

# Assisted suicide, euthanasia, and the neurologist

The Ethics and Humanities Subcommittee of the American Academy of Neurology\*

Over the past several decades, it has become generally accepted that competent patients have the right and the responsibility to accept or reject medical treatments proposed by their physicians. Respect for patients' autonomy does not require that any and all decisions made by patients must be honored. A patient's right to refuse unwanted treatment must almost always be respected, but the rights of patients to request certain treatments may be limited by the requirements of good medical practice and by the legal and professional obligations of physicians to avoid taking any action to injure a patient, even if asked to do so.

The scope of patient autonomy has been gradually expanded, however, to the point where it has been argued that virtually *any* choice made by a patient must be accepted, regardless of the consequences. Recent years have seen growing acceptance of the notion that patients' rights include a "right to die" that implies that physicians should be permitted, or even obligated, to provide assistance to patients who wish to actively end their lives. These developments threaten to dramatically alter the most basic principles that have guided the professional behavior of physicians for centuries. These matters are of special concern to neurologists, whose patients (in chronic and unrelenting pain or with progressive debilitating diseases such as MS, Alzheimer's disease, or ALS) are among those for whom the choice of an "easy" death seems most compelling. Neurologists are likely to be asked to provide specific medical advice and effective means to enable patients to actively end their own lives or even to take some direct action with the intent of causing a patient's death.

As professionals dedicated to the welfare of their patients, physicians have always struggled with their sometimes conflicting obligations to respect and preserve life on the one hand and to strive to relieve pain and suffering on the other. Death, although accepted as inevitable and sometimes recognized as a "blessing," was not consciously sought as the *goal* of medical treatment. Nonetheless, it has long been understood that some actions taken to relieve suffering

might also have the effect of hastening death; such actions have traditionally been regarded as morally and ethically permissible as long as the intent of the physician has been to relieve suffering and not to directly cause the patient's death. The growing acceptance of the notion of a right to die implies that physicians must abandon this long-established principle and should be permitted, or perhaps even obligated, to assist in hastening the death of their patients. In recent years, many physicians, members of the public, and some courts have begun to reject the long-held distinction between permitting and causing patients' deaths and have concluded that therefore neither may be prohibited. The American Academy of Neurology affirms that a valid distinction can be made and that this distinction remains an important guide to the proper professional actions of physicians.

**Respect for autonomy.** Respect for patients' autonomy does not require that any and all decisions made by patients to accept, refuse, or request treatment should be honored. For patients' decisions to be valid, they must be based on an adequate understanding of the nature and consequences of the choice to be made (informed consent), the patients should be free of undue coercive influence, and patients must have the capacity to make a reasoned choice. In addition, the choice must not require that the physician act to intentionally harm the patient. If patients are unable to make their own choices, decisions may be made on their behalf by surrogates, ideally acting as the patients would act if they were able to do so.

It is understood that a patient (or surrogate) might reject a treatment as unduly burdensome, even when the effect of withholding or withdrawing the treatment might be to hasten the patient's death. Conversely, a patient might request a treatment that carries a great risk of harm or death but offers some hope of substantial benefit. Such actions have been accepted as morally and ethically permissible under the principle of double effect.

\* See the Appendix on page 598 for a list of Subcommittee members.

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**The principle of double effect.** The principle of double effect has a long and convoluted history in philosophy. Briefly, the principle recognizes that certain actions, morally or ethically acceptable in themselves, may have foreseeable but unintended undesirable consequences; the principle holds that the morality of a given action depends on the morality of the intended outcome, not on the unintended outcome. For the principle to be applicable, several conditions must be met. First, the action to be carried out must itself be morally or ethically acceptable or at least neutral. Second, the good effect of the intended action must not depend on the undesired or bad effect. Third, the good effect sought must be sufficient to justify the risk of the undesired outcome. The application of the principle is well illustrated by the well-known case of Karen Ann Quinlan. The parents of Ms. Quinlan (who was in a permanent vegetative state after an anoxic event) requested that mechanical ventilation be discontinued, even though they recognized and accepted that she might die as a result. They judged (on her behalf) that the ventilator was an unduly burdensome treatment that she would have rejected if she was able to do so. That Ms. Quinlan lived for nearly a decade after the ventilator was removed is eloquent evidence that the intended result (removal of a burdensome treatment) neither required nor depended on the unintended effect (her death).

Many persons, and several courts, have concluded, wrongly in our opinion, that there is no significant difference between permitting a patient's death (by withholding or withdrawing unwanted treatments) and intending a patient's death by providing or administering the means of death. It has also been argued that the intentions of physicians and their patients cannot always be clearly known and that therefore such intentions are of no consequence. Physicians have always known that any medical intervention carries risks; patients may be injured or even die as a result of any medical treatment. Good medical practice has always required that the risks and benefits of any proposed intervention should be carefully weighed and that decisions should be made on the basis of the intended outcome. The death of the patient has never before been generally accepted as the desired outcome of any medical treatment.

**Physician-assisted suicide.** Physician-assisted suicide occurs when a physician provides to a patient the medical means and the necessary knowledge to allow the patient to end his or her own life at a time of his or her choosing. Because of the negative connotations of violence and personal and family tragedy often associated with the term suicide, some now chose to refer to this practice as "physician-assisted death" or of "helping the patient to find death." Such euphemisms should not obscure the reality that the

intent of the physician's action is to enable the patient to kill himself or herself.

**Euthanasia.** The term "euthanasia" means a good or happy death; it has long been understood that death is not always an unmitigated evil and that it was possible to die well. In modern times, the term has acquired an additional meaning; an act or omission intended to cause the death of another person. The term "voluntary active euthanasia" is used to denote action taken to end the life of another person with that person's consent and approval. "Nonvoluntary active euthanasia" would be a similar action taken on the basis of a person's prior expressed wishes in the absence of a concurrent request (usually because of the person's incapacity). "Involuntary active euthanasia" occurs when such an action is taken in opposition to the known or expressed wishes of the person being killed. In these circumstances, the physician is the active agent who acts directly to cause the patient's death.

Some have used the term "passive euthanasia" to refer to the withholding or withdrawing of medical treatment that results in a patient's death. It should be clear that the term euthanasia is incorrect in this circumstance unless the *intent* of the action is that the patient will die as a result.

**Palliative care.** Palliative care is medical treatment offered to relieve pain and suffering rather than to cure disease or even to restore the patient to a condition of acceptable health. The American Academy of Neurology and the World Health Organization have defined the intent of palliative care as the achievement of the best quality of life for patients and their families. Although aggressive palliative care may sometimes have the effect of shortening the patient's life, the *intent* of palliative care is not to hasten or cause the patient's death. Palliative care must therefore be distinguished from euthanasia or physician-assisted suicide.

**Position statement.** The American Academy of Neurology joins with numerous professional medical societies and lay support organizations in vigorously opposing physician-assisted suicide, euthanasia, and any other actions by neurologists that are directly intended to cause the death of patients. Even if such actions by physicians should become legally acceptable, the Academy emphasizes that this will not make them morally or ethically acceptable ipso facto.

The Academy reaffirms its previously articulated positions that all patients should be treated with respect and compassion; that aggressive and effective palliative care should be provided to all patients who need and desire such care, even if such care might unintentionally hasten death; and that proper care of dying persons requires that assistance in living is as easily accessible as assistance in dying. In taking this position, the Acad-

emy affirms its obligation to speak in defense of the large number of cognitively impaired or otherwise vulnerable persons for whom its members care; such persons are at special risk to the allure of the "easy death" promised by the actions opposed by the Academy. The Academy does not accept the conclusion that the failures of society and of modern medicine to provide adequate compassionate care for the dying can be used as justifica-

tion for permitting physicians to hasten, or assist in hastening, the deaths of persons in their care.

#### **Appendix**

The following are the members of the Ethics and Humanities Subcommittee of the American Academy of Neurology: Thomas R. Pellegrino, MD; Richard Beresford, MD; James L. Bernat, MD (Committee Chair); David Goldblatt, MD; Michael P. McQuillen, MD; Robert Nelson, MD; Russell Snyder, MD; Robert Taylor, MD; and Alison Wichman, MD.