Physician-Assisted Suicide: Against Medical Neutrality

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To the Editor:
Clayville and Miller misrepresent our article. We do not argue for the "radical autonomy of physicians," but against the "radical autonomy of patients." Rejecting the latter does not imply the former. Physician autonomy, in our view, is not absolute, but is constrained by the internal morality and rationality of medicine, the common good, and by the particularity and individuality of patients. Pitting the patient against the physician in a contest of competing autonomous wills is exactly the approach that we reject. Medicine is best understood as a joint project undertaken by health care professionals in conjunction with patients towards a shared goal of healing and prevention.

We *do* argue that all patients have intrinsic value, but this value is not, as Clayville and Miller would characterize it, "subjective." Rather, the intrinsic value of all persons is the bedrock upon which respect for patients and their particular values and preferences rests. It is out of respect for the intrinsic value of the sick that medicine has its moral warrant to provide care in the first place. It is this value, which is anything but subjective, that the legalization of physician-assisted suicide (PAS) subverts.

We agree with Clayville and Miller that hospice care is given in teams and that hospice workers often get to know patients well. However, even if many patients who elect assisted suicide are enrolled in hospice, the fact remains that one in four hospice patients are enrolled for fewer than five days, which is hardly enough time to develop an intimate relationship.[1] Moreover, PAS is frequently prescribed by physicians who have never met the patient. For example, between 2001 and 2007, 23% of lethal prescriptions in Oregon were written by just three physicians.[2] One California physician devotes his entire practice to PAS, belying the idea that PAS is an extension of long-term, intimate, patient-physician relationships.[3] Moreover, it is not uncontrolled symptoms, but loss of meaning, loss of independence, being tired of living, and fears of burdening others that drive requests for PAS.[4, 5] Even under ideal conditions, no physician, *qua* physician, can claim the expertise needed to evaluate such matters and render a judgment that a patient's suffering has become unbearable and warrants death.

It is for these reasons, among others that we detailed in our article, that we hold that PAS has no place in medical practice, that organized medicine ought to continue to oppose its legalization, and that the permissiveness implied by so-called neutrality ought to be rejected.

Sadly, our dear colleague Dr. Richard Payne, of Duke University, expired after this manuscript was accepted. May he rest in peace.

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Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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