COMMENTARY

Physician-Assisted Suicide and Euthanasia: Can You Even Imagine Teaching Medical Students How to End Their Patients' Lives?

J Donald Boudreau, MD

Abstract

The peer-reviewed literature includes numerous well-informed opinions on the topics of euthanasia and physician-assisted suicide. However, there is a paucity of commentary on the interface of these issues with medical education. This is surprising, given the universal assumption that in the event of the legalization of euthanasia, the individuals on whom society expects to confer the primary responsibility for carrying out these acts are members of the medical profession. Medical students and residents would inevitably and necessarily be implicated. It is my perspective that everyone in the profession, including those charged with educating future generations of physicians, has a critical interest in participating in this ongoing debate. I explore potential implications for medical education of a widespread sanctioning of physician-inflicted and physician-assisted death. My analysis, which uses a consequential-basis approach, leads me to conclude that euthanasia, when understood to include physician aid in hastening death, is incommensurate with humanism and the practice of medicine that considers healing as its overriding mandate. I ask readers to imagine the consequences of being required to teach students how to end their patients' lives and urge medical educators to remain cognizant of their responsibility in upholding long-entrenched and foundational professional values.

Humanism

If one accepts the definition of humanism as "a deep-seated personal conviction about one's obligation to others, especially others in need,"[1] its importance to medicine becomes incontestable. The literature is increasingly attentive to the roles of humanism in clinical practice.[2] In spite of the airtime devoted to the topic, little heed seems to have been paid to an issue, waiting in the wings, with the potential to reverberate at the very core of humanism in medicine. The issue is euthanasia. When I use the term *euthanasia* in this commentary, I am referring to "physician-inflicted death." In other words, I am asking the reader to consider a situation in which the physician is prepared to administer a lethal injection to a legally and factually competent patient who has given informed consent to the act. In many respects physician-assisted suicide raises many of the same ethical and professional issues as euthanasia because in both cases the physician is complicit in the patient's death.

There is extensive literature on the physician-assisted suicide debate. Proponents argue that physician-assisted suicide acknowledges the primacy of personal autonomy, promotes human dignity, and may represent a deeply humanizing act. Opponents raise the specter of the slippery slope, appeal to the notion that physicians must maintain an absolute repugnance to killing, and point out that autonomy and self-determination are rarely pressing concerns once people actually find themselves at the end of life.[3] This essay does not offer new empirical findings or a reconfigured conceptual framework for the debate. Rather, it anchors the dialogue explicitly in the educational context—a context in which there is a paucity of commentary on the interface of euthanasia with pedagogy. This contentious issue is not exclusively one of axiology. Pedagogic considerations are important. Regardless of which side of the argument one stands, an analysis of possible consequences on the professionalization of medical students and residents must not be neglected.

It is widely recognized that clinical educators contribute more to students' development than the acquisition of new knowledge and skills; they transmit values and participate in the forging of professional identities. They are "professionalizers." Collectively, they instill, insinuate, and instantiate a way of seeing, thinking, acting, and being in the clinical world. The socialization and

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formative process is powerful and pervasive; it leads inevitably to clashes for influence over the hearts and minds of learners. It is thus not surprising that a 2008 review on the teaching of humanism emphasized the importance of role-modeling of reflection and focused mentorships.[4] Students are required to delve into many issues that are permeated with personal values and situated within belief systems. Controversies such as abortion, reproductive technologies, alternative and complementary medicine—all of these and many more—can readily challenge entrenched explanatory models and worldviews. To that list has now been added the "right to a dignified death."

Right to a Dignified Death

Discussion of this topic has become prominent in the public squares of many communities. Two recent examples are the Death with Dignity Act in Washington State in the US and bill C-384 that was before the Canadian federal government in 2010. The latter, if enacted, would have legalized euthanasia, stating, "A medical practitioner does not commit homicide if he or she aids a person to die with dignity … ."[5] It was debated in the parliament—and defeated. Whether or not it is considered part of the formal curriculum, the topic of dying with dignity—its definition(s), clinical correlates, scope, access, moral dimensions, and political overtones—has become a salient feature of the ecology of medical schools.

Euthanasia

In Western societies—often described as secular, pluralistic, liberal, and tolerant—there is a predilection to equating assisted suicide with ensuring a "good" death. In contrast, for some members of the medical profession, a more apt synonym might be *assisted self-murder.* A source of conflict may be the word *euthanasia*. Some clinicians, frustrated with lack of semantic clarity, have recommended that it be abandoned.[6] Its meaning in English has evolved. The *Oxford English Dictionary* defines the noun as "a gentle and easy death."[7] The concept of euthanasia has fluctuated since it was used in writing by Suetonius, the Roman historian. In the 19th century, it came to be understood as "the care of the dying." An 1826 Latin manuscript referred to medical euthanasia as the "skillful alleviation of suffering."[8] The physician was expected to provide for conditions that would facilitate a gentle death and was admonished: "… and least of all should he be permitted, prompted either by other people's request or his own sense of mercy, to end the patient's pitiful condition by purposefully and deliberately hastening death."[8] Euthanasia made reference to a state—a condition—at the time of death. Recently, it has acquired the notion of performance—the act of inducing a gentle and easy death. Mirroring this evolution, the words *euthanize* and *euthanatize* have been coined and are newcomers in our lexicon. The first sample sentence given by the *Oxford English Dictionary* to illustrate the use of the transitive verb *euthanize* dates to 1975.[7] The notion of physician aid in dying has accreted to the word *euthanasia* through time; it stands at a considerable distance from the word's original meaning and intention. Given the plasticity and adaptability of language, one can foresee the eventual appearance of a new noun, one that will represent the individual who performs acts of euthanasia. I refer here to that person as a "euthanatrician." The term *euthanizer* has been used.[9] Other neologisms such as *euthanologist* or *euthanasist* may eventually prevail.

Few would argue against a death characterized by gentleness. The comments that follow thus revolve around *euthanasia* cloaked in its contemporary connotation, that of hastening death—death where, when, and in the manner the patient chooses, within the customarily accepted bounds of unremitting suffering, terminal illness, and informed and voluntary consent. It has been referred to as "requested death."[10] To advance the discussion, I am prompted to consider medicine's relation with the other end of the life cycle—birth. The paper by Cane refers to "euthanasia" as "obstetrics of the soul."[8] Although there are obvious limitations to the analogy of euthanasia as delivery of the soul, it may be useful in illustrating a critical distinction. It is self-evident that an obstetrician may facilitate and be a witness to birth; however, an obstetrician can now also induce labor and delivery. Similarly, the euthanatrician could, on one hand, limit the range of action to facilitating care of the dying patient or, on the other hand, extend the scope of interventions by applying strategies to induce death. The obstetrician has a relationship to life, just as our imagined euthanatrician might have to death.

Education of a Medical Act

What might the adoption of euthanasia *as a medical act* bring into medical education, and how might it influence the nurturing of humanism? The literature is sparse concerning this issue. One can ferret out empirical studies conducted to understand the perspectives of physicians.[11,12] The attitude of medical students

toward euthanasia has been aptly described.[13,14] Investigators in locations where physician-assisted suicide has been legalized have chronicled the experiences of professionals and institutions.[15,16] Not surprisingly, there are articles on the teaching of euthanasia in veterinary medicine.[17,18] However, consideration of consequences for medical education is largely absent from the literature. With the goal of consciousness-raising, I will suggest what these may consist.

Medical schools, which are expected to be socially responsive, would have to respond with targeted initiatives. Although one might anticipate residency education to be more directly affected, impacts throughout the education continuum can be anticipated. Modules in euthanasia would be proposed, and notwithstanding traditional arguments that curricula are overburdened with content, an academic home would be found. The process would necessitate the identification of specific objectives in knowledge, skills, and attitudinal domains. The call for integration of basic sciences (eg, physiology of dying) with clinical concerns (eg, advanced communication-skills training in end-of-life talk) would be inevitable. There would be negotiations between academic units for leadership, and bioethicists would be commandeered into service roles. Ethicists would surely be in demand to help uncover moral boundaries and, as is evident in veterinary medicine, be called on to negotiate ethical tensions.[19] Conceivably, internecine battles would erupt in certain institutions. Sources of conflicts and distress have already been outlined by a palliative-care team in a Swiss hospital.[20] Diametrically opposed viewpoints, even between colleagues within the same medical specialty, have been recorded in the peer-reviewed literature.[21,22]

For competency-based programs, there would be an impetus to clarify "competency" in euthanasia. Because this approach rests on a foundation of unambiguous, measurable, and enabling outcomes,[23] the idea of proficiency in expediting death would have to be explored. Leaders in undergraduate education would have to decide whether to accept it as a core competency and resolve whether medical students' responsibility should be confined to the communicative and decision-making process with patients and families or whether it should include procedural skills. If it were considered most appropriate to limit medical students' involvement to ethical discussions, clinical supervisors could in theory deploy emergent clinical practice guidelines. An eight-step approach of potential use to physicians facing requests for physician-assisted suicide has already been published.[24] One can foresee a need for addressing issues such as assessment of performance, level of competency in euthanasia based on levels of training, graded responsibility for resident teaching in the skill of "euthanizing," and requirements (eg, numbers of procedures observed and/or performed) for maintenance of competence. As unimaginable as these notions may appear, euthanasia could not—indeed should not—be exempt from standard discussions attendant to any new curricular objective. Parallel to the deployment of modified educational programs, the clinical discipline would become increasingly complex. It is hardly far-fetched to envision the emergence of evidence of best practices. Accreditation bodies would likely be subject to efforts by various stakeholder groups to formulate additional standards relating to physician aid in hastening death. Developments would inevitably mirror the experiences of academic institutions with respect to the issue of abortions. For example, the Accreditation Council for Graduate Medical Education has set forth guidelines mandating that residencies in obstetrics and gynecology must include learner experiences in induced abortion.[25] The Association of Professors of Gynecologists and Obstetricians has listed abortion as a core objective for medical students.[26] A long-established volunteer group, Medical Students for Choice, has successfully lobbied academic centers to expand abortion training.[27]

A New Corpus?

Finally, as preposterous as it may appear at first glance, credentialing bodies might be pressured to confer recognition on a new corpus. Given the unceasing pressure for specialization, the profession might witness the birth of a new discipline. I refer to it here as "euthanatrics." The notion of a new specialty for assisting in death is not an original concept; in an argument in favor of conferring the responsibility for euthanizing on the legal profession, it was called "legistrothanatry."[28]

Laws legalizing euthanasia and/or physician assistance in dying have been enacted in the US in Oregon, Washington, and Montana and in the Netherlands and Belgium. Early reports of the impacts of evolving jurisprudence have identified areas of concern. One account examining the transcript of a conversation between a patient requesting assisted suicide and her physician identifies lacunae in the consent-seeking process.[29] A formal assessment by the Dutch Ministries of Health and Justice of their 2002 law recommended

that "[p]hysicians should be further educated on the effects and side effects of morphine and benzodiazepines so that they can *select the correct medicines* if life termination is the envisaged objective"[15] (emphasis added). In the report's "Quality Improvement" section, the regional euthanasia review committees are described as having the option of inviting physicians whose adherence to standards of due care are deemed lacking for an "instructive talk."[15] Although this is a somewhat overbearing reformulation of formative feedback, it does presage quality-assurance issues that the profession will be required to address if obliged to prepare itself for delivery of services related to physician-assisted suicide.

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Is this trajectory toward euthanatrics desirable? Do we wish to embrace a discipline that has the induction of death as one of its defining clinical acts? How would undergraduate programs, such as the one I am affiliated with, currently renewing itself on the assumption that the primary mandate of medicine is healing,[30] reconcile its foundational premise with the goal of physician-assisted suicide? As much as the original conception of euthanasia—the skillful relief of suffering—is harmonious with an emphasis on healing, its evolving meaning is (arguably) in conflict. I would predict that many physicians would recoil at the prospect of being called on to become authentic role models for euthanatricians. Attempts at integrating "intentional hastening of death" into the clinical methods taught in many schools might call their cohesive force into question. For example, at our school two of the desired behavioral characteristics of the healer include "presence" and "accompaniment."[31] In the context of physician-assisted suicide, would these attributes then come to be seen as facultative or of secondary importance? To accept euthanatrics and much of what it entails (eg, the obligation to select the correct medication for life termination) as core content risks undermining the curriculum's conceptual framework. This development has the potential to erode commitments to whole-person care, which many believe includes the potential for a transformational, perhaps transcendental, movement toward personal integrity—even in the face of death.

Healing and Euthanizing—Miscible?

My personal belief is that healing and euthanizing are simply not miscible. I believe it to be expressly true in medical schools, which are crucibles of professional identity formation. However, it must be acknowledged that divergent viewpoints exist. For example, it is intriguing that the institutional motto for the medical school of the Oregon Health & Science University is "Where healing, teaching and discovery come together."[32] Though it is located in a US state with legislation that permits physician-assisted suicide, and presumably the school's programs have addressed issues related to Oregon's Death with Dignity Act, it continues to fly the banner of healing. This situation points either to the existence of alternative perspectives or to conflicting values (the latter perhaps unrecognized or ignored). The presence of ethical tensions within hospices in Oregon, as they face the challenge of respecting the Death with Dignity Act while simultaneously striving to adhere to their institutional values, has already been documented.[33] It is therefore not a flight of fancy to speculate that similar tensions may be experienced by members of the academic community in that jurisdiction. Regardless of one's personal beliefs, it is incumbent on medical educators to consider the consequences of teaching euthanasia—that is, as the word is understood today—of teaching an act intended to hasten death.

Surely, all readers would agree that we need to teach *eu*-thanasia, euthanasia as described in 1826: compassionate, competent, and consummate care of the dying. A more debatable point is: To what extent should we, as a profession inextricable from humanism, travel down the road toward euthanatrics? Responses to this question must take into account both professional and personal values.

Undeniably, physicians endorsing pro-euthanasia legislation have honorable intentions, motivated by humane considerations grounded in prima facie ethical principles such as respect for dignity (even though there are deeply conflicting views on what such respect requires). Whatever the views in this regard, it is nonetheless plausible that proponents of euthanasia may be blind to unintended harmful consequences, especially at institutional and societal levels. What would legalizing physician-assisted suicide do to the institutions of medicine and law, to the medical profession, and to fundamental societal values, in particular respect for each individual human life and human life in general? Ethicist Margaret Somerville has argued that in secular societies, medicine and law are the principal carriers of these values. She describes the medical profession and its related institutions as "value-creating, value-carrying and consensus-forming for society as a whole"[34] As a consequence, it should be obvious

that we share a profound obligation to consider the implications of our actions on this value-laden system. In the case of legalized physician-mediated suicide, harm may be done to the profession and to those charged with replenishing its membership.

A physician's assistance in suicide can indeed be construed as helping the patient: helping in the sense of being an ally in the patient's quest to fulfill personal goals, or helping by buttressing individual autonomy. However, there are also features of such action that can be qualified as harmful: harmful by sowing confusion in trainees about the conceptual core of traditional clinical methods, or harmful by eroding respect for absolute moral values such as "do not kill."[35]

The phrase *primum non nocere* is greatly cherished by the profession. It is the first "golden rule" that we transmit to our junior colleagues. Another related but less well known phrase, used by medical luminaries such as Thomas Syndenham[36] and James Makittrick Adair[37] is *juvantia et laedenti*. It is derived from the Latin verbs *iuvo* ("help") and *laedo* ("hurt"). I propose that in our deliberations about euthanasia, we keep in our collective imagination the notion of *juvantia et laedentia*: "things that [can] help and things that [can] harm." ❖

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Mercy

Lord Verulam [Sir Francis Bacon] blames physicians for not making the euthanasia a part of their studies: and surely though the recovery of the patient be the grand aim of their profession, yet where that cannot be attained, they should try to disarm death of some of its terrors, and if they cannot make him quit his prey, and the life must be lost, they may still prevail to have it taken away in the most merciful manner.

— Commentaries on the History and Cure of Diseases*, Ch 51, William Heberden, 1710-1801, English physician*