



DECEPTIVE LANGUAGE AND PHYSICIAN-ASSISTED SUICIDE

Richard Florentine, MD

The traditional formulation of the Oath of Hippocrates of Kos, 5th century BC, states, “I will apply dietetic measures for the benefit of the sick according to my ability and judgment. I will keep them from harm and injustice. I will neither give a deadly drug to anybody who asks for it, nor will I make a suggestion to this effect.”¹ The oath is consequential for more than just the individual practitioner, as it affects the social role and esteem in which the entire profession of medicine is held. Both parties in the physician-patient relationship are at risk by any abuse of power in this inherently unequal relationship.²

The fact that the 2,500-year-old Hippocratic Oath explicitly mentions the prohibition to assisted suicide is an indication of how long the temptation to act in this unethical manner has existed. Having access to potent pain-killing medications that can also end life has given the practitioner of medicine a powerful aid to patients in their most difficult circumstances, but with this power also comes the possibility of abuse. The oath reminds the practitioner of the importance of restraint: first do no harm.

Although we should respect the autonomy of our patients and engage in shared decision-making with them, the debate over physician assisted suicide (PAS) has not given sufficient attention to other principles that need to be addressed in these discussions. In trying to offer a sound ethical analysis of this movement, we must weigh consequences that go beyond the individual patient and the physician. Concerns about unintended consequences to the social dimension of human life take us into the policy domain.³ The act of PAS affects both justice and human dignity.

The World-Wide Spread of PAS

One of the major worries of those who oppose PAS is that it will metastasize throughout the population of patients. A recent American Medical Association Council on Ethical and Judicial Affairs report (2019) stated:

A prominent argument raised against permitting physician-assisted suicide has been that doing so will have adverse consequences for individual patients, the medical profession, and the society at large. Scholars have cited the prospect that boundaries will be eroded and practice will be extended beyond competent, terminally ill adult patients; to patients with psychiatric disorders, children; or criteria will be broadened beyond physical suffering to encompass existential suffering; or that stigmatized or socioeconomically disadvantaged patients will be coerced or encouraged to end their lives.⁴

The author also reports on concerns that permitting PAS will compromise the integrity of the profession, undermine trust, and harm the physicians and other health care professionals who participate, and that forces outside medicine will unduly influence decisions. “The question is whether safeguards—which in the U.S. jurisdictions that permit assisted suicide, restrict the practice to terminally ill adult patients who have decision-making capacity and who voluntarily request assisted suicide ... can actually protect patients and sustain the integrity of medicine remains deeply contested.”⁵

Review of the world-wide medical and legal landscape where the practice of PAS has been legally permitted indicates that these unintended consequences are not mere speculation or part of some slippery-slope fear. They have in fact already come to pass. Observation of the world stage has become a sort of natural experiment in which there is abundant evidence that these unintended consequences are not speculations.⁶ The concern about restricting the practice to terminally ill adult patients who have decision-making capacity and who voluntarily request assisted suicide has already been breached, as documented throughout the world, especially in Belgium, the Netherlands, and Canada.⁷

Supporting this observation, “*Legalizing Euthanasia: What We Can Learn from the Netherlands*,” by Diederik van Dijk and Leo Van Doesburg, brings our attention to this point:

In 2001, the Netherlands was the first country in the world that legalized euthanasia by adopting the “Termination of Life on Request and Assisted Suicide Act. Initially, this act was meant for persons who were in the last stages of life and who were terminally ill. In the meantime, however, the category of people qualifying for euthanasia kept expanding. Even euthanasia on babies and patients with dementia has become a practice now; euthanasia for defenseless people who do not realize they are being put to death. In another effort to erode the euthanasia law standards, sustained political pressure is now being carried out to pass ‘completed life law’ and to legalize ‘a kill pill’ for those who do not have an unbearable physical or mental disease, who decide for themselves when to end their life ... Our fear is that a ‘completed life law’ will put undue pressure on vulnerable people. We fear that our society will find it normal eventually that people who grow old take their own lives; that they will have to defend themselves if they choose to live rather than die.”⁸

Another consideration of the social dimension of PAS is that it inherently degrades the ethical principle of the dignity of all human beings. Dignity requires that we not be valued for what we are able to do but for the mere fact that we share a common humanity. Not surprisingly, the group that frequently registers the most vociferous opposition to the legal acceptance of PAS is the disability community. Many fear that the already tenuous human respect they sometimes receive from others will be further eroded by those who are given the power to determine the qualities of a “life unworthy of life,” words reminiscent of the euthanasia movement in Nazi Germany.⁹