We have read with deep appreciation the comments by Dr Leonard Bernstein in the guest editorial entitled “Changing the Physician Mindset” published in Volume 78 Issue 1 of the Caribbean Medical Journal. This is undoubtedly a growing global issue that profoundly affects the healthcare professional and we therefore support his call for an open and honest discussion of this topic within the fraternity. Please allow us to share our thoughts on this matter from a bio-ethical perspective.

Religious views may often conflict with well-accepted practices in healthcare; this is poignantly evident in cases related to end-of-life decisions [1]. Physician-assisted death (PAD) is one of the most debated issues in bioethical as well as ecclesiastical circles. It is therefore remarkable when a religious and social activist, such as Archbishop Desmond Tutu of South Africa, publicly announced on his 85th birthday that he supported the option of physician-assisted death [2]. Although the terms euthanasia and assisted suicide may be slightly different, they are being interchangeably used to describe the mode of ending a life without prolongation of the process of dying with an ultimate goal of preventing suffering [3]. Herein exists a conflict of a healthcare professional’s ethos who is morally bound with the responsibility to preserve human life on the one hand and the ethical requirement of preventing human suffering on the other [4]. The core debate surrounds the ethical as well as the legal perspectives of physician assisted suicide, with the understanding that not all legal perspectives may be ethical and vice versa.

Firstly, in modern medicine, patients are enabled to make decisions regarding their interventions, according to the ethical principle known as autonomy [5]. Research into empirical relationships between autonomy and quality of life outcomes after healthcare interventions have clearly demonstrated significant improvements in patient satisfaction and mental health, when patients were well informed and made personal choices about their healthcare [6]. Assisted death for a patient with a terminal illness should also be considered as a medical option chosen by the patients or surrogates by the principle of ‘autonomy’. This intervention, when explained in detail to the patient and relatives, and chosen by them by their own will, has the potential to improve their overall satisfaction. This may conform to the ethical theory of Buber, where the so-called “I-THOU” relationship is established, wherein physician
exhibits ‘caring and compassion’ for the patient and relatives.

Secondly, legalization of assisted death may potentially address the second ‘pillar’ of medical ethics - ‘justice’. A statute will facilitate clear formulation of guidelines and regulations, which can be implemented when a decision is made to pursue this option for a given patient. It has been well documented that terminally ill patients are more likely to commit suicide because of frustration, depression and guilt [7]. In the absence of an assisted mode, patients have chosen to shoot or hang or poison themselves, which may augment their intense suffering before death [8]. Hence it may be argued that legalization of assisted-death to patients with terminal diseases can potentially decrease the likelihood of self-inflicted suffering and also provide safe means to end their misery. The ethical theory of Mill espouses the concept that the ‘numbers’ benefiting from an intervention must be greater than the situation of not having the intervention. Legalization of PAD may well conform to this theory, since more and more patients with terminal illnesses can chose this option and physicians may not have the hesitation to undertake this intervention. The third pillar of medical ethics is ‘beneficence’. Implementation of PAD should address ‘beneficence’ by preventing patients and relatives undergo immense pain and suffering before the inevitable happens. Terminally ill patients are at risk of developing many psychological derangements including depression, anxiety and delirium, which negatively impact both on them and their family [9]. Transferring the task of caring for the terminally ill patients to non-medical persons including relatives has been shown to cause both physical and psychological burnout [10]. By legalizing assisted-death, these patients can be provided with an opportunity of dignified passing that would remove the burden from relatives in dealing with such a difficult situation. Kantian ethical theory considers the ‘absolute value’ of a person to be important. Opponents of physicians-assisted death argue that legalization of this intervention may make this an easily available medical option, which may be abused by other patients who may not be terminally ill in the real sense. This is however not supported by statistics. In the state of Oregon in USA, assisted death was legalized in 1997. In 2015, this mode of death accounted for only 38.6 per 10,000 deaths; additionally patients who chose this option were required to undergo rigorous assessment and approvals.
before the procedure was allowed [11]. Furthermore, preventing access to this option due to the fear of abuse may be contrary to Buber’s theory of ethics, reducing the physician-patient relationship to “I-IT”, where patients are seen as a ‘case with disease’, not a suffering human. Dissident opinion also consider PAD to be violating the ‘sanctity of life’ as ascribed by religious bodies. If one considers the 2.7 million animals that are euthanized every year in the USA alone by charitable organizations on so-called ‘humanitarian grounds’ [12] and the 56 billion that are farmed exclusively for food [13], the morality associated with the concept of ‘sanctity of life’ is highly questionable. Sanctity of life cannot be only for humans, and certainly the suffering of animals is a more compelling moral issue, both in numerical and philosophical terms. It is an unjust action with an anthropocentric perspective as if only human life is sacrosanct, while animal life can be sacrificed. Finally, there is also a misconception of the opponents of PAD, likening it to ‘torture’ of patients, with an unsubstantiated claim that they are being starved and dehydrated until death. The prototype legislation in Oregon that has been used as a model for other regions, specifies the type of institution, counselling requirements, the grade of physician and the characteristic of the patient that qualifies for PAD [14]. PAD option is available only to the terminally ill patient with no chance of any recovery. PAD (and its legal access) is thus a paradigm based on well-researched and scientific principles; the view that it is akin to ‘torture’ is quite illogical. Thus, preventing access to this dignified medical option for patients who are really suffering, would remove goodwill and empathy from patient care. (Again, I did not want to bring back Kant here, which we already mentioned previously) In summary, healthcare professionals are constantly faced with a challenging dilemma of deciding between the apparently conflicting needs to preserve human life and prevent suffering. While it is well understood that it is an extremely difficult decision to make, ultimately it is the decision that should rest with the patients, their relatives and the healthcare teams, who must engage in discussions in an honourable manner within the legal framework. We also understand that our viewpoint may not be exhaustive to cover every aspect of PAD, we sincerely hope that this may add material to the local discussion on this matter.

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References: