PHYSICIAN-ASSISTED SUICIDE

The Ethics and The Dangers

FACT SHEET
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THE BASICS

What is physician-assisted suicide?

According to the American Medical Association, "Physician-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 may commit suicide)."[1]

Why is physician-assisted suicide wrong?

Physician-assisted suicide has been ethically and morally opposed in medicine for more than 2,000 years. The Hippocratic Oath says the doctor, "will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect." The original version of the oath contained the principle of preventing harm, which later became, "First, do no harm." This golden rule is the foundational, moral principle of medicine. It reminds doctors, as they attempt to cure and relieve suffering, they should never do anything to inflict injury or death upon their patients. The American Medical Association states, "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[1]

Why has physician-assisted suicide been accepted by our culture in recent years?

Several factors are driving the physician-assisted suicide movement in the 21st century. More than 77 million baby boomers—Americans born between 1946 and 1964—are becoming eligible for Medicare enrollment,[2] and those aged 65 and older account for eight percent of all suicides.[3] While elderly adults make up 12 percent of the population, they constitute roughly 18 percent of deaths by suicide.[4] Proponents of "hastened death" speak of compassionate solutions to painful illnesses through "death with dignity." Combine these powerful forces with an impersonal and technological healthcare system, and the result has proven lethal. Assisted suicide is an immoral, slippery slope that corrupts doctor-patient trust and destroys public policy.

Where is physician-assisted suicide legal?

Currently, physician-assisted suicide and/or voluntary euthanasia is legally available in parts of Australia, Belgium, Canada, Colombia, Luxembourg, The Netherlands, Switzerland and several states in the U.S., including California, Colorado, Maine, New Jersey, Oregon, Vermont, Washington and the District of Columbia.

Why is legalizing it the wrong step to take?

Legalizing physician-assisted suicide is not about giving patients the right to die but about giving physicians the right to kill. Suicide is tragic but not illegal. Verbal engineering always precedes social engineering, so pro-suicide groups are trying to wrap the respectability of the medical profession around something society has tried to prevent for many years. They've also cloaked the word "suicide" in the camouflage of good words like "compassion," "choice" and so-called "death with dignity." Dignity is not found in a handful of lethal pills.

Proponents of legalization are trying to scare people to death by convincing them they may have only two choices: a long and painful death or legalized physician-assisted suicide. This might have been a reasonable assertion 150 years ago when there were few pain control options, but today we have the best pain control methods in the history of medicine. Doctors can control virtually all pain with analgesics, sedatives, tranquilizers, anesthetics and other modalities.

Healthcare professionals are morally obligated to relieve suffering without intentionally hastening death.

THE DANGERS

It is dangerous for healthcare professionals.

It destroys trust which is the foundation of the doctor-patient relationship. That's why major medical associations adamantly oppose it. It takes no great skill to kill, but it does to provide superb end-of-life care. It is the easy option for a busy or stressed or physician. It gives too much power as the physician is judge, jury and assistant executioner. They can convince a patient this is a reasonable step just in the way they describe their diagnosis and prognosis. It assumes physicians are perfect moral agents. If we couldn't control Jack Kevorkian when it was illegal, what makes us think we can control 700,000 physicians when it is?

It is dangerous for families.

Families don't have to be informed. They can be left with guilt, anger and sadness. It will cause family dissension as some oppose it and others encourage it. It opens the door to the worst form of elder abuse by self-centered, exhausted care providers or greedy relatives.

OUR RESPONSE

AAME Position Statement on Physician-Assisted Suicide

"We, as compassionate and caring healthcare professionals, therefore, reject assisted suicide and euthanasia categorically, as these practices are incompatible with the nature of medicine and would do violence to the best interests of our patients and society. Complying with a patient's request for assisted suicide is ethically indefensible. Killing a patient is not medical care."

"AAME affirms that it is the duty of health care professionals to address the many physical, emotional, spiritual and social issues involved with illness, to ameliorate the patient's suffering short of deliberately taking the patient's life, and to educate all practitioners of existing tools to accomplish those ends. It is medicine's duty to continue to search for better means of pain and symptom management."

It is dangerous for patients.

The "right to die" will become the duty to die for senior citizens, as some bioethicists already advocate. Not wanting to be "a burden," the elderly will take their own lives. Mental and physical suffering preclude rational decision-making.No mental evaluation is required. Most people commit suicide due to depression which is extremely common but treatable in the terminally ill.[5] In an economically challenged healthcare system, the cheapest form of healthcare for any illness is a handful of lethal medications.

It is dangerous for society.

There is a slippery slope. When society states that some lives are "not worthy to be lived" because of subjective suffering, and those people have a "right to die," doesn't someone with a chronic illness who will suffer more or longer than the terminally ill deserve this "right?" Don't we have the duty to provide physician-assisted suicide to those who can't swallow the pills? A total of 20 percent of patients taking lethal pill dosages don't die.[6] Shouldn't we let doctors give lethal injections so it is done compassionately? What if a patient can't give consent because they are mentally incompetent or too young? Shouldn't we let someone else do this for their benefit? Psychiatric illness causes suffering, so don't those patients need this "benefit?" In Europe, countries have taken the "logical step" and answered "Yes" to all these questions. The right was given to the terminally ill, then the chronically ill, the mentally ill, the disabled and finally those not ill at all. The so-called safeguards don't work. It is impossible to accurately predict a patient will only live six months. Physicians under physician-assisted suicide laws are immune from malpractice. Only positive information is published, with no possibility of examining how well it is working.

RECOMMENDATIONS

Legalizing physician-assisted suicide is wrong. The evidence is clear it is ***TOO DANGEROUS***. The better alternative is to: train more palliative care physicians; modify laws to allow adequate pain/symptom control at the end of life; encourage better identification and treatment of depression; promote hospice; and mobilize communities and others to provide emotional and relational end-of-life support to struggling patients and families.

1 *https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide*
2 *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1464018/*
3 *https://www.npr.org/2019/07/27/745017374/isolated-and-struggling-many-seniors-are-turning-to-suicide*
4 *https://www.aamft.org/AAMFT/Consumer_Updates/Suicide_in_the_Elderly.aspx*
5 Maytal, G., & Stern, T. A. (2006). The Desire for Death in the Setting of Terminal Illness: A Case Discussion. *The Primary Care Companion to The Journal of Clinical Psychiatry*, 08(05), 299-305. doi:10.4088/pcc.v08n0507
6 *https://lozierinstitute.org/a-reality-check-on-assisted-suicide-in-oregon*

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