Assisted Suicide: A Challenge for Family Physicians

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In this issue, Koenig[1] offers a balanced and comprehensive review of physician-assisted suicide and its implications for public policy. Koenig approaches the subject from the viewpoint of a geropsychiatrist who would play a key role in any well-considered policy that allowed regulated physician-assisted suicide. He accurately points out that family physicians, regardless of their personal views on this controversial topic, will inevitably be involved in the debate.

Koenig's reasons for concern about any move to legalize physician-assisted suicide are persuasive. As family physicians, however, we may find case studies more congenial than policy analyses. The following two cases illustrate, for me, some of the most important difficulties that arise when assisted suicide is not allowed to be a part of the medical armamentarium.

Case 1

A 74-year-old man, previously very vigorous and active, became severely incapacitated after becoming legally blind as a result of macular degeneration. As he was beginning to cope with this loss of function, throat cancer was diagnosed, and he underwent a course of radiation. The side effects were severe; the patient permanently lost most of his hearing and was unable to swallow solids. Over the next 18 months he lost weight, was increasingly fatigued, and had constant headaches. Most troublesome for his sense of dignity, however, was the progression of the cancer to his sinuses, resulting in the discharge of copious amounts of mucus. The patient constantly had to wear a sanitary pad under his nose to keep himself dry.

The patient finally decided to commit suicide, primarily because of his sense of degradation and disability and his feeling that he was a burden to his wife (who had been fully supportive in every possible way). He consulted a friend who was a member of the Hemlock Society and who determined that he had enough medication to take a fatal overdose. The patient, his wife, and the friend eventually planned his suicide by overdose, with the friend being willing to assist if needed by placing a plastic bag over the patient's head.

On the day appointed, the patient abruptly announced that he had decided that he could not involve his wife and his friend in the suicide; he was too worried about possible legal complications for them. Both of them protested that they would assist him regardless of the legal risk, but he remained adamant that he loved them too much to place them in jeopardy. He went to the bathroom while the wife and friend continued their conversation. They heard a gunshot, and found the patient with a large self-inflicted head wound, but still alive. They called the police and ambulance, and the patient was rushed to the emergency department. The physician on duty concluded that the wound was most probably fatal and that he would provide comfort measures only; the patient died 3 hours later.[2]

Case 2

A 20-year-old woman with widely metastatic Ewing's sarcoma suffered greatly from bony metastases. Even massive intravenous doses of opiates and corticosteroids and palliative radiation had not relieved her pain. She did have good pain relief with a lumbar intrathecal infusion of bupivacaine and hydromorphone. However, when the infusion was inadvertently stopped for 20 minutes, she had recurrence of such severe pain that she begged to be killed. When a large bolus of intravenous hydromorphone failed to give immediate relief, she was deeply sedated with pentobarbital, and the intrathecal infusion was restarted. The pain team then discussed with her family whether she would wish to be awakened from the barbiturate coma. The family stated that she would choose to remain in a coma because her overriding fear of

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severe pain made her existence miserable. The pentobarbital infusion was continued, and the patient died in 2 days.[3]

Case 1 challenges a number of arguments commonly heard against physician-assisted suicide: good hospice care can relieve all unpleasant symptoms and remove any incentive to die; fears of legal liability are useful in helping to prevent abuses; and physician assistance is unnecessary since, if a person really wants to commit suicide, he will find a way on his own. The patient's wife never recovered emotionally from the tragedy of the manner in which her husband died. At least the on-duty physician in the emergency department had the compassion to allow the patient to die. All of us know of instances in which this patient would have been intubated and admitted to intensive care for one last round of indignities before expiring.

Case 2 describes a situation appealed to by some thoughtful and compassionate opponents of assisted suicide: in the most extreme cases, one can always sedate to the point of coma, thereby removing any need to kill the patient directly to relieve suffering. My problem with this is my inability to see any significant moral difference between what transpired in Case 2 and mercy killing. It is understood that inducing barbiturate coma in such a patient is incompatible with prolonged life. The patient could have been revived from coma only to go on living in constant fear (if not in pain) for a few more days or weeks. The family and physicians decided (compassionately, in my view) not to adopt that course of action. If we are willing to do this, but not to assist a patient in committing suicide, have we honored our principles or merely clothed ourselves in comfortable semantics?

I have argued previously that the dangers of abusing the right to physician-assisted suicide would arise if it were *routinely* employed and would be much less likely to be abused if it were used only as a method of last resort in exceptional cases. From a medical standpoint, careful case-by-case review, starting with the presumption that assisting a suicide is a form of malpractice until proven otherwise, seems to me to combine an assurance that physicians will assist a patient's death only as a last resort after trying all other methods of palliation, while acknowledging that exceptional cases may demand exceptional remedies. (I think the presumption against assisting a patient's death could be overcome in both of the cases cited above.) Of course, the public policy and legal dimensions of such a proposal are far more challenging than the medical dimensions.[4]

Family physicians may legitimately disagree among ourselves as to the morality of physician-assisted suicide; nevertheless, we are committed to caring for patients who may at times feel driven to request that we assist them in terminating their lives. Are there any principles that should guide our behavior? Our answers to the following questions may serve as guideposts.

1. Have I created the sort of relationship with this patient so that he or she will feel comfortable enough with me to tell me that he or she has been contemplating suicide in the face of irreversible or terminal illness? If I believe that it is moral to assist, then I must still try all reasonable measures before agreeing to do so; if I am morally opposed, I will try to offer my patient what I believe to be better alternatives. In either case, I cannot aid the patient if I do not know what he or she is thinking.

2. Can I listen in an open-minded and nonrejecting manner to the patient's discussion of suicidal thoughts, while still pursuing the differential diagnosis for mental disorders and providing expert psychiatric consultation if needed? I must avoid the twin dangers of missing a treatable mental disturbance and of allowing the patient to conclude that I have labeled him as crazy without listening to his distress.

3. Where my own skills in symptom control and palliative care are limited, can I identify the best local consultants to advise me, to ensure that I have explored all realistic alternatives for control of pain and other distressing symptoms?

4. How can I make a commitment to the patient to follow the course of the illness and his or her coping with suffering *to the end*, regardless of whether, at the last juncture, I am willing to assist him or her in committing suicide? This seems to be a touchy issue for physicians opposed to physician-assisted suicide. To say, "I will go with you every step of the way, and yet I am not willing in the end to give you what you are asking for" may sound very hollow to the patient. For some ambivalent patients, merely knowing that a personal physician has made a long-term commitment to their care may be enough to dissuade them from seeking a premature death. Moreover, many patients are not seeking an early death when they contemplate suicide but rather a sense that the "safety valve" is there if they ever need it. Ironically, a physician's commitment to assist with suicide if the patient asks may actually reduce the likelihood of the patient choosing suicide.

5. Have I adequately explored with the patient what the illness *means* to him or her? Have I made sure that the patient is receiving adequate emotional and spiritual support while I have been addressing the physical aspects of his or her care?

6. Assuming that the patient who requests assisted suicide may actually fear loss of control more than pain, have I taken all possible steps to ensure that the patient is an active participant in all medical decisions? Have I

addressed the creation of advance directive documents that will prevent unwanted life-prolonging treatment? (These steps should be morally acceptable even to physicians who would refuse to assist in suicide.)

If we decide that despite Koenig's concerns, physician-assisted suicide should be a medical option, then addressing these questions will help to ensure that it is never employed prematurely and also that as few patients as possible actually choose suicide. If our ultimate conclusion is that physician-assisted suicide is simply too dangerous to employ, then questions like these may guide us toward the best available alternatives for suffering and anguished patients. In either event, family physicians will continue to have a key role in caring for chronically and terminally ill patients who may soon face even harder questions about their lives and how they should end.

References

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