
FROM THE EDITOR

The physician's role in physician-assisted suicide

“There is but one truly serious philosophical problem, and that is suicide”

Albert Camus, *the Myth of Sisyphus*, 1955

A philosophical, existential, ethical, legal, and medical debate regarding the availability of Physician-Assisted Suicide (PAS), and the more current term, preferred by proponents, Physician Assisted Dying (PAD), has taken place over the last 2 years in the editorial pages of *Palliative and Supportive Care* (Breitbart, 2010a; Rich, 2011). Intelligent people of good will can disagree.

On December 31, 2009, the Montana Supreme Court ruled that nothing in state law prevents patients from seeking physician-assisted suicide (PAS), thus paving the way for the procedure to take place legally in Montana, without any of the guidelines in place in states like Oregon and Washington where PAS is already legal. In my 2010 editorial (Breitbart, 2010a), on the events in Montana that made PAS permissible, I argued against PAS as an option for palliative care clinicians and physicians in general, from my 28 year perspective as a psychiatric palliative care clinician, and researcher (studying the causes of requests for PAS and interventions to ameliorate the suffering leading to requests for PAS). My argument was based on a variety of issues, including the fact that the communication of a request for PAS by a distressed patient with a terminal disease was extraordinarily complex and required an intensively sophisticated response that utilized an interdisciplinary care team, including mental health professional. I argued that the solution to suffering was the elimination of suffering *not* the elimination of the sufferer, perhaps by utilizing new interventions developed for despair at the end of life by researchers like Chochinov (2011) and Breitbart (2010b, 2012). I argued that the potential for abuses of legalizing PAS would adversely affect vulnerable populations in our society (e.g., the under-insured, the uninsured, the elderly, the disabled, those whose voices are under-represented in the health care system). I also ultimately

argued that PAS was not an appropriate role for the physician in our human society. A recognition that physicians should not concurrently be responsible for preserving life as well as taking life or being active participants in procedures that only have the purpose of intentionally inducing death. The proper role for the physician is to provide “care,” that is, to preserve the human essence of their patients and assert the unique human possibility of experiencing meaning, even in the last moments of life, while providing amelioration of suffering, and respecting the autonomy of patients to refuse or stop life prolonging measures.

Ben. A. Rich, a lawyer and Ph.D. ethicist with an endowed Bioethics Chair at the University of California School of Medicine (and Chair of the Bioethics Committee of the American Pain Society), responded in an Editorial in *Palliative and Supportive Care* (2011) with an argument for PAS as a legitimate tool in the armamentarium of the palliative care provider; an option of last resort. Dr. Rich writes, “However, those whose professional responsibilities focus on the ‘care’ of dying patients should acknowledge the possibility that in a small percentage of patients the nature and extent of the suffering they experience is genuinely refractory to even the most innovative palliative measures. It is important that in our zeal to provide all patients with a dying process infused with dignity, meaning and purpose, we do not inadvertently and unintentionally cross the line and deprive them of one that is authentic and true to their own needs, values, and priorities.” Dr. Rich goes on later to write, “Despite the best palliative care available... some small percentage of patients do experience unbearable suffering at the end of life, a medical fate worse than death in which the burdens of the dying process far exceed such meager benefits as these patients may reasonable hope to experience that palliative sedation or a humane hastened death with a lethal dose of medications becomes their strong preference. Ultimately only the patient can determine when that point has been reached. As

a society we should be circumspect in the imposition of barriers to clinicians who choose to be the responsive to the wishes of [such] patients.”

Dr. Rich raised many issues in his piece that merit counter-arguments, but allow me to focus primarily on the question of the “authenticity” of our choices and actions as human beings. In the context of a patient’s choices and actions during the course of a terminal illness, I would suspect that Dr. Rich and others would not require a lower standard for “authenticity” than during any other period of adult life. For an individual choice or action to be “authentic” it, in fact, should be a “free” choice that is made fully informed, with full capacity, unencumbered by coercion, and be truly representative of one’s values, beliefs and freedom. The questions thus arises as to who is best suited to make the determination that a particular patient’s choice or action, such as asking for and receiving PAS, is in fact “authentic,” and who should assist the patient in carrying out the act? Should it be the physician? Should it be other experts and the physician? Should the physician not be involved at all in that determining authenticity is not necessarily a primarily medical determination, or that it is harmful to the practice of medicine for physicians to perform PAS? Thus the role of the physician in PAS or assisted dying is brought into question once again.

THE PHYSICIAN’S ROLE IN PAS or ASSISTED DYING

A recent “Perspective” piece in the *New England Journal of Medicine* (NEJM- Prokopetz and Lehmann, 2012) has focused us once again on the role of the physician in PAS or Assisted Dying. In their NEJM piece called “Redefining Physicians’ Role in Assisted Dying,” the authors argue there have been “six primary objections to legalizing assisted dying, four of which have been largely invalidated by 13 years of data from Oregon.” The authors claim that the quality of palliative care has not worsened in Oregon (objection #1). The next 3 concerns that the authors claim have not been borne out by the Oregon experience center on fears of a) discrimination against vulnerable groups, b) expansion to include non-terminally ill patients, and c) that requests may stem from mental illness or coercion by unscrupulous relatives. Now the authors do not take into account the folly of extrapolating the experience of legalized PAS in the very small, homogeneous, and unique crucible of Oregon to predict the experience in a large diverse nation of 300 million Americans, 50 million of who are uninsured and even more under-insured. But I will not make that argument here. The authors go on to say that “The fifth objection holds that

allowing assisted dying undermines the sanctity of life.” They have no clear objective answer to this question, but state that those with a religious objection would not utilize the option of PAS.

The sixth objection is at the crux of question of this editorial: the role of the physician in PAS and assisted dying. Prokopetz and Lehmann write, “Finally, there are objections from the medical community . . . some physicians believe it’s inappropriate or wrong for a physician to play an active role in ending a patient’s life. We believe there is a compelling case for legalizing assisted dying, BUT ASSISTED DYING NEED NOT BE PHYSICIAN ASSISTED (Editor’s added emphasis).” The authors go on to write, “Prognosis and treatment options are part of standard clinical discussions, so if a physician certifies that information in writing, patients could conceivably go to an independent authority to obtain the prescription. We envision the development of a central state or federal mechanism to confirm the authenticity (Editor’s note: *there’s that word again*) and eligibility of patient requests, dispense medication, and monitor demand and use. This process would have to be transparent, with strict oversight. Such a mechanism would not only obviate physician involvement beyond usual care but would also reduce gaps in care coordination.”

I realize some of you may have to read the above paragraph a few times to absorb the full nature of what Prokopetz and Lehmann have suggested with all seriousness, and I presume well thought out intention. With apparent acceptance of the argument that the role of the physician is to provide care, not to assist in dying, or prescribe lethal drugs to commit suicide, these authors have confirmed the validity of the argument that this is not an appropriate physician role. But the solution has struck me as simultaneously naive, impractical, unfeasible, and bizarrely futuristic in an Orwellian nightmarish fashion. This solution will simultaneously be lauded by defenders of individual rights (e.g., the NRA) and derided by conservative Palin Tea Party types as big government death panels.

The fact is that my first association to this “modest proposal” by Prokopetz and Lehmann was to my reading of Kurt Vonnegut Jr’s short story *Welcome to the Monkey House* (1968), which I read in college in the mid 1970s. *Welcome to the Monkey House* is a short story set in the distant future where the world’s population has grown to over 17 billion, and thus resulted in strains on economies, food and energy supply. To help solve the problem, Federal Ethical Suicide Parlors were established. Individuals who were terminally ill, or had lost the will to live, or felt life was meaningless, or were suffering, or even those without any particular reason in fact, could

come to one of these “death centers” and receive a painless death by injection. The death provided was truly futuristic and high tech. It was not merely death by painless injection, but rather there was a menu of various scenarios that could be replicated via virtual reality and other techniques, that would allow you to die in a specific location, doing specific actions, and experiencing specific sensations. You could die on a beach in Hawaii, or in bed with a bevy of beauties. I must admit that my 20 year old mind, for a moment, thought, “cool, maybe I could start a business like that, I could make a fortune!” Science fiction is fiction no more. I am afraid that Prokopetz and Lehmann’s modest proposal is not likely to evolve into practice anytime soon. But in thinking their proposal through to the next steps, I am forced to ask such questions as: 1) Who will make the determination of the “authenticity” of a request for PAS or assisted dying? Will it be Bioethicists? Lawyers? Philosophers? 2) Who will dispense the lethal prescriptions or perhaps more directly the lethal injection? Our friendly Walmart pharmacist? Or perhaps the experts on lethal injections in the Texas Prison system who are quite competent at this practice. 3) Who will oversee this federal system of assisted dying? “Brownie,” President Bush’s FEMA Director during Hurricane Katrina? Ezekiel Emanuel M.D. (Editor’s note: sorry Zeke, I had to pick a highly competent individual as a counterpoint!)?

The question as to the role of the physician still remains. Physicians are responsible for the care of our patients, and have unique care challenges that face us in the care of those living as death approaches. Our ability to fulfill this responsibility of care is quite susceptible to the economic and political environment that affects health care delivery, even now. I believe that political and legal intrusions into what many consider the sacred doctor – patient relationship have historically been a negative influence on care (e.g. inadequate

health care coverage, restrictions on access to opioids, etc). I fear both laws that criminalize the provision of physician care or legalize what I believe to be out of the scope of physician care. Ultimately, as Camus wrote, there is really only one fundamental human question: is life worth living? The answer to that question, the choice, is ultimately a personal one, but one that is made by an individual who is part of a culture and a society that exists to care for that individual. The physician is our culture’s designee for the provision of care to the ill and those living with terminal illness.

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WILLIAM BREITBART, M.D.
Editor-in-Chief