining therapy have the right to stop treatment, even if their intent is to hasten death. About 10% of patients undergoing dialysis die in this way, although there is considerable variation between centers (30, 31). The practice of terminal sedation seemed to be given some legal protection with the Supreme Court decision (32–34), but there is no clear consensus about its moral acceptability or proper role. (Most position statements opposing physician-assisted suicide do not explicitly address this practice.) Access and utilization of other last-resort practices vary widely. For example, terminal sedation is used in 0% to 50% of deaths in different hospice programs (14).

## WHAT CAN WE LEARN ABOUT THE EFFECT OF LEGALIZATION FROM OREGON?

### Will There Be Many Cases, Particularly from Vulnerable Groups?

Physician-assisted suicide accounted for only 0.1% of all deaths in Oregon (35–37). Of the 70 deaths over the first 3 years, 68 of patients were white (2 were Asian-American), only 1 lacked insurance (insurance status was unknown for 3 patients), only 1 was partially motivated by financial concerns (by physician report), and all had serious chronic progressive illnesses (74% had cancer).

### Will Physician-Assisted Suicide Be Viewed as an Alternative to Palliative Care?

In 2000, 85% of patients who died from physician-assisted suicide were enrolled in hospice programs, compared with 38% hospice enrollment for patients who died without physician-assisted suicide. Inadequate pain control was infrequently cited as the reason for physician-assisted suicide (less frequently than cited by matched controls) and

was never cited as the sole factor. More commonly cited factors were loss of autonomy, loss of control of bodily functions, feeling a burden on family, and decreased ability to enjoy life (35).

### Will Physicians Evaluate Their Requesting Patients Carefully?

Over the first 3 years of legalized physician-assisted suicide in Oregon, about 5% of physicians received requests; about 1 in 6 requests led to a lethal prescription and 1 in 10 led to a lethal act (38). (Request rates were 21% in 1997, when the legal injunction was in place [39].) Physicians reported evaluating their requesting patients for pain and depression, and many reported that substantive palliative interventions caused some patients to change their minds.

### Will Legalization Undermine Efforts To Improve Palliative Care, or Will It Be a Small Part of a Larger Movement To Improve Care of the Dying?

Evidence of concomitant improvements in end-of-life care in Oregon includes increased hospice referrals, morphine prescription per capita among the highest in the United States, the lowest rate of in-hospital deaths in the nation (31%), high levels of do-not-resuscitate orders in nursing home residents (91%), high levels of advance directive completion, and increased physician attendance at palliative care conferences (40, 41).

### What Are the Limitations of the Oregon Data?

Oregon has a relatively small, homogeneous population with a history of working proactively and collaboratively on issues of universal access and on restricting treatments of marginal utility. Oregonians pride themselves on being independent thinkers, a quality that has particular resonance with this issue. Furthermore, most studies looking at the first 3 years of practice depend on physician reporting, with inherent risks for underreporting of problems. Nonetheless, Oregon provides the best data available in the United States and is likely to be more reliable than the rest of the country, where physician-assisted suicide is prohibited by law but not aggressively prosecuted.

## PSEUDO-CONSENSUS VERSUS STUDIED NEUTRALITY

Many surveys show that physicians, like the rest of the population, are divided about physician-assisted suicide (26, 39, 42–45). A majority of physicians favor legalization (approximately 60%), but only about half of those would be willing to provide such assistance to their patients. A follow-up survey after the American Medical Association issued its position opposing legalization of physician-assisted suicide showed significantly more opposition to legalization in the House of Delegates than in the membership at large (46). Opposition was strongly associated with self-defined politically conservative beliefs, religious affiliation, and the importance of religion to the respondent.

Some organizations have explicitly adopted a position

of studied neutrality, usually to recognize and respect the diversity of personal and religious views and choices of its members and their patients and to encourage open discussion. Other organizations have made no explicit statement on physician-assisted suicide or its legalization, sometimes to avoid a contentious issue about which there is no consensus and to focus on the broader issue of improving palliative care (2). Neutral positions by the organizations listed in the Appendix show respect for the diversity of views among their memberships and encourage members to struggle with the deep and not easily resolvable issues involved in the question of legalizing physician-assisted suicide.

For example, the Task Force on Care of Terminally-Ill Oregonians' neutral position on physician-assisted suicide (47) has allowed its members to work to improve palliative care, but also to help physicians and other caregivers with diverse values struggle with how to respond to requests for physician-assisted suicide. These providers were challenged not only to ensure that palliative care was being fully implemented but also to learn how to evaluate such requests, to use them as opportunities to understand and respond to other dimensions of suffering, and to develop a way of working with such patients regardless of whether a particular physician supported or was opposed to physician-assisted suicide.

In our opinion, organizations issuing position statements about the legalization of physician-assisted suicide must address how physicians should respond to the difficult cases. We all agree that inadequacies in the delivery of palliative care must be addressed and that these improvements not be avoided through solutions such as physician-assisted suicide. But predictable, accountable ways of responding to infrequent cases of intractable suffering must also be developed, lest we leave patients and families with the fear that they cannot count on us to work creatively with them to find an acceptable solution. Organizational positions of studied neutrality encourage our profession to continue this discourse and not to leap to overly simplistic policies or prohibitions. Preliminary data from Oregon suggest that these challenges may not be incompatible and in fact may be synergistic and complementary.

## CONCLUSION

The question "Would you rather have excellent palliative care or access to physician-assisted suicide?" offers a false dichotomy. A better question might be something like "If you have access to excellent palliative care, and your suffering becomes intolerable, what options should you be able to pursue with your physician?" Or, from a policy point of view, "Is it better to have an open, legally regulated response, or an underground, more idiosyncratic, passively prohibited process?" As our multicultural society seeks to recognize and strengthen respect for different religious and cultural views, patients and physicians will some-

times have diverse opinions on this subject. Reinforcing our duty not to abandon while taking a position of studied neutrality on physician-assisted suicide simultaneously expresses respect for diversity and reinforces the importance of maintaining an ongoing commitment in the face of adversity.

## APPENDIX: MEDICAL ORGANIZATIONS WITH NEUTRAL STANCE ON PHYSICIAN-ASSISTED SUICIDE

American Academy of Hospice and Palliative Medicine: [www.aahpm.org/pas](http://www.aahpm.org/pas)  
 American Medical Students Association: [www.amsa.org/about/ppp/36.html](http://www.amsa.org/about/ppp/36.html)  
 American Pharmaceutical Association: [www.aphanet.org/](http://www.aphanet.org/)  
 Oncology Nursing Society: [www.ons.org/](http://www.ons.org/)  
 Oregon Health & Science University: [www.ohsu.edu/ethics](http://www.ohsu.edu/ethics)  
 Oregon Hospice Association: [www.oregonhospice.org/](http://www.oregonhospice.org/)  
 Oregon Medical Association: [www.ormedassoc.org/](http://www.ormedassoc.org/)  
 Task Force to Improve the Care of Terminally Ill Oregonians: [www.ohsu.edu/ethics/guide.htm](http://www.ohsu.edu/ethics/guide.htm)  
 Society for Health and Human Values: See reference 48.

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