

Sometimes a case can be made for physician-assisted suicide

NO

Working for most of my professional lifetime with people who are dying, it has been common for me to hear requests from individuals for their lives to be ended—mostly, I think, because of their sense of frustration, sadness, hopelessness or fear. Some express their explicit opinion that they may be a burden on their family or on society and that is why they are asking for their life to be ended.

It is hard to imagine—even though I spend much of my clinical life with people who are desperately ill—what it must be like to reach a stage where they ask for death. Whatever it is that triggers such a request they are rarely repeated over time—once adequate palliative care is instituted, the request to die loses its urgency and the focus is once again on living. What I believe is that most, if not all, of these requests are from people telling me they ‘don’t want to live like this’, which is, of course, very different to wanting to die. The notion of real or potential suffering that cannot be relieved is a potent driver in some of these requests. Some years ago the European Association for Palliative Care Ethics Task Force¹ produced a carefully constructed and well thought out document that crystallised the thinking of many who are involved in end-of-life care. In that document they suggested, among other things, that: ‘Individual requests for euthanasia and physician-assisted suicide are complex in origin and include personal, psychological, social, cultural, economic and demographic factors. Such requests require respect, careful attention, together with open and sensitive communication in the clinical setting.’

They go on to suggest that ‘requests for euthanasia and physician-assisted suicide are often altered

by the provision of comprehensive palliative care. Individuals requesting euthanasia or physician-assisted suicide should therefore have access to palliative care expertise’. This is to say that we need to explore, to our utmost abilities, what it is that is driving this request for the ending of a life and, in doing so, find ways to alleviate or mitigate suffering to such a degree that the desire for death is diminished.

The Task Force argues that ‘if euthanasia is legalised in any society, then the potential exists for:

- i. pressure on vulnerable persons;
- ii. the underdevelopment or devaluation of palliative care;
- iii. conflict between legal requirements and the personal and professional values of physicians and other health care professionals;
- iv. widening of the clinical criteria to include other groups in society;
- v. an increase in the incidence of non-voluntary and involuntary medicalised killing;
- vi. killing to become accepted within society.’

All of these are real concerns that are met on a regular basis when caring for the most vulnerable and sick in our society and it is not unreasonable to suppose that any intention to ‘permit’ assisted dying would put varying degrees of pressure on those who ask for the end of their life to be precipitated.

Many who are receiving palliative care have a fear of their life being prolonged unnecessarily or for it to end in ‘unbearable’ distress. Clearly no-one would want this, least of all for someone they love, so it is incumbent upon us to ensure that all who need it receive the best possible physical, psychological, spiritual and social care. In this way, assisted dying is not an option that needs be considered.

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Establishing palliative care within mainstream health care systems of all countries is essential and this must be supported by appropriate finance, education and research. In New Zealand, successive governments have demonstrated a willingness to support the provision of palliative care through hospice programmes, but we still fall behind many countries in the way in which we teach our health professionals to deal with this most challenging of health-related issues. Doctors have repeatedly reported being unprepared to deal with end of life care on a practical level, let alone a legal or moral one. Repeatedly, the majority of doctors have voiced their views that physician-assisted suicide is wrong.² Another compelling discussion is to be found in the writing of McLachlan³ who asserts that one can 'consider particular actions to be contrary to appropri-

could be argued that, in palliative care, one of the main things we have to offer is that personal bond, but I would like to think that people who are sick or dying should all be attended by those who cared as well as attempted to cure, and neither of those aspects involves the ending of a life. When people consult their doctor it is because they feel unwell, uncertain or they are suffering. It is hard enough to provide humane medical care for these people who seek help without the added burden of an expectation that somewhere in that relationship between doctor and patient there may be a tacit understanding that this person, in whom they have entrusted their life, their fears, their concerns, may be required ultimately to end their life. There is never a case to be made for physician-assisted suicide in any humane society.

One of the many tensions in the doctor–patient relationship is the different perspective from which each party views the medical encounter. Patients need caring as much as they need curing and it is often caring that can be missing

ate professional conduct even in the absence of legal and ethical objections to them.'

The major reason that physician-assisted suicide is so at odds with the rest of medical practice is because of the unique bond that develops between doctor and patient. We need to ensure that we strive to fully understand what it is that the patient is experiencing. Shimon Glick⁴ writes that one of the many tensions in the doctor–patient relationship is the different perspective from which each party views the medical encounter. Patients need caring as much as they need curing and it is often caring that can be missing.⁵ Francis Peabody, in the *Journal of the American Medical Association* in 1927 wrote: 'The reward is to be found in that personal bond which forms the greatest satisfaction in the practice of medicine.'⁶ Any situation where physician-assisted suicide is contemplated will irreparably damage that relationship or bond. It

References

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