Physician's Role as Healer: American Medical Association's Opposition to Physician-Assisted Suicide

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SUICIDE

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There is a great deal of concern in this nation about the issue of physician-assisted suicide. It is important, in fact, incumbent upon the American Medical Association to spell out its position on this important issue. Just what is our position?

Simply put, we oppose it.¹ We believe that physician-assisted suicide is unethical.² It is fundamentally inconsistent with the pledge that physicians make to devote themselves to healing and to life.³ We believe laws sanctioning physician-assisted suicide serve to undermine the foundation of the patient-physician relationship, which is grounded in the patient's trust that the physi-

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cian is working wholeheartedly for the patient's health and welfare.

Some people, of course, will question why the AMA has any stance on this issue. After all, is it not simply a legal issue? Physician-assisted suicide is every bit as much an ethical issue as it is a legal one.4

Let me explain why we take a stand on this issue. Everyone in this room has heard of the Hippocratic oath.5 Yet, people question the relevance, in today's society, of an oath created twenty-four centuries ago. It is very important to understand why the Hippocratic oath is set aside as a demarcation from all of the pronouncements and utterances that physicians made for the eight millennia prior to it.

It is because Hippocrates tacitly acknowledged that there are three times when a patient is incredibly vulnerable during the interaction the patient has with the physician. First is when a physician asks that patient to provide information about their circumstances, which may be very personal, in order to arrive at a proper diagnosis of the patient's health. The second is when physician asks a patient to submit to an examination—the physical examination—in order to arrive at a diagnosis. And a third point is when physicians prescribe a course of treatment, either medication or surgical therapy.

In all three circumstances patients are incredibly vulnerable to the physician. What Hippocrates said was this: I swear that I will never take advantage of the vulnerable patient.6 I will keep all that is said in secret and confidence.7 I will never, ever seduce a patient8 and I will never give a deadly medicine or treatment...

4 See Dan W. Brock, Life and Death 164-66 (1993) (discussing ethical and legal concerns); see also James Rachels, Active and Passive Euthanasia, 292 N. Y. J. Med. 78, 80 (1975) (explaining how ethical considerations are being altered to adhere to legal conclusions).

5 See Ludwik Edelstein, The Hippocratic Oath: Text, Translation and Interpretation 2-3 (1943) (setting forth text of Oath in Greek and its translation in English).

6 See id. The Oath states that "I will keep [my patients] from harm and injustice." Id.; see also People v. Kevorkian, 527 N.W. 2d 714, 731 n.50 (Mich. 1994). The court notes that physician-assisted suicide has "traditionally been regarded as contrary to the Hippocratic Oath." Id.

7 See Edelstein, supra note 5, at 3. The Oath reads: "What I may see or hear in the course of the treatment . . . I will keep to myself . . ." Id.

8 See id. "[I will remain] free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons." Id.
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The American Medical Association believes this has served as the foundation, a tri-partite foundation, for the trust that has existed between patients and doctors for the past twenty-four centuries. That foundation is, in fact, a social contract.\(^9\)

Illustration of the importance of this trust can be found in a story about Alexander the Great. Alexander, as you know, conquered the then known world. History tells us that, as he was crossing Asia Minor on his way to engage Darius and the Persians, he fell ill. Since he was accompanied by his entire army, he had a full company of doctors to attend to his needs and those of his army.

But as it turned out, virtually all of those doctors were frightened to death at the possibility of being asked to attend to Alexander—they feared that if their remedies proved inadequate and Alexander were to die, they believed that the generals would kill them. Now, you talk about malpractice concerns!

Well, all of the doctors were afraid except one. A young man named Philip. Philip had treated Alexander before and believed he had a relationship with him. Therefore, he went to the King, examined him, and arrived at a diagnosis. Philip then went to his tent to compound some medication for Alexander.

Well, while he was gone someone slipped a note to Alexander that read: “Do not trust Philip, he is in the employ of Darius, and he will try to poison you.” Well, Alexander folded the note up and put it underneath his pillow. A few moments later, Philip walked in, pouring from one goblet to the other the medication he prepared for Alexander. Alexander took the goblet and gave Philip the note.

Philip read the note and, of course, was struck with consternation. He fell on his knees and said: “Oh, King, I don’t know why anyone would say such a thing. There is no truth to it. I certainly am loyal to you.” Whereupon Alexander took the goblet, drained it, put his hand on Philip’s shoulder and said: “You are my physician in whom I have complete trust.”

\(^9\) See id. “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.” Id.; see also AMA CODE OF ETHICS § 2.211. The Code states that “physician assisted suicide is fundamentally incompatible with a physician’s role as healer.” Id.

\(^{10}\) See Edelstein, supra note 5, at 60-64 (discussing evolution and free-will social acceptance of Oath).
History tells us that three days later Alexander was well enough to resume leading his armies. He eventually crossed Asia Minor and soundly whipped Darius and the Persians.

The importance of this story is to illustrate the value of the trust that exists between patients and doctors. Every time a doctor writes a prescription most patients do not know what it contains or how appropriate it is for the health condition that they may have. Every time an operation is recommended, most patients have not checked out the operating room or all the individuals who work there.

Instead, they rely upon their trust for their physician. The AMA feels that such trust is founded on that tri-partite commitment that I mentioned earlier. Now, having said that, we as the AMA also will say quite frankly that we listen to and we care about what the public is saying. It is not enough to simply come up with a well founded ethical, moral position about what is right and wrong in terms of what a physician does.

We understand and recognize the concern that the public is expressing to us and we intend to address that forthrightly. But we intend to address it in the way that we believe a profession should. We acknowledge that people are fearful of the possibility of pain that is not being treated properly. We acknowledge that people are fearful of the possibility of losing dignity, of the possibility of losing control, of being able to say it is enough—I do not want anymore care. We are acknowledging that people are fearful of losing the ability to decide whether to be a further burden on their family or loved ones. When people do request physician-assisted suicide if you take the time to inquire what it is they really are concerned about, almost invariably they do so for a definable cause which can be addressed.

Now, as a nation and as a profession we have done a great deal for the beginning of life. We have well baby care; prenatal care;

12 See Paul D. Simmons, Birth and Death: Bioethical Decision-Making 11-13
and neonatology. We have everything you can imagine to ensure that life begins happily and appropriately. Yet, we have done precious little about the end of life. We do have hospice, and hospice care, but even that is not supported in the fashion that it should.\footnote{13}

What the American Medical Association is saying is that the time has come for us, as a profession, to address the needs of our patients at the end of their lives in a meaningful, aggressive manner. How do we plan to do this? Well, we started a program that will train the vast majority of physicians in this country in appropriate end of life care.\footnote{14} We will do this by conducting a series of courses that invite physicians, starting with the leaders of American medicine from all over the country to central locations.\footnote{15} They will be given several days of instruction concerning aggressive palliative care. Specifically, they will learn the proper way to help patients create advanced directives so that their wishes can be followed as to when to pull the plug, cease artificial nutrition and hydration, etc. Also, they will be trained in how to teach other doctors. The objective is to train cohort after cohort and hope that those cohorts then return to their own communities and train others. The medical education community will be involved in making sure that new doctors are given


\footnote{14}{See J. Randall Curtis & Gordon D. Rebenfeld, Aggressive Medical Care at the End: Does Capitated Reimbursement Encourage the Right to Care for the Wrong Reason?, 278(12) JAMA 1025 (1997) (discussing problems of improving end of life care through directives and education); see also Gail Kinsey Hill & Mark O'Keefe, Measure 51: Doctor-Assisted Suicide Repeal, OREGONIAN, Nov. 2, 1997 (discussing Oregon's move to improve end of life before allowing physician-assisted suicide).}

\footnote{15}{See NHR: Medicine Gets Serious about Patient-Centered Care, US NEWSWIRE, Mar. 24, 1998 available in (reporting AMA conference provided information to medical educators enabling them to incorporate into their medical school curriculum study of end-of-life care).}
appropriate training in aggressive palliative care and how to take advantage of helping patients create advance directives. This is not an easy task, particularly if the doctor was never trained to help a patient create an advanced directive. That can be corrected, though, with education. It is our objective, over the course of the next five years, to continue to train cohort after cohort in this fashion.

We believe it is possible for people to have the same focus and attention and compassion exhibited at the end of life as is exhibited at the beginning of life. We also feel that this is the way our profession should respond to the needs of its patients, not by taking their lives. We believe it is far more preferable than simply saying: “Take these two tablets and don’t call me in the morning, because you won’t be here.”

Compassion, in our view, lies in caring, not in killing. It is true that even stars eventually die. But it is not for us to pull them from the sky before their time. Rather, let us focus our efforts on gently guiding their dissent, adhering to the same principles and showing the same compassion and the same concern that they enjoyed in their brightest days.

All of us, just like those stars, will die eventually. But the value of the human spirit must continue to be respected and must live on.