Ten physicians sit around the polished conference table, talking earnestly, each visibly uncomfortable. The subject is physician-assisted suicide; the goal to provide ethical guidance on the subject for a large and influential organization of physicians. On some aspects of the topic, there is consensus. We agree that comfort and palliation should always be provided, and that such care should, for most patients, erase the need to consider suicide. We also agree for the most part that there are convincing moral and ethical arguments against physician-assisted suicide. And yet, there is profound hesitation to state that, as a matter of public policy, physician-assisted suicide should be considered a criminal offense.

It is not a matter of colleagues protecting other colleagues who act wrongly. Rather, there is a profound sense of respect for and humility in the face of others’ suffering and the moral obligation of the physician to alleviate suffering as much as possible. And there is awareness that for all our knowledge about palliation, pain is not the only or even the most important issue in many patients’ interest in suicide.

And so we struggle. Many of us carry within us a story of a patient or a family member, a story that will not allow us the comfort of uniform condemnation of a practice whose wrong or rightfulness seems to rest so completely on the particulars. The committee is caught within the tension between philosophical arguments about physician-assisted suicide as a matter of policy, and the character of physician-assisted suicide as a phenomenon of private lives and relationships. Physicians must live within this tension whenever a patient asks “can you help me?”

1. PRIVATE RELATIONSHIPS, PUBLIC CONSEQUENCES

It is not difficult to identify the egregious situations that engender wholesale rejection of physician-assisted suicide. The *deus-ex-machina*-like interventions of Kevorkian, for instance, bear no resemblance to clinical medicine provided in the context of a durable and committed, doctor–patient relationship (Quill, 1995). Yet, even in situations where
the relationship apparently exists, as in the Netherlands, some find evidence of a slippery slope from limited application to less cautious and perhaps less patient-initiated assisted euthanasia (Henk and Welie, 1992). Still others have pointed out that, whether or not the data demonstrate abuse, legal affirmation of access to physician-assisted suicide is immoral because it fundamentally contradicts and undermines the role of the physician as healer (Singer, 1990). To most physicians, such arguments convincingly override those advocating permissiveness toward physician-assisted suicide, whether they are based on grounds of autonomy or on comparability to withholding life-sustaining treatment (Brock, 1992). Yet, many of those same physicians are loathe to recommend statutory intrusion into this aspect of doctor–patient decision making.

One explanation for this reluctance is the physician–patient relationship itself. Physicians who distinguish between themselves and Dr. Kevorkian, yet who publicly advocate for permission to engage in physician-assisted suicide, emphasize the centrality of a meaningful physician–patient relationship to any such decision. Indeed, the relationship that is a sine qua non of justifiable physician-assisted suicide also may provide the best protection against unwarranted choice of such a path (Quill, 1992). A physician who knows the patient well can identify factors such as depression, cognitive change, or external stresses, including inadequate pain management, which might lead the patient to request assistance in dying, however contrary to his or her own stated values or interests. In such instances, the fact that the physician is not a priori opposed to physician-assisted suicide lends credibility to his or her efforts to dissuade a patient from an irrevocable decision at a particular moment of frustration or remediable misery. Appropriate management of pain and disability is the first duty of the physician, no matter what else follows. Yet fear of legal intrusion into the relationship, whether through monitoring of prescribing practices or investigation of means of death, may nevertheless prevent some physicians from treating the patient optimally. The appropriate management of pain blurs into the management of death.

2. MANAGING PAIN, MANAGING DEATH

Barely 70, she lies quietly, day after day. Although cancer cells originating in her breast now eat at bone everywhere, morphine and