Doctors can't predict time of death, so how can they aid in suicide (Opinion)

The medical profession has adhered to codes of ethics since the 5th Century BCE. They have included the Oath of Hippocrates and the Oath of the great teacher/philosopher/physician Maimonides.

Seven years after America was founded, in 1803, Thomas Percival introduced our country's first medical ethics standards. These codes were adopted by the AMA in 1847 and have been revised continuously.

What has never changed is the requirement that physicians focus 100% of their efforts on healing.

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Physicians are terrible at predicting death. At six months out, fewer than 33% of predictions end up being correct. HB 140, the medical aid in dying bill, relies on the physician informing patients of their life expectancy.

If we can't do that with even a 50% accuracy, how can we be asked to help them decide to commit suicide instead of seeking additional treatment or palliative care?

The myth that physicians can provide a speedy and pain-free death needs to be confronted with the reality of the evidence. Nothing in our training teaches us how to help people kill themselves. There are no courses in medical school, no CME's, no conference lectures, no journals and no controlled experiments to guide us.

We are trained to heal, not to harm, and certainly not to kill. The American “experiment” with physician-assisted suicide, begun in Oregon, and wrongly adopted by a minority of other states, shows that the average time to death is 2 hours, but has been as long as 140 hours.

Data says 10% of these people vomit up the drugs they took, 2% awaken from their comas, and 33% took 30 hours to die. In addition, 25% were depressed, yet only 2% were ever referred for psychiatric treatment.

And, there is a “contagion effect.” Oregon’s overall suicide rate is now 40% above the US average. “Normalizing” suicide is not a message this legislature should send to the teenagers of our great state.

Pro HB144: Take a stand and protect health care workers

Already over 40,000 people kill themselves annually and do this without involving physicians. Clearly, there is no great need to corrupt the medical profession by encouraging doctors to be handmaidens of self-inflicted death!

The most recent revision of the AMA Code of Medical Ethics, Section 5.7, specifically addresses the topic. It says: “PAS occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable a patient to perform the life-ending act. Permitting physicians to engage in assisted suicide would ultimately cause more harm than good. PAS is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.”

Instead, physicians must aggressively respond to the needs of patients at the end of life. Physicians should not abandon a patient once it is determined that cure is impossible; must respect patient’s autonomy; must provide emotional support and communicate effectively; and must provide comfort care and appropriate pain control.

Creation of a strong end-of-life system is long overdue. Legislative leaders can emphasize proper access to palliative care and hospice. In that strong system, it is critical that the medical profession redouble its efforts in providing optimal treatment at the end-of-life to limit suffering, both physically and psychologically. Together, we can foster real conversations about end of life using tools like the Delaware Medical Orders for Scope of Treatment. Patients and their loved ones can form a plan that allows the patient to die peacefully, with dignity, and without taking drastic measures.