

What is the Proper Approach to the Terminally Ill Patient?

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The terminally ill patient poses a unique dilemma to the average physician. No longer able to “cure,” the doctor’s role is limited to palliative and other supplementary care. This is a difficult role for the doctor, who is used to being proactive, to heal. But it is perhaps one of the most important.

The Terminally Ill Patient Law focused the spotlight on the problem of how best to care for these patients and how to maximize their autonomy at a time so fraught with anxiety and emotional and physical dependency. In this issue of *IMAJ* Katz et al. [1] explain how the law, although well intentioned, is not sufficiently understood or implemented, a premise that is anecdotally supported by discussions the Israel Medical Association has had with its member physicians. When the law was first promulgated, we prepared a handbook for physicians in fields likely to encounter dying patients (such as oncology, internal medicine, etc.) in an effort to simplify the law for them.

The article reflects the importance of sitting with the patient and explaining his or her options in a clear, understandable fashion. While one patient may choose to decline further interventions, another may seek to optimize the quality of life remaining to him by means of pain relief, psychological, social and/or spiritual support and other measures. In fact, a

campaign launched in England in 2010 to engage the public on matters of death and bereavement showed that the absence of a conversation is the most important reason why people’s wishes go ignored or unfulfilled [2]. In Israel, another reason patients’ wishes sometimes remain unfulfilled may be the fact that the signed advance directives sit in the Ministry of Health and don’t reach those who will have to make a decision in real time whether or not to extend the person’s life [3]. This lack of conversation about the true needs and wishes of the patients can lead to information that is incomplete or (even subconsciously) influenced by the views of the caregiver or family members.

The recently proposed amendment to the TIPL sanctioning physician-assisted suicide throws a snag into an already complex and sensitive situation. Besides changing the paradigm of the physician-patient relationship, in which healing and sustaining life are the main constants, we are concerned that the proposed amendment will make it too easy for doctors to abdicate their responsibility to the patient in the face of the doctors’ own helplessness. We are concerned that it will make it too easy for patients to view suicide as their only option and to perhaps feel pressure – direct or, more likely, unintended – from their families to choose this option.

Those who support physician-assisted suicide often point to patient autonomy as the underlying rationale and determining value. And, indeed, patient autonomy is an integral and central principle in medical care. However, autonomy is not inviolable and cannot be viewed in isolation. As two opponents to physician-assisted

suicide have stated, “giving individual autonomy absolute priority runs roughshod over competing values, protections and needs and ignores the harmful effects on other people, societal institutions (the medical profession in particular) and the general community” [4]. Certainly it has a social impact on the way we view life and death and, as such, cannot be viewed solely as an individual decision or right.

Additionally, patient autonomy cannot and should not supersede physician autonomy. Although the law does provide a technical exemption for doctors who feel morally or otherwise incapable of carrying out the patient’s wishes, the minute the law allows for a patient to request of her physician to provide her with a prescription for life-ending means, the onus shifts to the physician and refusal to do so is liable to be interpreted as the provision of inferior care.

Another argument put forth to support the amendment is that it is already accepted in the world. In Europe, physician-assisted suicide is legal in four countries, and in the USA it is currently legal in three states [5]. The World Medical Association, the umbrella organization for over 90 national medical associations, has expressed, in several statements, its approach to the terminally ill patient in general and physician-assisted suicide in particular, which conforms to the current legislative situation in Israel. The WMA Statement on physician-assisted suicide, adopted in 1992 and revised in 2005, explicitly addresses this issue by asserting: “Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession.”

TPL = Terminally Ill Patients Law

WMA = World Medical Association

The WMA Declaration of Venice on Terminal Illness adopted in 1983 and revised in 2006 states:

The WMA condemns as unethical both euthanasia and physician-assisted suicide.” The statement continues by saying that “in the care of terminally ill patients, the primary responsibilities of the physician are to assist the patient in maintaining an optimal quality of life through controlling symptoms and addressing psychosocial needs and to enable the patient to die with dignity and in comfort...The patient’s right to autonomy in decision making must be respected with regard to decisions in the terminal phase of life. This includes the right to refuse treatment and to request palliative measures to relieve suffering...however, physicians are ethically prohibited from actively assisting patients in suicide.

The WMA Declaration on End-of-Life Medical Care (2011) gives more specific recommendations on what can be done to improve patient care during this medically and ethically difficult phase.

So, what can a physician do to reconcile between the ethically and publicly recognized value of life and the no less important value of patient autonomy? First, let us recognize that the main factors involved in a terminally ill patient’s desire to end his or her life often involve unbearable pain and depression [6]. Both of these are treatable conditions and every effort should be made to address them comprehensively. Second, true patient autonomy means involving the patient every step of the way. It requires a discussion within the medical community and society in general of how to increase access to good end-of-life care. And it requires a conversation with the individual patient about the range of options at the end of life [2].

The innate justification for allowing physician-assisted suicide is clear. No one, least of all a physician, wants another human being to suffer. But aside from the other difficulties raised, the option of physician-assisted suicide engenders a slippery slope. Although some maintain that legal and administrative safeguards prevent such scenarios, there is evidence to the contrary [3]. We must ensure that our weakest patients are not placed in untenable positions of having to make decisions they do not freely wish to make.

Finally, even among those who feel the patient should have the right to end his life in certain situations, this belief should not obligate physicians to take part and breach their ethical norms. Regardless of whether a physician has tools at her disposal to heal or not, her task is not to assist the patient in ending his own life. *Primum non nocere* must remain the physician’s guiding principle even where the line between what is helping and what is hurting has become faint.

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