

Toxic abandonment: a case for non-participation in physician-assisted suicide

I recently read with interest Dr Thomas Strouse's article written to support physician aid in dying. Within the article he made the following statement: "I have come to view 'active non-participation' in legal PAD [physician aid in dying] – that is, decisions by individual physicians and/or health systems not only to not provide, but also not refer patients to possibly willing providers and systems without regard for specific clinical contexts – as a toxic form of patient abandonment."¹ Within the article, Dr Strouse lays out for us thoughtful precautions in the aid-in-dying laws, attempting to demonstrate that no vulnerable population is abused. Such precautions are important but provide the same result for all participants: the death of a patient. This is the central problem with aid in dying. Certainly there is nothing wrong with dying, and we all will have that opportunity. Though most of us would choose to put that moment off a while, for some, the suffering in this life makes death seem a welcome relief.

What is a physician's central responsibility in the care of his or her patients near the end of their lives?

As program director for the hematology and oncology fellowship at my institution, I impress upon my fellows the importance of goal-oriented decision-making. I specifically teach them that there are only four goals worth achieving in any therapeutic or diagnostic decision making: to cure the disease; to help patients live longer despite the disease; to maximize the patient's quality of life, and to prevent impending disasters. I know of no other worthwhile goal in any decision we are to make for our patients. I can point to none of these goals that physician aid in dying achieves. When it comes to physician-assisted suicide, some would argue that selecting an early death is a way of "maximizing quality of life." And certainly our task is to make life the best it can be for our patients while they live through the dying process, but I am unaware of any published quality of life formula that calculates the end of life as a positive measure.

The question for us is the role of the doctor. Dr Strouse raises two issues with those whom he accuses of toxic abandonment. The first is whether physicians should provide aid in death, and the second is whether physicians should refer for the same service if they believe it is wrong for their patients.

It certainly has not been well established that physician-

assisted suicide is a good thing rather than a tragic thing. A 2012 statement from the Ethics, Professionalism and Human Rights Committee of the American College of Physicians suggests otherwise: "After much consideration, the College concluded that making physician-assisted suicide legal raised serious ethical, clinical and social concerns and that the practice might undermine patient trust; distract from reform in end-of-life care; and be used in vulnerable patients, including those who are poor, are disabled, or are unable to speak for themselves or minority groups who have experienced discrimination."² The disability rights group, Not Dead Yet, has agreed with the ACP: "It cannot be seriously maintained that assisted suicide laws can or do limit assisted suicide to people who are imminently dying, and voluntarily request and consume a lethal dose, free of inappropriate pressures from family or society. Rather, assisted suicide laws ensure legal immunity for physicians who already devalue the lives of older and disabled people and have significant economic incentives to at least agree with their suicides, if not encourage them, or worse."³

Such statements sound prophetic within both our present cost containment health care culture and in the real world of personal family economic pressures that can lead a patient toward the understanding that a right to die is actually a "duty to die."

As society is driving physicians to be technicians to carry out their bidding, physicians should be clinging tightly to their role as trusted advocates for their patients. Certainly our patients have fears and pain that would at times lead them to prefer death to living, but a patient's move to non-existence is not the task of the physician. Our task as physicians was well described recently by Yang and Curlin: "Many patients with terminal illnesses fear unbearable pain or other symptoms. The physician's role is to care for them in their illness so as to relieve pain or otherwise help them bear up under the symptoms they endure. Many patients loathe the prospect of abject debility. The physician's role is to maintain solidarity with those whose health is diminished, not to not to imply that debility renders a patient's life not worth living."⁴

Statements such as these by reasoned people suggest we, as a country, have no consensus for the question whether aid in dying is possibly good or seriously bad for our patients.

So it is quite reasonable for compassionate physicians to refuse to administer lethal medicines to their patients in order to “do no harm.”

The second question Dr Strouse explores is whether physicians who disapprove of physician-assisted suicide are abandoning their patients because they do not refer them to a provider who will provide such services. Dr Edmund Pellegrino, a well-respected medical ethicist, in his discussion of moral absolutes in medicine establishes the moral absolute, “Do not kill” and then addresses the ethical problem of complicity in killing. “Formal cooperation is absolutely and always, forbidden. This is the case when the physician shares the evil intent, partakes directly and freely, or in any way facilitates an intrinsically evil act like abortion or assisted suicide.”⁵ Though personally I would not use the word, “evil,” as he does, since evil implies motive; I would substitute the word “harm” and suggest that we should never be complicit in an act that we feel brings the harm of death to our patients. I would suggest that the expectation that physicians referring for aid in dying is analogous with the patient who comes to me demanding a chemotherapy

that I know would cause her harm. I would refuse to give it to her and refuse to send her to a doctor who would be willing to give to her. Referral to produce harm is complicity with causing the harm itself. Our society should never go there. Our society should never ask a physician to cross the boundary line of conscience that is the ultimate protection for vulnerable patients.

I know what it is like to watch our patients suffer. I know what it is like to watch our loved ones suffer. I pushed the morphine at my father’s bedside until he quit screaming in pain. But I did not kill him. I cared for him. Such is the physician’s role. If society decides to allow patients the autonomy to end their lives early and wishes to provide skilled technical help in doing so, let it do so at their peril. But let it choose and train technicians to do it. Do not compromise the one person whom our patients should trust totally to never do them harm.

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Dr Strouse responds: I agree with many of the points made by Dr Weir in his thoughtful and reasoned letter to the Journal. Among the most important areas of agreement: yes, there are worrying national trends toward the “deprofessionalization” of physicians; yes, we must guard against engaging in efforts that would undermine patient trust; yes, we must remain vigilant to protect the rights, needs, and wishes of the less powerful and more vulnerable; and yes, it has not been well established that “physician-assisted suicide” is a good thing rather than a tragic thing.

I infer from his letter that Dr Weir is one of the many physicians who regard participation in aid in dying as fundamentally unethical and anathema to the role of a doctor. I respect that view, and further agree that no health care professional should be compelled to provide access to aid in dying against his or her ethical judgment.

Dr Weir takes issue with my assertion about “toxic abandonment” of patients by individual physicians and/or systems of care. To be clear, in my experience-based view, there can be grave harms to patients and families when their trusted, long-term treaters won’t “go there” for a discussion of all the options – and that laying claim to a moral, religious, or ethical “high road” in refusing to discuss or offer

aid in dying fails to meet the patient’s real and urgent needs.

My examples of patients who used violent means to bring about their own deaths is one element of that failure, but there are others. Many professional ethicists, including those whose work is based in Judeo-Christian precepts, conclude that there are circumstances under which participation in aid in dying is both permissible and appropriate. Some terminally ill patients find the cumulative burden of their suffering unbearable and rationally choose peaceful death over continued suffering. In such instances, the death of the patient is not a “harm” – indeed, the peaceful nature of the death and the ability of the patient to exercise this final bit of autonomy can prove to be a great to the patient and the family.¹

Dr Weir’s note contains some mis-statements and inferences that are worth addressing:

- He asserts that “precautions are important but provide the same result for all participants: the death of a patient.” In fact, the precautions elemental to all of the US state laws exclude many patients who inquire about aid in dying. It is also clear that the professional psychosocial attention mobilized in response to requests for aid in dying leads many patients to withdraw those requests.

But most important, the largest database available (the state of Oregon's annual reporting) makes it clear that as many as 40% of patients who receive lethal prescriptions under its law in a given year never use them.²

- Dr Weir identifies “four goals” of medical decision-making that in his view are the only worthwhile aims of oncology care: cure, extended survival, improving patient quality of life, and preventing impending disasters. Although those goals might seem reasonable, they are in fact reductionistic and physician centric. What about the patient's goals and values? What about the “whole patient?” Beauchamp and Childress provide us with widely referenced and long-available “four principles” of the ethical basis of all health care: respect for autonomy of individuals, nonmaleficence, beneficence, and justice.³ The states that have aid-in-dying laws have embraced these principles in drafting their laws.
- Dr Weir quotes various policy and political statements of the American College of Physicians and the disability rights group, Not Dead Yet, that raise hypothetical concerns, such as the possibility that vulnerable people may be coerced to seek aid in dying. However, although preventing that kind of abuse merits constant vigilance, the publicly reported data does not provide evidence that this is occurring.²
- Dr Weir quotes a widely referenced article by Yang and Curlin⁴ that says, among other things, “the physician's role is to maintain solidarity with those whose health is diminished, not to imply that debility renders a patient's life not worth living.” This incontrovertibly correct statement fails to acknowledge that the request for and drive to aid in dying is *initiated* by the patient, is *scrutinized deeply* by the physicians and other professionals who are charged with considering the request, and is by law *subjected to a litany* of procedural hurdles. I know of no health care professional who has initiated an aid-in-dying discussion, who has decided casually to participate in legal aid in dying, or who implies in word or deed that a patient's life is not worth living. On the contrary, the professionals in my experience try, in clinically neutral and genuinely inquiring ways, to understand why our patients might feel that dying would be preferable to living and suffering.
- The views of Pellegrino are well known to be based on his

Catholic faith, and on the assumption or assertion that death is always a harm. This seems patently untrue. Some dying patients conclude that the cumulative burden of their suffering is so great that they would prefer a peaceful death. Enabling such a patient to die avoids brutal harm. Where aid in dying is an option, it must be based on the patient's autonomous, durable, rational, nonpathologic, noncoerced judgment that death is at this point in his/her life a desired goal, weighed against the current and predicted future circumstances of his/her short anticipated survival. This choice can be a means of preserving a sense of self and coherence with how the person has lived up to this point. It seems patronizing for any of us to presume to know that death is a harm for a dying patient making a rational choice.

- In the evocative description of his own father's suffering, Dr Weir describes treating his father's pain with parenteral opioids and caring for him with great compassion. But the narrative suggests a false moral equivalence between that situation and aid in dying. In fact, aid in dying requires patients to be able to self-administer the lethal medication. Since the act must be self-directed, people who cannot swallow, or take medication themselves through feeding tubes, are disqualified – a disqualification some critics find discriminatory. The important point is that administration of a lethal dose of parenteral medication by a physician, even to a patient who requests it, is euthanasia rather than aid in dying; and euthanasia is explicitly prohibited by all state aid-in-dying laws.

As a palliative care physician and a psychiatrist, I believe it is fundamentally moral for us to stay engaged with our patients who are well along on the path to dying, and to support people whose capable judgment leads them to prefer a peaceful death, with a physician's help, to continued suffering. I am concerned that to identify aid in dying as a forbidden “third-rail” topic about which we will not openly engage with our patients does indeed potentially constitute a harm: a form of abandonment at time of extraordinary vulnerability for patients and their families. I do not suggest that doctors who object to aid in dying should be compelled to participate. I would urge them instead to refer dying patients to colleagues who are willing to consider help people exercise this final bit of autonomy over their lives and medical care.

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