END OF LIFE CARE

All end-of-life choices and medical decisions have complex psychosocial components, ramifications, and consequences that have a significant impact on the suffering and the quality of living and dying. However, medical end-of-life decisions are often the most challenging for terminally ill patients and those who care about them. Each of these decisions should ideally be considered in terms of the relief of suffering and the values and beliefs of the dying individual and his or her family.

RESPECT FOR AUTONOMY

The principle for respect for autonomy acknowledges the right of patients to have control over their own life, including decisions about how their life should end. Thus, a competent person should be able to refuse life-saving treatment in both current situations and future foreseeable situations.

BENEFICENCE

The duty of beneficence, that is to act in a way that benefits the patient, is an important ethical principle in health care. In treatment decisions at the end of life the dilemma often revolves around what course of action will be in the patient's best interests. It is difficult to see how death can be a benefit or in the patient's interests, but in some circumstances, if existing quality of life is so poor, or treatment is very burdensome, then the balance of harms and benefits may suggest that continuing treatment is not a benefit to the patient.

NONMALEFICENCE

The concept of nonmaleficence - an obligation not to inflict harm intentionally, is distinct from that of beneficence - an obligation to help others. In codes of medical practice the principle of nonmaleficence has been a fundamental tenet. However, in the context of health care it can sometimes be difficult to comply with this principle depending on the definition of harm. Many medical treatments may have harmful side effects but save or improve lives. In end of life decisions the question of how much harm is caused by the treatment needs to be considered, and whether death itself is always a harm.

SUPPORT FOR ASSISTED SUICIDE

Medical arguments contend that competent terminally ill patients wishing to choose assisted suicide may feel abandoned by physicians who refuse to assist. The criticism that doctors agreeing to assist in suicide would be violating the Hippocratic Oath is refuted on several grounds. First, the original Oath prohibiting killing also prohibited abortions, surgery, and charging teaching fees, all of which have been modified to meet contemporary realities. Second, assisted suicide does not involve the ending of life by a physician, as it is the dying person himself who takes the steps to end his life. Third, the Oath requires physicians to take all measures necessary to relieve suffering, and some interpret this to include assisted suicide when that is the only way suffering can be relieved.

OPPOSITION OF ASSISTED SUICIDE

Medical arguments against assisted suicide include the possibility of misdiagnosis, the potential availability of new treatments, and the probability of incorrect prognosis. Because medicine is fallible and research is ongoing,

incorrect diagnoses may result in unnecessary requests for assisted suicide or in requests that are carried out just before the introduction of a new treatment that could prolong life. Another medical argument is that requests for assisted suicide may indicate that improved palliative care and better psychosocial support are needed. Finally, it is argued that physicians are barred from helping persons to die because of the Hippocratic Oath, which states that doctors should not kill.