

# On Assisted Suicide, Going Beyond ‘Do No Harm’

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DURHAM, N.C. — Out of nowhere, a patient I recently met in my clinic told me, “If my heart stops, doctor, just let me go.”

“Why?” I asked him.

Without hesitating, he replied, “Because there are worse states than death.”

Advances in medical therapies, in addition to their immense benefits, have changed death to *dying* — from an instantaneous event to a long, drawn-out process. Death is preceded by years of disability, countless procedures and powerful medications. Only one in five patients is able to die at home. These days many patients fear what it takes to live more than death itself.

That may explain why this year, behind the noise of the presidential campaign, the right-to-die movement has made several big legislative advances. In June, California became the fifth and largest state to put an assisted suicide law into effect; this week the District of Columbia Council [passed a similar law](#). And on Tuesday voters in Colorado will decide whether to allow physician-assisted suicide in their state as well.

Yet even as assisted suicide has generated broader support, the group most vehemently opposed to it hasn't budged: doctors.

That resistance is traditionally couched in doctors' adherence to our understanding of the Hippocratic oath. But it's becoming harder for us to know what is meant by "do no harm." With the amount of respirators and other apparatus at our disposal, it is almost impossible for most patients to die unless doctors' or patients' families end life support. The withdrawal of treatment, therefore, is now perhaps the most common way critically ill patients die in the hospital.

While "withdrawal" implies a passive act, terminating artificial support feels decidedly active. Unlike assisted suicide, which requires patients to be screened for depression, patients can ask for treatment withdrawal even if they have major depression or are suicidal. Furthermore, withdrawal decisions are usually made for patients who are so sick that they frequently have no voice in the matter.

Some doctors skirt the question of assisted suicide through opiate prescriptions, which are almost universally prescribed for patients nearing death. Even though these medications can slow down breathing to the point of stoppage, doctors and nurses are very comfortable giving them, knowing that they might hasten a "natural" death.

In extreme cases, when even morphine isn't enough, patients are given anesthesia to ease their deaths. The last time I administered what is called [terminal sedation](#), another accepted strategy, was in the case of a patient with abdominal cancer whose intestines were perforated and for whom surgery was not an option. The patient, who had been writhing

uncontrollably in pain, was finally comfortable. Yet terminal sedation, necessary as it was, felt closer to active euthanasia than assisted suicide would have.

While the way people die has changed, the arguments made against assisted suicide have not. We are warned of a slippery slope, implying that legalization of assisted suicide would eventually lead to eugenic sterilization reminiscent of Nazi Germany. But no such drift has [been observed](#) in any of the countries where it has been legalized.

We are cautioned that legalization would put vulnerable populations like the uninsured and the disabled at risk; however, years of [data](#) from Oregon demonstrate that the vast majority of patients who opt for it are white, affluent and highly educated.

We are also told that assisted suicide laws will allow doctors and nurses to avoid providing high-quality palliative care to patients, but the data suggests the [opposite](#): A strong argument for legalization is that it sensitizes doctors about ensuring the comfort of patients with terminal illnesses; if suicide is an option, they'll do what they can to preclude it.

And, again, we are counseled that physicians should do no harm. But medical harm is already one of the [leading causes](#) of death — and in any case, isn't preventing patients from dying on their terms its own form of medical harm?

With the right safeguards in place, assisted suicide can help give terminally ill patients a semblance of control over their lives as disease, disability and the medical machine tries to wrest it away from them. In Oregon, of the exceedingly [few patients](#) who have requested a lethal prescription — 1,545 in 18 years — about 35 percent never uses it; for them, it is merely a means to self-affirmation, a reassuring option.

Instead of using our energies to obfuscate and obstruct how patients might want to end their lives when faced with life-limiting disease, we physicians need to reassess how we can help patients achieve their goals when the end

is near. We need to be able to offer an option for those who desire assisted suicide, so that they can openly take control of their death.

Instead of seeking guidance from ancient edicts, we need to re-evaluate just what patients face in modern times. Even if it is a course we personally wouldn't recommend, we should consider allowing it for patients suffering from debilitating disease. How we die has changed tremendously over the past few decades — and so must we.