

Going beyond ‘do no harm’: a critical annotation

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Submitted Sep 11, 2017. Accepted for publication Sep 14, 2017.

doi: 10.21037/apm.2017.09.08

View this article at: <http://dx.doi.org/10.21037/apm.2017.09.08>

The Op-Ed article in the *New York Times* (November 4th, 2016), “*On Assisted Suicide, Going Beyond Do No Harm*” by Haider Javed Warraich provides an articulate and timely plea for more widespread availability and application of physician-assisted dying, or “suicide”, as part of end-of-life (EOL) medical care. While this profound intervention should be considered by physicians and others as an option for those able to express their wishes at the EOL, it must be considered in the context of the ethical principles appropriate for all health care interventions and recognized for its limited role in the overall approach to compassionate care for terminally ill people.

Italicized text represents direct excerpts from the Warraich’s Op-Ed article: “*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...’*”

The inclusion by a patient or his or her spokesperson of goals, values, and preferences related to quality of life (QOL) in addition to, or at times instead of, survival and longevity is expected and inherent in the decision-making process for medical interventions of consequence, including those relevant to EOL issues.

“*...Death is preceded by years of disability, countless procedures, and powerful medications...*”

Significant trends in the patterns of dying are approached but over-generalized. While physician assistance in dying should be considered as an available option for selected cases, scenarios demonstrating these unfortunate features would be potentially prevented or at least more favorably influenced by patient and family-centered communication through the course of a serious illness and compassionate holistic EOL management directed toward the various issues causing distress at the EOL.

“*...yet even as assisted suicide has generated broader support, the group most vehemently opposed to it hasn’t budged: doctors...*”

National and international provider organizations have for the most part taken a stance against physician-assisted dying. The American Academy of Hospice and Palliative medicine (AAHPM—an interdisciplinary organization) has adopted a stance of “studied neutrality.” This involves an ongoing consideration of the merits and hazards while carefully studying and making recommendations regarding the clinical practices for optimal care to apply in those locations where legality has been established.

“*...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...*”

Providing care at the EOL is emotionally demanding. However, while withdrawal of an established intervention may feel different to the provider than, for example, the more clearly passive decision to withhold an intervention not yet started (e.g., a DNR order); years of reflection and analysis have supported the moral equivalency of these actions. “Foregoing” medical interventions is used as a term encompassing the concepts of withholding and withdrawing.

“*...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 they frequently have no voice in the matter...*”

Judging decisional capacity precedes a shared decision-making discussion for consideration of physician-assisted dying or withdrawal of life-sustaining intervention. Lack of decisional capacity precludes physician-assisted dying as currently defined. Much more common is the situation

where incorporation of a surrogate decision-maker provides a voice for the decisionally incapacitated patient, hopefully designated and guided by an advance directive. Patients who “ask for treatment withdrawal” must be deemed capable of participating in the decision-making process.

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

Once a shared decision-making process leads to a plan for withdrawal of life-sustaining interventions that are no longer leading to patient-desired outcomes, treatment—or more correctly expressed-care, of the patient is not withdrawn. Care is continued with newly established goals. Provision of palliative care assures maximum avoidance of suffering at the EOL. This can include the use of opioid and sedative medications delivered with the goal of patient comfort during the dying process. Death is recognized as inevitable but optimal symptom management is the goal, not deliberate hastening of the death. In fact, studies have shown that in such circumstances the time to death does not differ significantly when specialist-directed palliative care is used in this manner. The use of the term assisted suicide in reference to this practice is inappropriate and does not involve “skirting the issue.”

“...In extreme cases, when 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...yet terminal sedation, necessary as it was, felt closer to active euthanasia than assisted suicide would have...”

Anesthesia, terminal sedation, and active euthanasia are conflated into an inappropriate and misleading mishmash of words and constructs. None are relevant to the topic at hand.

“...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 illness; if suicide is an option, they’ll do what they can to preclude it...And, again we have 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?...”

Are we to understand that the presence of physician-

assisted dying as an option will spur otherwise reluctant clinicians to provide high-quality EOL care? This clinician-centered and perverse motivation is alien to practitioners competent in EOL care using shared decision-making to determine the goals, values, and preferences of an individual patient and then carrying out a plan consistent with these patient-centered factors.

“...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...”

After 18 years of the Oregon Death with Dignity Act, 125 people died in 2015 in Oregon as a result of ingesting medications provided by physician prescription. This represents approximately 3–4 of every 1,000 deaths in Oregon that year. The most important concerns expressed by those receiving prescriptions, whether eventually making use of it or not, were related to decreased enjoyment of life, impairment of a feeling of dignity, and diminished autonomy rather than intractable physical symptoms. Not available with the current data are the number of people considering a request for assisted-dying who do not formalize the request after discussion with a capable clinician experienced in EOL management.

“...Instead of using our energies to obfuscate and obstruct how patients might want to end their lives when faced with life-limiting illness, 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 they can openly take control of their deaths...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.”

Consideration by all as to their values and preferences with regards to health care and designating a spokesperson as part of an advance directive provides the basis for active participation in shared decision-making in the various circumstances that can be encountered during life and as death nears. These reflections and conversations combined with the availability of high quality palliative care and hospice services at the EOL is the most important component of “doing no harm”.

Acknowledgements

None.

Footnote

Conflicts of Interest: The author has no conflicts of interest to declare.

Cite this article as: Johnson RF. Going beyond 'do no harm': a critical annotation. *Ann Palliat Med* 2017;6(Suppl 2):S266-S268. doi: 10.21037/apm.2017.09.08