To the Editor:

Attorney Kathryn Tucker’s guidance in an issue of CHEST (July 2012) for physician aid in dying is troubling. A citation error was apparent in a reference to the Expert Consensus Statement of the Heart Rhythm Society (HRS) regarding withdrawal of cardiovascular implantable electronic devices (CIEDs). Tucker wrote, “Provision of aid in dying does not constitute assisting a suicide or euthanasia.” The HRS statement reads, “Ethically, CIED deactivation is neither physician-assisted suicide nor euthanasia.”

CIED deactivation is not aid in dying, and the HRS statement said why: “The clinician’s intent is to discontinue the unwanted treatment and allow the patient to die naturally of the underlying disease - not to terminate the patient’s life.” This reaffirms a half century of understanding in medical ethics that withdrawal of undesired care is just that and not aid in dying.

Per Tucker, “Principles of autonomy that underlie respecting patient rights...to request pain medication even if it advances time of death support the choice for aid in dying.” Providing medication doses that might hasten death is not equivalent to giving them because they will do so. Even autonomy has its limits.

Tucker again appears to misapply the HRS CIED statement. “A clinician cannot be compelled to provide treatment that conflicts with his or her personal values. In these circumstances, the clinician cannot abandon the patient but should refer the patient to a colleague who is willing to provide the service.” The issue was CIED removal. Refusal to aid a suicide request is not abandonment, and referral for it is morally equivalent to providing the aid in dying. Requiring it violates three federal statutes protecting conscience rights.

Tucker asserted, “Modern medicine can extend the dying process so long that some terminally ill patients may find the process unbearable.” The reality of aid in dying scenarios is rarely this dramatic, and exceptional cases make for bad guidelines. The claim of unbearable process refutes futile care rather than arguing for aid in dying, and futile care is preventable under existing guidelines by patients and their surrogates without violating any profession, legal, or moral precepts.

Compassion means to come along side and suffer with, not to aid patients in self cessation. Terminal patients have well-defined needs: Treat depression, loneliness, and pain, and death wishes abate. Palliative care and aid in dying are at odds: A clinician cannot be both patient advocate and assistant in dying. The conflict of interest is insurmountable.

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References

Response

To the Editor:

Dr Van Mol misunderstands the reference to the consensus statement regarding deactivation of cardiovascular implantable electronic devices in my recent article in CHEST. The statement is cited not to suggest device deactivation is aid in dying, but as an example of how medical practice in an evolving arena benefits when such a statement or clinical practice guidelines are promulgated, offering guidance on an emerging practice. It is timely for guidelines to emerge regarding the practice of aid in dying, which has been openly available for 15 years in Oregon and more recently in Washington, Montana, and Hawaii. It is likely to become more widely available nationwide as the consensus grows that the option harms no one, galvanizes improved communication and care for all terminally ill patients, and offers a peaceful death to the relatively few patients who choose it. The consensus is based on evidence. Health professionals who embrace evidence-based medicine, including the American Public Health Association, have carefully examined evidence from Oregon and have concluded that the availability of aid in dying poses no danger and offers a desired choice for some patients; accordingly, the association adopted policy supportive of aid in dying. Other national medical organizations have also done so. Physicians willing to provide this compassionate option to patients experiencing a dying process they find unbearable, despite excellent pain and...