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**Editor's Note:** The narration and closed captions in this video are in English. For subtitles in 13 other languages, see this video on the website of the [**World Health Organization**](http://www.nejm.org/action/clickThrough?id=10300&url=http%3A%2F%2Fwww.who.int%2Fgpsc%2F5may%2Fhand_hygiene_video%2Fen%2F&loc=%2Fdoi%2Ffull%2F10.1056%2FNEJMclde1302615&pubId=40994955).

**Clinical Decisions**

**Physician-Assisted Suicide**

N Engl J Med 2013; 368:1450-1452[April 11, 2013](http://www.nejm.org/toc/nejm/368/15/)DOI: 10.1056/NEJMclde1302615

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**Audio Interview**

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Interview with Drs. Margaret Somerville and Nikola Biller-Andorno on their views on physician-assisted suicide. (20:45)

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**Case Vignette**

John Wallace is a 72-year-old man with metastatic pancreatic cancer. At time of diagnosis, the cancer was metastatic to his regional lymph nodes and liver. He was treated with palliative chemotherapy, but the disease continued to progress. Recently he has become jaundiced, and he has very little appetite. He has been seeing a palliative care physician and a social worker on an ongoing basis. His abdominal pain is now well controlled with high-dose narcotics, but the narcotics have caused constipation. In addition to seeing the social worker, he has also been seeing a psychologist to help him to cope with his illness.

Mr. Wallace has been married to his wife, Joyce, for 51 years, and they have three children and six grandchildren. He and his wife have lived in Salem, Oregon, for the past 23 years, and most of his family lives nearby. He understands the prognosis of the disease, and he does not wish to spend his last days suffering or in an unresponsive state. He discusses his desire for euthanasia with his wife and family members, and they offer him their support. The next day, he calls his physician and asks for information about physician-assisted suicide.

**Treatment Options**

Do you believe that Mr. Wallace should be able to receive life-terminating drugs from his physician? Which one of the following approaches to the broader issue do you find appropriate? Base your choice on the published literature, your own experience, and other sources of information.

To aid in your decision making, each of these approaches is defended in the following short essays by experts in the field. Given your knowledge of the patient and the points made by the experts, which option would you choose? Make your choice and offer your comments at NEJM.org.

* **Option 1**: Physician-Assisted Suicide Should Not Be Permitted
* **Option 2**: Physician-Assisted Suicide Should Be Permitted

Option 1 (201)

Option 2 (201)

Option 1

Physician-Assisted Suicide Should Not Be Permitted

J. Donald Boudreau, M.D., Margaret A. Somerville, A.u.A. (pharm.), D.C.L.

We recognize that a patient in Mr. Wallace's situation is in a state of grief. We appreciate his desire to be of sound mind at the end of his life and not to have to suffer as death approaches. We also recognize the obligations of physicians to respect a patient's refusal of treatment, to relieve pain and suffering, and to provide palliative care. However, we believe that the art of healing should always remain at the core of medical practice, and the role of healer involves providing patients with hope and renewed aspirations, however tenuous and temporary. Within the realm of palliative care, there exists a well-recognized paradox that one can die healed.[1](http://www.nejm.org/doi/full/10.1056/NEJMclde1302615#ref1) Physicians have a duty to uphold the sacred healing space — not destroy it. Therefore, physicians must hear Mr. Wallace's request for death but never carry it out.

Supporters of physician-assisted suicide justify their position by placing the value of individual autonomy above all other values and ethical considerations. 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.

Permitting physician-assisted suicide creates a slippery slope that unavoidably leads to expanded access to assisted suicide interventions — and abuses. Advocates of euthanasia deny that slippery slopes exist, arguing that legal constraints and administrative safeguards are effective in preventing them. But the evidence is clearly to the contrary, as the High Court of Ireland recently affirmed. In upholding the constitutionality of the prohibition on assisted suicide, the justices wrote, “. . . the fact that the number of LAWER (`life-ending acts without explicit request') cases remains strikingly high in jurisdictions which have liberalised their law on assisted suicide . . . speaks for itself as to the risks involved.”[2](http://www.nejm.org/doi/full/10.1056/NEJMclde1302615#ref2) Vulnerable communities in our societies — persons who are old and frail and those who are disabled or terminally ill — perceive themselves to be threatened.[3](http://www.nejm.org/doi/full/10.1056/NEJMclde1302615#ref3) Physicians must not be willfully blind to these serious dangers.

Many aspects of physician-assisted suicide breach physicians' long-standing ethical norms. For instance, the 2011 annual report on the Death with Dignity Act in Oregon shows that physicians were present at fewer than 10% of “assisted deaths.”[4](http://www.nejm.org/doi/full/10.1056/NEJMclde1302615#ref4) Why might they want to disconnect themselves from what they have enabled? Perhaps they have a moral intuition that intentionally facilitating or inflicting death is wrong. Patients expect an empathic presence from their physicians, and authentic healers commit to accompanying patients throughout the illness trajectory.

Referring to physician-assisted suicide as “treatment” is a new rhetorical tool that is used by the advocates of euthanasia. The goal is to make assisted suicide seem less alarming to the public and to promote the idea that legalizing the practice is just another small step along a path already taken and ethically approved. By intentionally confusing physician-assisted suicide with legitimate palliative care, pro-euthanasia advocates hope that the public will conclude that it is a medically and ethically accepted end-of-life treatment.[5](http://www.nejm.org/doi/full/10.1056/NEJMclde1302615#ref5)

For palliative care to remain a healing intervention, it cannot include “therapeutic homicide.”[6](http://www.nejm.org/doi/full/10.1056/NEJMclde1302615#ref6) Euthanizing and healing are intrinsically incompatible. Involvement of physicians in such interventions is unethical and harms the fundamental role of the doctor as healer.

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**Source Information**

From the Department of Medicine and Centre for Medical Education (J.D.B.), the Centre for Medicine, Ethics and Law (M.A.S.), and the Faculty of Medicine (J.D.B., M.A.S.), McGill University, Montreal.