NETWORK NEWS
The newsletter of the Florida Bioethics Network
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ASSISTED SUICIDE
WHAT ARE THE PROBLEMS?

*By **Glenn R. Singer, MD,** Chairman-Bioethics Comm./Pulmonologist, Broward General Medical Center, Ft. Lauderdale.*

On January 31, 1997, Judge Joseph Davis gave AIDS patient Charles Hall the right to have Jupiter physician, Dr. Cecil McIver, assist his suicide. Thus a topic which we have been closely following from the Oregon referendum to the 9th and 2nd U.S. Circuit Courts of Appeals suddenly was on the front page throughout Florida. The Board of Medicine has stated that it is unequivocally opposed to physician assisted suicide. Mr. Hall himself has not gone through with the suicide now that he has received the court's approval. Nevertheless, through appellate court decision or future legislation it seems that assisted suicide is heading toward legalization. As a physician, there are several areas that worry me.

Assisted suicide derives from the ethical principle of patient autonomy or self determination. Respect for autonomy remains one of our most important principles in medical care and bioethics. All that we do for patients is done with their consent. Minor actions, such as drawing blood, are done with tacit approval. More complex interventions have long detailed formal consent documents and discussions.

Autonomy gives patients negative rights: the right to say, "Leave me alone." Under the principle of autonomy, patients may refuse treatment which may even be life saving. Sometimes this is distressing, such as when an otherwise healthy Jehovah's Witness patient refuses blood. In other cases though, patients or their surrogate decision makers refuse treatment which is not life saving but death prolonging. The elderly emphysema patient who develops pneumonia and kidney failure may refuse further treatment and allow his underlying disease to proceed naturally toward death.

Autonomy does not give patients the right to demand treatments or tests. Patients cannot demand laetrile. They cannot demand unindicated surgical procedures. Should they be able to demand lethal doses of medicine for the purpose of ending their life?

When a patient or family asks to withhold or withdraw treatment, the dying process is clearly advanced; the patient cannot be returned to a satisfactory functional state and comfort care is given. This decision is made either through advance directive or lengthy discussion with the patient or family. The health care team in this case, however, is not hastening death; rather, they are no longer delaying it.

Palliative medication can be given to relieve pain, shortness of breath, or other discomfort even if its administration causes respiratory arrest. This application of the "double effect" emphasizes that the medication is given for relief of symptoms, not shortening of life. Therefore, the action is permissible because of the intended salutary effect.

Herein is the principal difference between withdrawing care in a terminal patient and assisted suicide. In the former, death is imminent and technology is interfering with its natural progression. In the latter, the time of death is not clear, but the patient has determined to end his or her life.

If we could assure our patients access to compassionate care and palliation of pain and suffering at the end of their lives, would the clamor for assisted suicide be less? Traditionally, physicians have been trained to use unlimited resources to benefit their patients. Until recently cardiopulmonary resuscitation (CPR) was given to almost every in-hospital death.

More recently health care workers have recognized that CPR was not intended for some illnesses. Advance directives and discussions with the health care team have led to greater use of palliative care and hospices in cases for which CPR would be considered futile (e.g., widely spread cancer, end stage Alzheimer's). If assisted suicide becomes a legal possibility, can we ensure that physicians are informed about palliative care and hospice options and that patients understand these are available?

Advance directives and lengthy conversations with a trusted physician suppose that there is a strong patient-physician relationship. In Florida, however, there are 2.6 million people without insurance and unlikely to have that kind of strong relationship. Uncounted others have distant or ephemeral relationships with their doctors. How do we ensure that those patients have appropriate understanding of the range of care at the end of life?

There also are troubling economic issues. In the era of managed care can we guarantee that less expensive Seconal (generically available) is not chosen over more costly hospice referrals and analgesics simply for expediency? In capitated programs, might the temptation to limit care and therefore avoid financial loss not influence some providers to de-emphasize more expensive options?

Another important economic issue is the effect of a suicide on a patient's life insurance policy. In some cases, the death benefit might be voided by this action.

Other financial pressures might originate from the patient or family itself. If suicide is legal, might the right to die become the duty to die? If a family has limited means and one of its members develops a serious illness, the afflicted patient may altruistically feel an obligation to end his or her life. The appeal of suicide would be to avoid depleting whatever resources the patient or family has.

Some have argued that economic factors may play an analogously sinister role in withholding and withdrawing treatment, which is already permissible legally, ethically, and medically as discussed above under the principle of autonomy. In my mind, however, there remains a distinction between a patient refusing or discontinuing a mechanical ventilator or dialysis machine and a patient diagnosed with AIDS or breast cancer asking for a lethal prescription. The former patient is clearly at the end of an illness with failure of an organ system; the latter may have driven himself or herself to the doctor's office that day.

The definition of terminal presents still another problem. When is a patient terminal? Is a patient terminal after the diagnosis of AIDS is made? Many AIDS patients with poor prognoses just a few months ago now have quite different outlooks due to retroviral/protease inhibitor drug cocktails.

Another problem with assisted suicide is the problem of depression. Patients with serious illnesses may have severe depression. This may be difficult to separate from the terminal illness itself. The anger and depression experienced after learning of a poor prognosis may hasten a choice of suicide. Should all patients asking for lethal medication doses be required to see a mental health professional?

My last point is the process of suicide itself. What is the protocol? Do we know what prescription to write? If the attempt fails or is incomplete, what happens next? A call to 911 or a trip to the emergency department could lead to a confusing scenario. Without an official HRS canary yellow "Do Not Resuscitate" form, the patient may be resuscitated in stark contrast to his or her wishes.

If a patient has asked for assisted suicide, but becomes too weak or has gastrointestinal problems, should a friend or health professional be the assistant? Is that then not murder or actual euthanasia?

The failure of the medical community to persuade the population that a good death is possible has led to the demand for assisted suicide. The public has lost faith in the medical team's judgment, knowledge, and compassion. They have asked to be completely in charge of their fate at their most vulnerable, most critical moment.

Good ethics is often simply good communication. Perhaps the first step in solving the problems of assisted suicide is to do a better job at educating our patients that beneficence involves not only aggressive treatment of illnesses, but also the ability to provide compassionate care at the end of life.

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MEETING OF INTEREST

Annual Ethics Seminar ~ "How We Die"
April 30 - May 2, 1997
University Medical Center
Jacksonville, Florida

"How We Die" was developed by the University Medical Center Ethics Committee. This seminar, presented by a nationally-known faculty, will discuss physician assisted suicide, along with other related topics. Continuing education credits are offered in the following areas: CEU, CME, Social Work, CLE, and Psychology.

Registration is limited to 80 per day with a fee of $35 per day. For more information contact: *Linda M. Suydam, Secretary, Ethics Committee, University Medical Center, 655 W. 8th Street, Jacksonville, FL 32209 ~ 904/549-4723; Fax: 904/549-5090; E-mail: lms.umc8@mail.health.ufl.edu.*

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Submitted by ***Francille M. MacFarland, MD,*** *Winter Park.*

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2. Corscino, B.V. Bioethics Committees and JCAHO Standards: Everybody's Business. The Journal of Clinical Ethics 7; 2: 109-15.

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5. Covinsky, K.E., et al. Is Economic Hardship on the Families of the Seriously Ill Associated With Patient and Surrogate Care Preferences. Arch. Int. Med. 156: 1737-41.

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ADDITIONAL MEETINGS

- **May 22, 1997 ~ "Problems in the Emergency Room: A COBRA Update,"** sponsored by Florida Hospital Association. Meeting location: Hyatt Regency Pier 66, Fort Lauderdale. To request a brochure, please fax your name, title, organization, address, phone number, and fax number to the FHA Meetings Department at fax # 407/423-4648. Please state the title of the brochure that you are requesting.

- **June 12-15, 1997 ~ "Catholic Identity in Health Care: Public Responsibility and the Culture of Profit,"** Center for Clinical Bioethics, Georgetown Univeristy Medical Center, Washington, DC. For information and registration materials, contact Mr. Stacy Schultz, Center for Clinical Bioethics -- 202/687-1122; FAX: 202/687-8955; E-mail: ccb@medlib.georgetown.edu

- **SAVE THE DATE! October 8-10, 1997 ~ FBN 7th Annual Conference.** Meeting location: Hyatt Regency Westshore, 6200 Courtney Campbell Causeway, Tampa, FL 33607 -- 813/874-1234. Watch for future mailings for more details.

WELCOME NEW MEMBERS!

The Florida Bioethics Network welcomes **Diane Cox,** Executive Director, Hospice of Naples, Naples -- 941/261-4404; **Diane Dube,** Administrator, St. John's Rehabilitation and Healthcare Center, Lauderdale Lakes -- 954/739-6233 x267; and **Rev. Lawrence Lyons,** Director of Pastoral Care/Staff Ethicist, St. John's Rehabilitation and Healthcare Center, Lauderdale Lakes -- 954/484-4716.

F.Y.I.

Enclosed with this issue of *Network News* is the April 1996 issue of Action Report. The article, "Medical Board of California in a Managed Care Environment," may be of particular interest.

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ESSENTIAL READINGS #9

*Submitted by **Francille M. MacFarland, MD,** Winter Park.*

Research Ethics 2

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11. Gordon, V., et al. Family Dynamics and Children in Medical Research. The Journal of Clinical Ethics 1996; 7 (4): 349-354.