Maryland Medicine
The Maryland Medical Journal Volume 17, Issue 4

Words Matter: It Is Still Physician-Assisted Suicide and Still Wrong

by Ira Byock, MD

Physician-assisted suicide is back on Maryland's political agenda. The End-of-Life Option Act was introduced in the Senate (SB 418) and House of Delegates (HB 404) last winter. All thirteen of the Senate bill's sponsors and all-but-one of the 41 House sponsors are Democrats. The message from supporters is that in common with women's rights, voting rights, gay marriage, and long-overdue raises to the minimum wage, it's only a matter of time before physician-assisted suicide becomes legal. After all, it is the right thing to do. Right?

I'm a life-long Democrat who supports all those other liberal causes, but I oppose physician-assisted suicide and I'd ask my fellow progressives to shine a cold hard light on this particular issue. Left-leaning voters have been the target of a decades-long branding campaign that paints hastening death as an extension of our personal freedoms. We should bring the same healthy skepticism to physician-assisted suicide that we do to claims of the safety of fracking, clean coal, and genetically modified food.

Groups such as Compassion and Choices, the organization spearheading SB 418 and HB 404 and similar bills elsewhere, skillfully employ marketing techniques that characterize political propaganda: Redefine words to mean what you want them to mean. Repeat key points until they acquire an unquestioned air of truth.

"Suicide" is distasteful, so they promote "physician aid-in-dying," "death with dignity," and the "right to die." And yet all of these mean taking action to end one's own life, the dictionary definition of suicide. The media has largely adopted the assisted suicide movement's terminology, so these euphemisms are worth unpacking here.

"Physician aid-in-dying" makes it sound like giving someone a lethal drug is an extension of hospice and palliative care. It is not. Palliative care physicians, such as myself, regularly aid people in dying by treating their symptoms and

supporting them through the difficult practical and emotional tasks of completing their lives. In more than 35 years of practice I have never once had to kill a patient to alleviate the person's suffering. When other measures fail, palliative sedation for alleviation of physical suffering is reliably effective. [1] Alleviating suffering is different than eliminating the sufferer. [2]

"Death with dignity" implies that frail or physically dependent people aren't already dignified. But they are. The UN Universal Declaration of Human Rights stipulates that all members of the human community are inherently dignified. People who are disabled, frail or facing life's end can be cared for in ways that allow them to feel respected, worthy and valued.

The phrase "right to die" is brilliant branding. You will not, however, find a right to physician-assisted suicide or euthanasia within the UN Declaration of Human Rights, nor the Magna Carta or U.S. Constitution. Americans have a constitutional right to refuse life-prolonging treatments. But there's a big difference between being allowed to die of your disease and having a doctor prescribe a medication for self-administration to intentionally end your life.

Supporters of bills like SB 418 and HB 404 repeatedly assert that legalizing physician-assisted suicide is not a slippery slope. Evidence, however, shows that reasons for dispensing life-ending drugs are changing.

In the 1990s proponents in Oregon campaigned to legalize physician-assisted suicide in cases of unrelievable physical suffering. Oregon Health Authority research, however, shows that over 70% of terminally ill patients who took doctor-prescribed drugs to end their lives didn't cite physical pain as a concern. The more-common issues were emotional or existential: loss of autonomy, inability to do things they enjoy, loss of dignity and feeling a burden to family and friends. [3]

One need only look at Belgium and the Netherlands to glimpse the future. In both countries suicide by self-administration of life-ending drugs and euthanasia by doctor-administered lethal injections have been available for several decades and are increasingly prevalent. According to the annual report from the Dutch Euthanasia Review Committees 3.9% of all deaths in the Netherlands were intentionally hastened, including 5,277 people who were euthanized by physicians. [4] Dutch people are being euthanized at their request by their public health system for non-terminal conditions which include chronic pain, tinnitus or blindness. In excess of 50 of those euthanized in 2015 suffered from psychiatric disorders. Many mentally ill patients who request

euthanasia suffer from personality disorders and socially isolation; depression, anxiety, post-traumatic stress disorders are common. [5]

Think it couldn't happen in the United States? Final Exit Network, one of other key groups supporting HB 404 and SB 418, has its mission to advance, "…the basic human right of competent adults to choose to end their lives on their own terms when they suffer from irreversible physical illness, intractable pain, or a constellation of chronic, progressive physical disabilities."

The movement is also pushing to expand the means of hastening death to lethal injections delivered by physicians. Dr. Marcia Angell, who regularly testifies in court cases and legislative hearings, wrote in favor of that in the New York Review of Books, "…after my husband's death, I have come to favor euthanasia as well, for home hospice patients in the final, agonal stage of dying, who can no longer ingest medication orally."[6] This is the practice in Netherlands and Belgium that the American assisted-suicide groups still claim won't happen here.

I share the sense of anger, urgency and frustration over the sorry state of end-of-life care. There is a legitimate fear of dying badly that fuels this movement. The Institute of Medicine's 2014 report, Dying in America, [7] detailed deficiencies in medical training and practice that contribute to needless suffering. It also lays out steps that healthcare and long-term care systems, insurers, medical schools, and policymakers can take to reliably resolve this crisis. SB 418 and HB 404 address none of those; the bills merely give doctors legal authority to prescribe medications that patients self-administer to end their lives.

The authors and supporters of SB 418 and HB 404's have good intentions. However, I believe that deliberately ending the lives of ill people represents a socially erosive response to basic human needs. If people on both sides of this issue can be remain civil and acknowledge the good intentions of those with whom we disagree, we can continue vigorously debating physician-assisted suicide while also getting constructive things done that would substantially improve care and the lives of people who are dying.

Progressive voters who support physician-assisted suicide should at the very least demand two important amendments to SB 418 and HB 404. First, medical schools must increase required curriculum in palliative care (to be at minimum on par with the hours devoted to obstetrics and neonatology) and test medical students' performance on managing pain and conducting conversations about serious illness before giving them a degree. Second, the Maryland Board of Physicians must institute tests of basic skills of pain management, communication, and shared decision-making, before licensing a

physician. Of course, while opposing SB 418 and HB 404, conservative voters should advocate for these measures as well.

Sponsors and supporters will worry about encumbering their bills. Many of us worry about the effects of their social engineering. If the legislature decides to grant doctors authority to write lethal prescriptions, how could lawmakers do any less?

Ira Byock, M.D., is founder and chief medical officer of The Providence Institute for Human Caring, based in Torrance, California. He is an emeritus professor of medicine at Dartmouth's Geisel School of Medicine and author of "Dying Well" and "The Best Care Possible."

References:

1. Quill TE, Byock IR. Responding to intractable terminal suffering: the role of terminal sedation and voluntary refusal of food and fluids. ACP-ASIM End-of-Life Care Consensus Panel. American College of Physicians-American Society of Internal Medicine. *Ann Intern Med.* 2000;132(5):408-414.
2. Byock I. The Case Against Physician-Assisted Suicide and Euthanasia. In: Younger SJ, Arnold RM, eds. *The Oxford Handbook of Ethics at the End of Life*: Oxford University Press; 2016:366-382.
3. Department OPH. Death with Dignity Act Annual Reports. 2016; https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx. Accessed September 25, 2016.
4. DyingForChoice.com. Netherlands - 2015 euthanasia report card. 2016; http://www.dyingforchoice.com/resources/fact-files/netherlands-2015-euthanasia-report-card. Accessed October 30, 2016.
5. Olie E, Courtet P. The Controversial Issue of Euthanasia in Patients With Psychiatric Illness. *JAMA.* 2016;316(6):656-657.
6. Angell M. May Doctors Help You to Die? . *The New York Review of Books*2012.
7. Approaching Death Co. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life.* National Academy of Sciences; 2014.