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The controversy continues and I once again find myself urging physicians to speak out against Physician Assisted Suicide (PAS) and Physician Assisted Death (PAD). Again the Hawaii legislature and even letters to the editor in the HMJ are raising the issues.

I found it interesting that the title of the article in last month's issue of the HMJ spoke of growing support of physician-assisted suicide. This was based on a survey sent to 2,079 physicians, resulting in a response of 224 of which a slight majority were in favor of PAS/PAD. I suppose if there are now 150 physicians in support, when there were only 115 in support four years ago, the support could be considered to have grown.

Support certainly isn't growing on a national level; four states outside of Oregon have voted on PAS and turned it down. Forty-six states have criminalized PAS. It is not growing in popularity. The people are solidly opposed to it.

Your Hawaii Medical Association continues to support the AMA policy opposing both PAS and PAD. We strongly support the various efforts to improve pain management and end-of-life care that will eliminate the horror stories of terminal suffering that we have all heard. In 1996 in the AMNews said it very well: *"Although for some patients it might appear compassionate to intentionally cause death, institutionalizing physician-assisted suicide as a medical treatment would put many more patients at serious risk for unwanted and unnecessary death. Rather than recognize any right to physician-assisted suicide, our society instead should recognize the urgent necessity of extending to all patients the palliative care they need to redouble our efforts to provide such care to all."*

The power to assist in intentionally taking the life of a patient is counter to and fundamentally incompatible with the physician's role as healer. It would be difficult or impossible to control, and would pose serious societal risks. It is a power that most health-care professionals do not want. A brief filed by the AMA holds that *"The right to control one's medical treatment is among the most important rights that the law affords each person. This includes the right to have unwanted life-prolonging treatment withheld or withdrawn and to have all medication necessary to alleviate physical pain, even where such medication would hasten death. Through these means, patients can avoid entrapment in a prolonged, painful, or overly medicalized dying process."*

The AMA and HMA firmly believe that the lower court was wrong in taking the unprecedented step of announcing a right to control the timing and manner of one's death through the use of PAS. The power to assist in intentionally taking the life of a patient is counter to the physician's central mission of healing. It is a power that physicians do not want and could not control if they had it.

The AMA brief concludes, *"The sentiment for physician-assisted suicide is not the right answer to the problem of inadequate*

care. Although for some patients it might appear compassionate to hasten death, institutionalizing physician-assisted suicide as a medical treatment would put many more patients at serious risk for unwanted and unnecessary death." Rather than recognize a right to physician-assisted suicide, the AMA asserts, *"We should recognize instead the urgent necessity of extending to all patients the palliative care they need and to redouble our efforts to provide such care to all."*

After attending a Bioethics seminar on End of Life issues, I came away with this thought. **"The difference between withholding Nutrition and Lethal Injection is the difference between letting die and killing."** To me this is the essence of the debate. Will we overthrow the teachings of the philosophers of the last 2000 years or will we hew to some new idea that physicians are to be the instruments by which an individual chooses to end his or her life? As for me, I will continue to support the concept that physicians preserve life as long as possible, while at the same time prevent suffering. If by giving a dose of MS adequate to relieve pain I cause respiratory failure, then so be it. The patient's disease has been the essential reason for the death, not my action. On the other hand, if I inject a lethal dose of KCl or knowingly prescribe a lethal dose of barbiturate for a patient, then I am the primary cause of the death of the patient. It is the *intention* for our actions that determines their ethical nature. If the state wishes to provide a methodology so that people can voluntarily end their own life for whatever reason, do so, but leave medicine out of it.

In *Decisions Near the End of Life* it is proposed that instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients cannot not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician's professional role. (2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychological or psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.

See *Letter to the Editor*, p.97

(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. Suffering may be caused by physical, psychological, social or spiritual causes. Treatment should be directed at the cause. (5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome the 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 and not be afraid to use adequate dosages for pain relief. All methods of relieving suffering short of directly causing death should be used.

As with so many other problems, education is the answer. Both education of our physicians and nurses who deal with dying patients, and education of our patients so that all present legal avenues are utilized to control their own dying process as much as is possible without crossing ethical and moral boundaries. I encourage all physicians to become more competent in end-of-life care so you will be comfortable when your favorite patient enters the dying process. After all is said, just remember that we are going to die under the same circumstances that we create for our patients today. To be able to deal with our patient's mortality, we, their physician, must have come to grips with our own mortality. That time will come for each of us.

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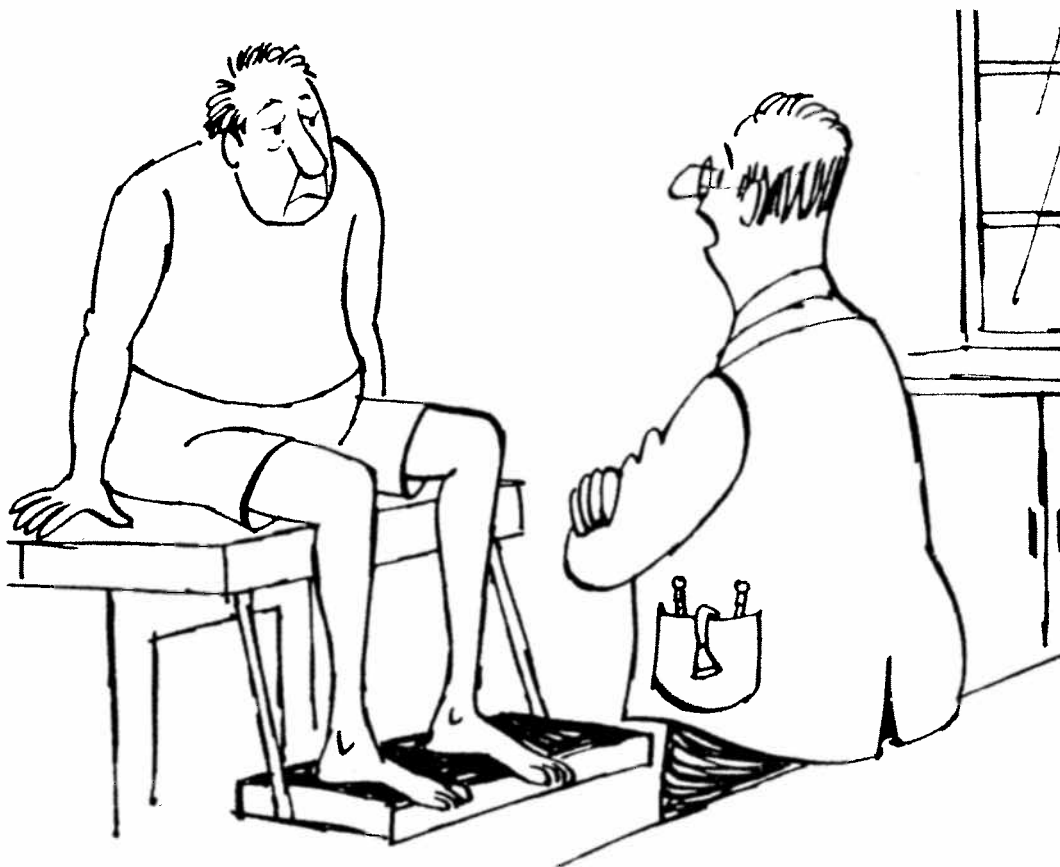
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