5.8 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

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 euthanasia would ultimately cause more harm than good.

Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.

Instead of engaging in euthanasia, 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 a 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

Background report(s):

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

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]

A version of this report was published as "Decisions Near the End of Life" (*JAMA*. 1992; 267 (16): 2229-2233)

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 of-ten 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 td 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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