THE NATIONAL CATHOLIC BIOETHICS CENTER
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August 10, 2017

Dr. Elliott Crigger, PhD
Secretary, Council on Ethical and Judicial Affairs
American Medical Association
330 N Wabash, Ste 43482
Chicago IL 60611-5885

Re: Potential Position of Neutrality on Physician-Assisted Suicide

Dear Dr. Crigger:

We are writing on behalf of The National Catholic Bioethics Center (NCBC) and the Catholic Medical Association (CMA) to ask the American Medical Association (AMA) to uphold its longstanding opposition to physician-assisted suicide, which is consistent with the Hippocratic tradition and the obligation of physicians to respect the ethical principles of justice and doing no harm.

The NCBC is a non-profit research and educational institute committed to applying the moral teachings of the Catholic Church to ethical issues arising in health care and the life sciences. The Center provides consultations to institutions and individuals seeking its opinion on the appropriate application of Catholic moral teachings to these ethical issues. The Center has 2,500 members (many of whom are institutional members representing thousands of persons) throughout the United States.

The CMA is a national, physician-led community of healthcare professionals that informs, organizes, and inspires its members, in steadfast fidelity to the teachings of the Catholic

Church, to uphold the principles of the Catholic faith in the science and practice of medicine. The CMA has a membership of 2,200 members and over 100 guilds nationwide. This mission is congruent with the values the Hippocratic tradition which the medical profession has asserted over the centuries. The proposed position of neutrality is a contradiction of this tradition.

As health care professionals, and those who provide bioethical consultation to them, we are intimately aware of the needs of persons experiencing end-of-life care issues. Ultimately, those needs can be addressed by expert palliative care, including physical, psycho-social, and spiritual care. Data from the Oregon Department of Health (the state with the longest experience with physician-assisted suicide), clearly indicate that fear of abandonment is the main reason for requesting physician-assisted suicide.[1] Pain and finances currently are the least frequent reasons for such requests.[2] However, there is growing evidence through analyzing reimbursement policies that providing the drugs for enabling physician-assisted suicide will be funded when treatment protocols are not.[3] In fact, data are clear that Oregon victims of physician-assisted suicide often have no health insurance or are covered only by Medicare or Medicaid (a total of 42.8%).[4] They are financially vulnerable populations, who again, under both the principles of justice and doing no harm, need our care and advocacy, not our assistance to kill themselves.

Increasingly, it is evident that, in countries that have legalized physician-assisted suicide, patient eligibility for physician-assisted suicide is no longer limited to competent adults who are terminally ill. Such eligibility now includes persons with cognitive and physiological impairments.[5] Furthermore, active euthanasia of persons, in which the administration of the lethal drugs is done by another, is allowed.[6] Informed consent is being eroded and, as evidenced in the Netherlands and Belgium, parents can consent to the assisted death of their children.[7] All of this should provide great concern for a profession charged with providing just and beneficent care to patients.

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[1] See Oregon Public Health Division, "Table 1. Characteristics and end-of-life care of 991 DWDA patients who have died from ingesting DWDA medications, by year, Oregon, 1998-2015," Oregon Death with Dignity Act 2015 Data Summary: Loss of autonomy (91.6%), loss of dignity (78.7%), and being a burden (41.1%) all equate to a fear of abandonment as a patient moves to an inevitable reliance on others. http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf.

[2] Ibid.

[3] Bradford Richardson, Assisted-Suicide Law Prompts Insurance Company to Deny Coverage to Terminally Ill California Woman," *The Washington Times* (Thursday, October 20, 2016). http://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den/.

[4] Op cit., Oregon Public Health Division.

[5] Rachel Aviv, "The Death Treatment: When should people with a non-terminal illness be helped to die?" Letter from Belgium, *The New Yorker* (June 22, 2015 Issue). http://www.newyorker.com/magazine/2015/06/22/the-death-treatment.

[6] Rachel Roberts, "Doctor who asked dementia patient's family to hold her down while she gave lethal injection cleared: Panel finds the doctor acted 'in good faith' in controversial case," *Independent* (February 5, 2017). http://www.independent.co.uk/news/world/europe/doctor-netherlands-lethal-injection-dementia-euthanasia-a7564061.html.

[7] "Under 12s have right to die: Dutch paediatricians," *Times Live* AFP (2015-06-19 14:32:10.0). http://www.timeslive.co.za/world/2015/06/19/Under-12s-have-right-to-die-Dutch-paediatricians; and Charlotte

False claims have been made by advocates for physician-assisted suicide that the taking of lethal medications by the terminally ill (and as evidence demonstrates, this has been extended to the non-terminally ill) is not an act of suicide. Furthermore, ethical distortions have been advanced asserting that physician-assisted suicide is no different than withholding or withdrawing disproportionality burdensome treatments, and can be justified under the Principle of Double Effect (PDE). No reputable ethicist can support such an assertion, which is inconsistent with the Hippocratic tradition.[8]

There is a clear distinction between physician "killing" and "allowing to die." In the first, the physician creates a pathology by the prescription of lethal drugs. In the second, the physician withdraws failed therapeutic interventions in the face of a preexisting fatal condition.[9] A critical criterion for invoking PDE is that the intended moral outcome (the alleviation of suffering) cannot be accomplished by means of the anticipated and intended immoral outcome (death of the patient). Unlike the use of pain control, or the withholding or withdrawing of disproportionately burdensome procedures, the very action of causing death through the writing of lethal prescriptions is the means and intended outcome, and not a side effect of physician-assisted suicide. And a physician cannot deny that by writing such a prescription that he or she is providing an essential circumstance to the death of a patient, and is intentionally cooperating in that death.

Furthermore, the U.S. Supreme Court has ruled that an assertion that there is no distinction between killing and allowing to die is "confused and mistaken."[10] The Supreme Court of New Mexico issued a similar finding in ruling that aid in dying (as physician-assisted-suicide laws are framed) is the same action as assisting in a suicide.[11] All cooperation in the "killing" of a patient requires an affirmative intervention by the health care provider, versus the refusal to intervene by cooperating in a disproportionately burdensome (to any realistic outcome) procedure.

One justification for proposing neutrality toward physician-assisted suicide by the AMA is that in states in which it is legal, and where physicians are willing to participate, moral dissonance will be created for those physicians. Once the health care professions accede to a moral framework for practice dictated by law, and not the profession, control over the professional standards is lost. Furthermore, trying to assuage a conscience inconsistent with the Hippocratic tradition, by altering the standards of that tradition, will result in the erosion of standards. When whatever is legal becomes ethical, eventually consciences become dulled and conscience protections for providers will be lost.

McDonald-Gibson, "Belgium Extends Euthanasia Law to Kids," *Time – World/ Brussels* (Feb 13, 2014). http://time.com/7565/belgium-euthanasia-law-children-assisted-suicide/.

[8] See Hippocrates, "The Hippocratic Oath: Text, Translation, and Interpretation," in O. Temkin and C.L. Temkin, eds., and I. Edelstein, trans., *Ancient Medicine: Selected Papers by Ludwig Edelstein* (Baltimore: Johns Hopkins University Press, 1967): 3-63.

[9] Daniel P. Sulmasy, "Killing and Allowing to Die: Another Look," *JAMA* 26:1 (Spring 1998), 56-64.

[10] *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

[11] *Morris v. Brandenberg*, S-1-SC-35478 NM S. Ct. (2016).

As health care providers, and those who advocate for ethical health care practice, we remain greatly concerned over the implications of the lack of autonomy of health care providers as evidenced in Vermont[12] as well as in Canada.[13] When something becomes legal, that does not necessarily equate to ethical, as time has demonstrated. Physicians are not vending machines, responsible for delivering services at the demand of a patient. There is nothing more likely to erode the autonomy of physicians and other providers to deliver just and beneficent care than an ethic that sees no limitations on what patient autonomy can demand of a health care provider.

There is so much at stake if the American Medical Association, which is not only an advocate for patients, but also for the integrity of the profession, takes a neutral position on physician-assisted suicide. It is well known that such a change in position caused the California enabling legislation to pass.[14] Our health care professions cannot abdicate their responsibilities to protect the most vulnerable from irreversible decisions such as an intended premature death. There are so many options for effective palliative care, even if the side effects of such care indirectly contribute to an earlier death. But to directly intend the end of a patient's life, and to cooperate in that death by providing the essential prescriptions to accomplish this intent, clearly is not the same as withdrawing or withholding disproportionately burdensome procedures, is the antithesis of good medicine, and eventually will erode the sacred trust between society and the medical profession.

Please retain your position of opposition to the legalization of physician-assisted suicide.

Sincerely yours,

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[12] Bradford Richardson, "Vermont doctors push back against assisted-suicide requirement," *The Washington Times* (Thursday, July 21, 2016). http://www.washingtontimes.com/news/2016/jul/21/vermont-doctors-push-back-against-assisted-suicide/.

[13] Lynn Wardle, "Canada's assisted suicide warning: Physicians' conscience rights at stake," *New Boston Post* (March 23, 2016, 6:37 EST). http://newbostonpost.com/2016/03/23/canadas-assisted-suicide-warning-physicians-conscience-rights-at-stake/.

[14] Kathy Robertson, "'Neutral' stance by doctors helped pave path to historic assisted-suicide law," *Sacramento Business Journal* (Oct 5, 2015, 2:43pm PDT). http://www.bizjournals.com/sacramento/news/2015/10/05/neutral-stance-by-doctors-helped-pave-path-to.html.