Attachment Q

170.994 Euthanasia and Physician-Assisted Suicide

"Euthanasia" contains the Greek words "eu" + "thanatos" (death) which means an easy death. Only the competent patient or the authentic proxy of the incompetent patient may decide what for each patient constitutes a good death.

Medical interventions may be withheld or withdrawn, allowing a disease process to continue its natural course leading to death. Competent patients have a moral right to seek a good death by refusing treatment if that is their wish. Furthermore, physicians have a moral obligation to honor the wishes of their competent patients or the authentic proxy of their incompetent patients, with respect to withholding and withdrawing undesired medical interventions.

"Euthanasia" has been used to describe a process in which an intervention by someone other than the patient is intended directly and immediately to bring about the death of a suffering patient at the patient's request. However, providing treatment or medication with the intention of easing the pain of a dying patient is acceptable treatment and not euthanasia, even though such treatment or medication may foreseeably hasten the moment of death.

"Suicide" describes the intentional termination of one's own life. Refusing a treatment, which may delay the moment of death, is not suicide. However, intentionally taking a lethal dose of medication even when fatally ill would be suicide. A physician who intentionally provides a lethal dose of medication for the purpose of aiding a patient to commit suicide is assisting suicide. This differs from providing an adequate dose of medication for the purpose of pain relief, even though it may foreseeably hasten death.

PHYSICIAN-ASSISTED SUICIDE

1. Physicians share with all society a duty to obey the law that currently prohibits both euthanasia and assisting suicide.
2. It is incumbent upon the medical profession to use all means to ensure that dying patients are provided optimal treatment for their pain and other discomfort. This may include the use of more aggressive comfort care measures, including greater reliance on hospice care, which can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
3. Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.
4. Requests for physician-assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.
5. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.
6. The principle of patient autonomy requires that physicians must respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics and artificial nutrition and hydration.
7. The professional and societal risks of involving physicians in medical interventions intended to cause patients' deaths are too great to condone euthanasia or physician-assisted suicide. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

(RES-22, AM 2000; Reaffirmed, BOD-1, AM 2014)

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