Council Report

Decisions Near the End of Life

Council on Ethical and Judicial Affairs, American Medical Association

OVER the last 50 years, people have become increasingly concerned that the dying process is too often needlessly protracted by medical technology and is consequently marked by incapacitation, intolerable pain, and indignity. In one public opinion poll, 68% of respondents believed that "people dying of an incurable painful disease should be allowed to end their lives before the disease runs its course."[1] A number of comparable surveys indicate similar public sentiment.[2]

Since the turn of the century, there has been a dramatic shift in the places where people die. Sixty years ago, the vast majority of deaths occurred at home. Now most people die in hospitals or long-term care facilities. Approximately 75% of all deaths in 1987 occurred in hospitals and long-term care institutions,[3] up from 50% in 1949, 61% in 1958, and 70% in 1977.[4] This transition from the privacy of the home to medical institutions has increased public awareness and concern about medical decisions near the end of life. "Since deaths which occur in institutions are more subject to scrutiny and official review, decisions for death made there are more likely to enter public consciousness."[5]

The development of sophisticated life support technologies now enables medicine to intervene and forestall death for most patients. Do-not-resuscitate orders are now commonplace.[6] The Office of Technology Assessment Task Force estimated in 1988 that 3775 to 6575 persons were dependent on mechanical ventilation and 1 404 500 persons were receiving artificial nutritional support.[7] This growing capability to forestall death has contributed to the increased attention to medical decisions near the end of life.[5]

The Council has issued opinions on withdrawing and withholding life-prolonging treatment from patients who are terminally ill or permanently unconscious[8] and has also published reports concerning do-not-resuscitate orders,[9,10] euthanasia,[11] and withdrawal of life-prolonging treatment from permanently unconscious patients.[12] This report will reexamine the Council's existing positions and will expand the analysis to include physician-assisted suicide and withdrawing or withholding life-sustaining treatment for patients who are neither terminally ill nor permanently unconscious. The report will focus on competent patients in nonemergency situations. The issue of decisions near the end of life for incompetent patients is addressed in a separate report by the Council.[13]

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DEFINITIONS

The decisions near the end of life examined in this report are those decisions regarding actions or intentional omissions by physicians that will foreseeably result in the deaths of patients. In particular, these decisions concern the withholding or withdrawing of life-sustaining treatment, the provision of a palliative treatment that may have fatal side effects, euthanasia, and assisted suicide.

Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. At one time, the term *passive euthanasia* was commonly used to describe withholding or withdrawing life-sustaining treatment. However, many experts now refrain from using the term passive euthanasia.

The provision of a palliative treatment that may have fatal side effects is also described as *double-effect euthanasia.* The intent of the treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a foreseeable potential effect of the treatment. An example is gradually increasing the morphine dosage for a patient to relieve severe cancer pain, realizing that large enough doses of morphine may depress respiration and cause death.

Euthanasia is commonly defined as the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy. In this report, the term euthanasia will signify the medical administration of a lethal agent to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

Voluntary euthanasia is euthanasia that is provided to a competent person on his or her informed request. *Nonvoluntary euthanasia* is the provision of euthanasia to an incompetent person according to a surrogate's decision. *Involuntary euthanasia* is euthanasia performed without a competent person's consent. This report will not examine involuntary euthanasia further, since it clearly would never be ethically acceptable.

Euthanasia and assisted suicide differ in the degree of physician participation. Euthanasia entails a physician performing the immediate life-ending action (eg, administering a lethal injection). *Assisted suicide* occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

Discussions about life-ending acts by physicians often refer to the patient's "competence" or "decision-making capacity." The two terms are often used interchangeably. However, *competence* can also refer to a legal standard regarding a person's soundness of mind. *Decision-making capacity* signifies the ability to make a particular decision and is not considered a legal standard. "Competence" for the Council's purposes will mean "decision-making capacity."

The evaluation of a person's decision-making capacity is an assessment of the person's capabilities for understanding, communicating, and reasoning. Patients

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should not be judged as lacking decision-making capacity based on the view that what they decide is unreasonable.[14] People are entitled to make decisions that others think are foolish as long as their choices are arrived at through a competently reasoned process and are consistent with their personal values.

ETHICAL FRAMEWORK

Determining the ethical responsibilities of physicians when patients wish to die requires a close examination of the physician's role in society. Physicians are healers of disease and injury, preservers of life, and relievers of suffering. Ethical judgments become complicated, however, when these duties conflict. The four instances in which physicians might act to hasten death or refrain from prolonging life involve conflicts between the duty to relieve suffering and the duty to preserve life.

The considerations that must be weighed in each case are: (1) the principle of patient autonomy and the corresponding obligation of physicians to respect patients' choices; (2) whether what is offered by the physician is sound medical treatment; and (3) the potential consequences of a policy that permits physicians to act in a way that will foreseeably result in patients' deaths.

Patient Autonomy

The principle of patient autonomy requires that competent patients have the opportunity to choose among medically indicated treatments and to refuse any unwanted treatment. Absent countervailing obligations, physicians must respect patients' decisions. Treatment decisions often involve personal value judgments and preferences in addition to objective medical considerations. We demonstrate respect for human dignity when we acknowledge "the freedom [of individuals] to make choices in accordance with their own values."[15]

Sound Medical Treatment

The physician's obligation to respect a patient's decision does not require a physician to provide a treatment that is not medically sound. Indeed, physicians are ethically prohibited from offering or providing unsound treatments. Sound medical treatment is defined as the use of medical knowledge or means to cure or prevent a medical disorder, preserve life, or relieve distressing symptoms.

This criterion of soundness arises from the medical ethical principles of beneficence and nonmaleficence. The principle of *nonmaleficence* prohibits physicians from using their medical knowledge or skills to do harm, on balance, to their patients, while the principle of *beneficence* requires that medical knowledge and skills be used to benefit patients.

Generally, a treatment that is likely to cause the death of a patient violates the principle of nonmaleficence, and a failure to save a patient's life is contrary to beneficence. However, for these decisions near the end of life the patient does not consider his or her death to be an absolutely undesirable outcome.

Practical Considerations

Policies governing decisions near the end of life must also be evaluated in terms of their practical consequences. The ethical acceptability of a policy depends on the benefits and costs that result from the policy. In addition to the impact on individual cases (eg, patients will die according to their decision to have life supports withdrawn), there are likely to be serious societal consequences of policies regarding physicians' responsibilities to dying patients.

WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENT

The principle of patient autonomy requires that physicians respect a competent patient's decision to forgo any medical treatment. This principle is not altered when the likely result of withholding or withdrawing a treatment is the patient's death.[4] The right of competent patients to forgo life-sustaining treatment has been upheld in the courts (for example, *In re Brooks Estate*, 32 Ill2d 361, 205 NE2d 435 [1965]; *In re Osborne*, 294 A2d 372 [1972]) and is generally accepted by medical ethicists.[4]

Decisions that so profoundly affect a patient's well-being cannot be made independent of a patient's subjective preferences and values.[16] Many types of life-sustaining treatments are burdensome and invasive, so that the choice for the patient is not simply a choice between life and death.[7] When a patient is dying of cancer, for example, a decision may have to be made whether to use a regimen of chemotherapy that might prolong life for several additional months but also would likely be painful, nauseating, and debilitating. Similarly, when a patient is dying, there may be a choice between returning home to a natural death, or remaining in the hospital, attached to machinery, where the patient's life might be prolonged a few more days or weeks. In both cases, individuals might weigh differently the value of additional life vs the burden of additional treatment.

The withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and nonmaleficence. The physician is obligated only to offer sound medical treatment and to refrain from providing treatments that are detrimental, on balance, to the patient's well-being. When a physician withholds or withdraws a treatment on the request of a patient, he or she has fulfilled the obligation to offer sound treatment to the patient. The obligation to offer treatment does not include an obligation to impose treatment on an unwilling patient. In addition, the physician is not providing a harmful treatment. Withdrawing or withholding is not a treatment, but the forgoing of a treatment.

Some commentators argue that if a physician has a strong moral objection to withdrawing or withholding life-sustaining treatment, the physician may transfer the patient to another physician who is willing to comply with the patient's wishes.[4] It is true that a physician does not have to provide a treatment, such as an abortion, that is contrary to his or her moral values. However, if a physician objects to withholding or withdrawing the treatment and forces unwanted treatment on a patient, the patient's autonomy will be inappropriately violated even if it will take only a short time for the patient to be transferred to another physician.

Withdrawing or withholding some life-sustaining treatments may seem less acceptable than others. The distinction between "ordinary" vs "extraordinary" treatments has been used to differentiate ethically obligatory vs ethically optional treatments.[17] In other words, ordinary treatments must be provided, while extraordinary treatment may be withheld or withdrawn. Varying criteria have been proposed to distinguish ordinary from extraordinary treatment. Such criteria include customariness, naturalness, complexity, expense, invasiveness, and balance of likely benefits vs burdens of the particular treatment.[17,18] The ethical significance of all these criteria essentially are subsumed by the last criterion—the balance of likely benefits vs the burdens of the treatment.[17]

When a patient is competent, this balancing must ultimately be made by the patient. As stated earlier, the evaluation of whether life-sustaining treatment should be initiated, maintained, or forgone depends on the values and preferences of the patient. Therefore, treatments are not objectively ordinary or extraordinary. For example, artificial nutrition and hydration have frequently been cited as an objectively ordinary treatment which, therefore, must never be forgone. However, artificial nutrition and hydration can be very burdensome to patients. Artificial nutrition and hydration immobilize the patient to a large degree, can be extremely uncomfortable (restraints are sometimes used to prevent

patients from removing nasogastric tubes), and can entail serious risks (for example, surgical risks from insertion of a gastrostomy tube and the risk of aspiration pneumonia with a nasogastric tube).

Aside from the ordinary vs extraordinary argument, the right to refuse artificial nutrition and hydration has also been contested by some because the provision of food and water has a symbolic significance as an expression of care and compassion.[19] These commentators argue that withdrawing or withholding food and water is a form of abandonment and will cause the patient to die of starvation and/or thirst. However, it is far from evident that providing nutrients through a nasogastric tube to a patient for whom it is unwanted is comparable to the typical human ways of feeding those who are hungry.[18] In addition, discomforting symptoms can be palliated so that a death that occurs after forgoing artificial nutrition and/or hydration is not marked by substantial suffering.[20,21] Such care requires constant attention to the patient's needs. Therefore, when comfort care is maintained, respecting a patient's decision to forgo artificial nutrition and hydration will not constitute an abandonment of the patient, symbolic or otherwise.

There is also no ethical distinction between withdrawing and withholding life-sustaining treatment.[4,15,17] Withdrawing life support may be emotionally more difficult than withholding life support because the physician performs an action that hastens death. When life-sustaining treatment is withheld, on the other hand, death occurs because of an omission rather than an action. However, as most bioethicists now recognize, such a distinction lacks ethical significance.[4,15,17] First, the distinction is often meaningless. For example, if a physician fails to provide a tube feeding at the scheduled time, would it be a withholding or a withdrawing of treatment? Second, ethical relevance does not lie with the distinction between acts and omissions, but with other factors such as the motivation and professional obligations of the physician. For example, refusing to initiate ventilator support despite the patient's need and request because the physician has been promised a share of the patient's inheritance is clearly ethically more objectionable than stopping a ventilator for a patient who has competently decided to forgo it. Third, prohibiting the withdrawal of life support would inappropriately affect a patient's decision to initiate such treatment. If treatment cannot be stopped once it is initiated, patients and physicians may be more reluctant to begin treatment when there is a possibility that the patient may later want the treatment withdrawn.[4]

While the principle of autonomy requires that physicians respect competent patients' requests to forgo life-sustaining treatments, there are potential negative consequences of such a policy. First, deaths may occur as a result of uninformed decisions or from pain and suffering that could be relieved with measures that will not cause the patient's death. Further, subtle or overt pressures from family, physicians, or society to forgo life-sustaining treatment may render the patient's choice less than free. These pressures could revolve around beliefs that such patients' lives no longer possess social worth and are an unjustifiable drain of limited health resources.

The physician must ensure that the patient has the capacity to make medical decisions before carrying out the patient's decision to forgo (or receive) life-sustaining treatment. In particular, physicians must be aware that the patient's decision-making capacity can be diminished by a misunderstanding of the medical prognosis and options or by a treatable state of depression. It is also essential that all efforts be made to maximize the comfort and dignity of patients who are dependent on life-sustaining treatment and that patients be assured of these efforts. With such assurances, patients will be less likely to forgo life support because of suffering or anticipated suffering that could be palliated.

The potential pressures on patients to forgo life-sustaining treatments are an important concern. The Council believes that the medical profession must be vigilant against such tendencies, but that the greater policy risk is of undermining patient autonomy.

PROVIDING PALLIATIVE TREATMENTS THAT MAY HAVE FATAL SIDE EFFECTS

Health care professionals have an ethical duty to provide optimal palliative care to dying patients. At present, many physicians are not informed about the appropriate doses, frequency of doses, and alternate modalities of pain control for patients with severe chronic pain.[22] In particular, inappropriate concerns about addiction too often inhibit physicians from providing adequate analgesia to dying patients. Physicians should inform the patient and the family that concentrated efforts to relieve pain will be a priority in the care of the patient, since fear of pain is "one of the most pervasive causes of anxiety among patients, families and the public."[2]

The level of analgesia necessary to relieve the patient's pain, however, may also have the effect of shortening the patient's life. The Council stated in its 1988 report on euthanasia that "the administration of a drug necessary to ease the pain of a patient who is terminally ill and suffering excruciating pain may be appropriate medical treatment even though the effect of the drug may shorten life."[11] The Council maintains this position and further emphasizes that a competent patient must be the one who decides whether the relief of pain and suffering is worth the danger of hastening death. The principle of respect for patient autonomy and self-determination requires that patients decide about such treatment.

The ethical distinction between providing palliative care that may have fatal side effects and providing euthanasia is subtle because in both cases the action that causes death is performed with the purpose of relieving suffering. The intent of the former is to relieve suffering despite the fatal side effects, while the intent of the latter is to cause death as a means by which relief of suffering is achieved. Most medical treatments entail some undesirable side effects. In general, the patient has a right to decide either to risk the side effects or to forgo the treatment. It does not follow from this reasoning that a patient also has a right to choose euthanasia as a medical treatment for their suffering.

An important concern is that patients who are not fully informed about their prognosis and options may make decisions that unnecessarily shorten their lives. In addition, severe pain might diminish the patient's capacity to decide whether to choose a treatment that risks death. Caution when determining decision-making capacity in this situation, therefore, must be exercised, and patients should be fully informed.

EUTHANASIA

Euthanasia is the medical administration of a lethal agent in order to relieve a patient's intolerable and untreatable suffering. Whether or not a physician may use the skills or knowledge of medicine to cause an "easy" death for a patient who requests such assistance has been debated as early as the time of Hippocrates. Recently, euthanasia has been gaining support from the public and some in the medical profession. In the Netherlands, while physician-performed euthanasia remains illegal, physicians have not been prosecuted since 1984 when they follow certain criteria.[23] These criteria include that (1) euthanasia is explicitly and repeatedly requested by the patient and there is no doubt that the patient wants to die; (2) the mental and physical suffering is severe with no prospect for relief; (3) the patient's decision is well-informed, free, and enduring; (4) all

options for alternate care have been exhausted or refused by the patient; and (5) the physician consults another physician.[24] The frequency of euthanasia in the Netherlands has been estimated to range from 2000 to 20000 persons per year.[23] Recently, the first nationwide study of the practice of euthanasia in the Netherlands estimated the incidence of euthanasia to be 1900 persons per year.[25]

In the United States there has been growing public support for legalized euthanasia. The Hemlock Society, an organization dedicated to legalizing voluntary euthanasia and assisted suicide, has doubled its membership in the past 5 years to approximately 33000.[26] Recently, an initiative in Washington State that would have legalized euthanasia for terminally ill patients was put to a vote. Although the initiative was unsuccessful, 44% of the voters supported the initiative.[27]

Though the principle of patient autonomy requires that competent patients be given the opportunity to choose among offered medical treatments and to forgo any treatment, it does not give patients the right to have a physician perform a treatment to which the physician has objections. Though patients have a right to refuse life-sustaining treatment, they do not have a right to receive euthanasia. There is an autonomy interest in directing one's death, but this interest is more limited in the case of euthanasia than in the case of refusing life support.

The question remains whether it is ethical for a physician to agree to perform euthanasia. To approach this question one must look to the principles of beneficence and nonmaleficence and to the larger policy implications of condoning physician-performed euthanasia.

Can euthanasia ever constitute sound medical treatment? Any treatment designed to cause death is generally considered detrimental to the patient's well-being, and therefore unsound. However, proponents of euthanasia argue that euthanasia is a sound treatment of last resort for the relief of intolerable pain and suffering. From the perspective of competent patients who request euthanasia in the face of such suffering, death may be preferable, on balance, to continued life.

On the other hand, most pain and suffering can be alleviated. The technology of pain management has advanced to the point where most pain is now controllable. The success of the hospice movement illustrates the extent to which aggressive pain control and close attention to patient comfort and dignity can ease the transition to death.[22]

There may be cases, however, where a patient's pain and suffering is not reduced to a tolerable level and the patient requests a physician to help him or her die.[2,22] If a patient's pain and suffering are unrelievable and intolerable, using medical expertise to aid an easy death on the request of the patient might seem to be the humane and beneficent treatment for the patient.

However, there are serious risks associated with a policy allowing physician-performed euthanasia. There is a long-standing prohibition against physicians killing their patients, based on a commitment that medicine is a profession dedicated to healing, and that its tools should not be used to cause patients' deaths. Weakening this prohibition against euthanasia, even in the most compelling situations, has troubling implications.[28,29] Though the magnitude of such risks are impossible to predict accurately, the medical profession and society as a whole must not consider these risks lightly. Two noted ethicists have expressed the role of this prohibition:

> The prohibition of killing is an attempt to promote a solid basis for trust in the role of caring for patients and protecting them from harm. This prohibition is both instrumentally and symbolically important, and its removal would weaken a set of practices and restraints that we cannot easily replace.[17]

If euthanasia by physicians were to be condoned, the fact that physicians could offer death as a medical treatment might undermine public trust in medicine's dedication to preserving the life and health of patients.[30] Some patients may fear the prospect of involuntary or nonvoluntary euthanasia if their lives are no longer deemed valuable as judged by physicians, their family, or society.[30] Other patients who trust their physicians' judgments may not feel free to resist the suggestion that euthanasia may be appropriate for them.[30-32]

Another risk is that physicians and other health care providers may be more reluctant to invest their energy and time serving patients whom they believe would benefit more from a quick and easy death. Caring for dying patients is taxing on physicians who must face issues of their own mortality in the process, and who often perceive such care as a reminder of their failure to cure these patients.[4,15] In addition, the increasing pressure to reduce health care costs may serve as another motivation to favor euthanasia over longer-term comfort care.

Allowing physicians to perform euthanasia for a limited group of patients who may truly benefit from it will present difficult line-drawing problems for medicine and society. In specific cases it may be hard to distinguish which cases fit the criteria established for euthanasia. For example, if the existence of unbearable pain and suffering was a criterion for euthanasia, the definition of unbearable pain and suffering could be subject to different interpretations.

Furthermore, determining whether a patient will benefit from euthanasia requires an intimate understanding of the patient's concerns, values, and pressures that may be prompting the euthanasia request. In the Netherlands, physicians who provide euthanasia generally have a lifelong relationship with the patient and the patient's family, which enables the physician to have access to this vital information.[33] In the United States, however, physicians rarely have the depth of knowledge about their patients that would be necessary for an appropriate evaluation of the patient's request for euthanasia.

More broadly, the line-drawing necessary for the establishment of criteria for euthanasia is also problematic. If competent patients can receive euthanasia, can family members request euthanasia for an incompetent patient? Would it be acceptable for physicians to perform euthanasia on any competent individuals who request it? Furthermore, since it will be physicians and the state who ultimately answer these questions, value judgments about patients' lives will be made by a person or entity other than the patients.

Since it is unclear at this time where these lines should be drawn, the proposition of allowing euthanasia is particularly troublesome. A potential exists for a gradual distortion of the role of medicine into something that starkly contrasts with the current vision of a profession dedicated to healing and comforting.

Furthermore, in the United States there is currently little data regarding the number of euthanasia requests, the concerns behind the requests, the types and degree of intolerable and unrelievable suffering, or the number of requests that have been granted by health care providers. Before euthanasia can ever be considered a legitimate medical treatment in this country, the needs behind the demand for physician-provided euthanasia must be examined more thoroughly and addressed more effectively. A thorough examination would require a more open discussion of euthanasia and the needs of patients who are making requests. The existence of patients who find their situations so unbearable that they request help from their physicians to die must be acknowledged, and the concerns of these patients must be a primary focus of medicine. Rather than condoning physician-provided euthanasia, medicine must first respond by striving to

identify and address the concerns and needs of dying patients.

PHYSICIAN-ASSISTED SUICIDE

Physician-assisted suicide has only recently become the focus of public attention. In June 1990, Dr Jack Kevorkian assisted the death of a person with the use of a "suicide machine," which he invented. This case has been criticized by many for the irresponsible way in which it was carried out by the physician.[26] Kevorkian has since used his suicide machine to assist the suicides of two more persons. Last March, an article was published in the *New England Journal of Medicine* by a physician who described his role in assisting his patient's suicide.[34] The care and compassion evidenced by the physician and the reasoned decision-making process of the patient marked this account as truly compelling. Besides these very public cases of physician-assisted suicide, there is reason to believe that it has been occurring for some time.[2]

There is an ethically relevant distinction between euthanasia and assisted suicide that makes assisted suicide an ethically more attractive option. Physician-assisted suicide affords a patient a more autonomous way of ending his or her life than does euthanasia. Since patients must perform the life-ending act themselves, they would have the added protection of being able to change their minds and stop their suicides up until the last moment.

However, the ethical objections to physician-assisted suicide are similar to those of euthanasia since both are essentially interventions intended to cause death. Physician-assisted suicide, like euthanasia, is contrary to the prohibition against using the tools of medicine to cause a patient's death. Physician-assisted suicide also has many of the same societal risks as euthanasia, including the potential for coercive financial and societal pressures on patients to choose suicide. Further, determining the criteria for assisting a patient's suicide and determining whether a particular patient meets the criteria are as problematic as deciding who may receive euthanasia.

While in highly sympathetic cases physician-assisted suicide may seem to constitute beneficent care, due to the potential for grave harm the medical profession cannot condone physician-assisted suicide at this time. The medical profession instead must strive to identify the concerns behind patients' requests for assisted suicide, and make concerted efforts at finding ways to address these concerns short of assisting suicide, including providing more aggressive comfort care.

CONCLUSIONS

- The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
- There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
- Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
- Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great in this culture to condone euthanasia or physician-assisted suicide at this time.

References

1. Associated Press/Media General. *Poll No. 4*. Richmond, Va: Media General; February 1985.
2. Wanzer SH, Federman DD, Adelstein SJ, et al. The physician's responsibility toward hopelessly ill patients. *N Engl J Med*. 1989;320:844-849.
3. National Center for Health Statistics. *Vital Statistics of the United States, 1987, II: Mortality, Part A*. Washington, DC: US Public Health Service; 1990.
4. *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions*. Washington, DC: President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research; 1987.
5. Capron AM. Legal and ethical problems in decisions for death. *Law Med Health Care*. 1986;14:141-144.
6. Lipton HL. Do-not-resuscitate decisions in a community hospital. *JAMA*. 1986;256:1164-1169.
7. Office of Technology Assessment Task Force. *Life-Sustaining Technologies and the Elderly*. Philadelphia, Pa: Science Information Resource Center; 1988.
8. Council on Ethical and Judicial Affairs. *Current Opinions*. Chicago, Ill: American Medical Association; 1989:13.
9. Council on Ethical and Judicial Affairs. Do-not resuscitate orders: report B. In: Proceedings of the House of Delegates of the AMA; December 1987; Chicago, Ill:170-171.
10. Council on Ethical and Judicial Affairs. Guidelines for the appropriate use of do-not-resuscitate orders: report D. In: Proceedings of the House of Delegates of the AMA; December 1990; Chicago, Ill:180-185.
11. Council on Ethical and Judicial Affairs. Euthanasia: report C. In: Proceedings of the House of Delegates of the AMA; June 1988; Chicago, Ill:258-260.
12. Council on Ethical and Judicial Affairs and the Council on Scientific Affairs. Persistent vegetative state and the decision to withdraw or withhold life support: joint report. In: Proceedings of the House of Delegates of the AMA; June 1989; Chicago, Ill:314-318.
13. Council on Ethical and Judicial Affairs. Decisions to forego life-sustaining treatment for incompetent patients: report D. In: Proceedings of the House of Delegates of the AMA; June 1991; Chicago, Ill:261-269.
14. Buchanan AE, Brock DW. *Deciding for Others: The Ethics of Surrogate Decisionmaking*. New York, NY: Cambridge University Press; 1989.
15. *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying: A Report by the Hastings Center*. Briarcliff Manor, NY: Hastings Center; 1987.
16. Brock DW. Death and dying. In: Veatch RM, ed. *Medical Ethics*. Boston, Mass: Jones & Bartlett Publishing Inc; 1989.
17. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 3rd ed. New York, NY: Oxford University Press; 1989.
18. Lynn J, Childress JF. Must patients always be given food and water? *Hastings Cent Rep*. October 1983:17-21.
19. Ramsey P. *The Patient as Person*. New Haven, Conn: Yale University Press; 1970:113-129.
20. Schmitz P, O'Brien M. Observations on nutrition and hydration in dying patients. In: Lynn J, ed. *By No Extraordinary Means: The Choice to Forego Life-Sustaining Food and Water*. Bloomington, Ind: Indiana University Press; 1986.
21. Billings JA. Comfort measures for the terminally ill: is dehydration painful? *J Am Geriatr Soc*. 1985;33:808-810.
22. Rhymes J. Hospice care in America. *JAMA*. 1990;264:369-372.
23. de Wachter MAM. Active euthanasia in the Netherlands. *JAMA*. 1989;262:3316-3319.
24. Rigter H. Euthanasia in the Netherlands: distinguishing facts from fiction. *Hastings Cent Rep*. 1989:19(suppl):31-32.
25. Van der Maas P, van Delden J, Pijnenborg L, Looman C. Euthanasia and other medical decisions concerning the end of life. *Lancet*. 1991:338:669-674.
26. Gelman D, Springen K. The doctor's suicide van. *Newsweek*. June 18, 1990:46-49.
27. Merz B. Despite defeat of state's suicide initiative, issue still unsettled. *Am Med News*. November 18, 1991:29.
28. Sprung CL. Changing attitudes and practices in forgoing life-sustaining treatment. *JAMA*. 1990;263:2211-2215.
29. Lifton RJ. *The Nazi Doctors: Medical Killing and the Psychology of Genocide*. New York, NY: Basic Books Inc; 1986.
30. Kass LR. Neither for love nor money: why doctors must not kill. *Public Interest*. 1989;94:25-46.
31. Orentlicher D. Physician participation in assisted suicide. *JAMA*. 1989;262:1844-1845.
32. Kamisar Y. Some non-religious views against proposed 'mercy-killing' legislation. *Minn Law Rev*. 1958;42:969-1042.
33. Battin MP. Remarks at University of Florida Colleges of Medicine and Nursing conference: Controversies in the Care of the Dying Patient. Orlando, Fla, February 14, 1991.
34. Quill TE. Death and dignity: a case of individualized decision making. *N Engl J Med*. 1991;324:691-694.