

The Debate of Physician-Assisted Suicide:

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A fundamental aspect of human life is the realization that death is inevitable. Whether sudden or expected, young or old, there will be a time in which each individual takes their last breath. Because death is such a universal idea, it has been explored more and more over the years in finding ways to prolong it, cope with it, ease the pain, and even shorten it. Physician-assisted suicide has been a controversial topic in health care, with debate for and against this process. It has always been expected for the role of the physician to do no harm; but supporters of physician-assisted suicide will describe how it can be means of carrying out the patient's wishes. The analysis of the slippery slope argument will provide evidence that legalization itself does not lead to acceptance of euthanasia. Palliative care has developed to play a crucial role in relieving suffering and is not impeded upon by the legalization of physician-assisted suicide. Lastly, the medical field has placed a monumental amount of emphasis on autonomy, both from the patient and physician perspective which recognizes control of one's own body. It is with these arguments that one can justify the legalization of physician-assisted suicide.

Legalization

Physician-assisted suicide was first introduced in the United States in 1994 in Oregon at state level law, approved by voters and later enacted in 1997 as the Death with Dignity Act, allowing for a competent adult to self-administer a fatal dose of medication prescribed by a physician (Ganzini & Back, 2016). In Oregon, from legalization until 2014, physician-assisted suicide accounted for the death of 859 Oregonians (Ganzini, 2016). This rate has increased slightly; jumping from 0.6 in 1000 deaths to 3 in 1000 deaths from the year 1998 to 2014 (Ganzini & Back, 2016). When comparing this to European nations, in 2013, Switzerland reported 11 in 1000 deaths whereas Belgium reported 46 in 1000 deaths (Ganzini & Back, 2016).

In 2001 the Netherlands legalized physician-assisted suicide and became the first country to legalize euthanasia, quickly influencing other European countries to follow suit.

Terminology

The medical field has made extraordinary strides in advancement over the years, ranging from vaccine development, anesthesia, organ transplants, and medical imaging such as x-rays. A more recent, almost forgotten, advancement would be physicians' involvement at the end of life. As this idea becomes more understood, it also brings with it a dilemma. Physician involvement has been seen as a continuum, starting with establishing care to control symptoms while educating families to plan for end-of-life goals, developing into withholding technology that is able to extend life, ranging from the prescription of sedation to self-administered drugs to quicken death, and even granting a patient's request to administer the drugs to accelerate the dying process (Quill, Back, & Block, 2016). The terminology behind this topic is many times inconsistent so it is necessary to fully understand each definition. Euthanasia is a broad term that is easily broken down into two categories, passive euthanasia and active euthanasia. Passive euthanasia refers to the action of withdrawing or withholding any life-sustaining process at the end of life whereas active euthanasia refers to a medical specialist's intentional act of ending a life through medical aid (Potter, 2019). Active euthanasia can be further broken down into three categories which is dependent upon the patient's willingness. Voluntary active euthanasia occurs when a patient consciously decides to request a physician to end their life, most common among terminal patients that have unbearable suffering (Potter, 2019). Non-voluntary active euthanasia occurs when a patient cannot explicitly request themselves, mainly among patients whom are incapacitated or in a vegetative state (Potter, 2019). Lastly, involuntary active euthanasia occurs when a patient specifically requests to not undergo euthanasia but the physician continues

anyway (Potter, 2019). Overall, euthanasia refers to the direct physician action of ending a life. This is distinctly different from physician-assisted suicide which refers to a physician indirectly allowing a patient to end their own life. The American Medical Association (2021) defines physician-assisted suicide as “when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act” (p.1). The main way to differentiate this from euthanasia is that the patient ultimately administers the fatal medication prescribed by the physician rather than the having the physician be the direct cause of the death through their action (Goligher et al., 2017). Although euthanasia and physician-assisted suicide are distinctly different by the actions of the physician, the overall goal of hastening death is similar, which could result in a concern of a slippery slope if legalized.

Slippery Slope

In this debate regarding physician-assisted suicide and the morality behind it, many opponents of legalization use the slippery slope argument as justification. This bioethical approach argues that compliance with one small action will lead to the compliance of a bigger, more extreme action (Potter, 2019). The slippery slope argument is broken down into two main categories, logical and psychological, with greater emphasis on the latter. What distinguishes these from each other is the fact that the logical slippery slope argument relies on the idea that the acceptance of physician-assisted suicide will logically lead to the acceptance of the less desirable practice of euthanasia because of the similarities between the two. This differs from the psychological slippery slope argument which stems from the idea that acceptance of one action will ultimately influence society’s view over time, resulting in the less desirable action as just as morally acceptable as the first (Potter, 2019). What makes this slope slippery is the idea that there is no possible way to stop the initial action once the consequence follows. Recent studies

provided by the New England Journal of Medicine shed light on significant increases in the rates of euthanasia in Belgium and the Netherlands that opponents of physician-assisted suicide utilize in the slippery slope argument. In August of 2017, the frequency of physician assistance in dying as well as other end-of-life practices in the Netherlands from 1990-2015 were reported, and while the rate of physician-assisted suicide was consistent at 0.2% across the 25 year span, shockingly there was found to be a 265% increase of euthanasia rates in the Netherlands, growing from 1.7% of all deaths in 1990 to 4.5% of all deaths in 2015. In addition, there was an increase from 39% to 58% in end-of-life decisions (van der Heide, van Delden, & Onwuteaka-Philipsen, 2017). A similar study in March of 2015 focused on the prevalence of euthanasia as well as other end-of-life practices in Belgium from 1998-2013. Coinciding results were seen as physician-assisted death rose from 4.4% in 1998 to 6.3% in 2013 while the rates of euthanasia increased from 1.1% to 4.6% in those years, including an increase in requests and requests granted (Chambaere et al. 2015). Opponents of physician-assisted suicide view these statistics as evidence that legalization of physician-assisted suicide in these two countries, for example, led to the slippery slope of the further increase of the more extreme action of euthanasia. On surface level, the numbers show a great increase in euthanasia despite a minimal increase in physician-assisted suicide, thereby creating the illusion that legalization of physician-assisted suicide has led to the immense amount of euthanasia. However, what must also be understood from these statistics is that in these two countries, euthanasia is legalized along with physician-assisted suicide, without a significant amount of time in between to truly see how one action affected the other. Therefore, it cannot be concluded that the legalization of physician-assisted suicide led to the legalization of euthanasia. In order to grasp the slippery slope idea, one would have to compare a country that has only legalized the first action.

Another concern regarding a slippery slope is the prediction that it could lead to exploitation among individuals that are seen as useless in the eyes of others. It could be thought that physician-assisted suicide is an easy excuse to limit the burden on society. However, the Oregon Death with Dignity Act: 2017 Data Summary directly contradicts this statement, as vulnerable groups were not taken advantage of. The report showed that 143 deaths occurred from physician-assisted suicide in 2017, and of these deaths, majority were white (94%), highly educated with a bachelor's degree or more (48.2%), and insured with some form of health insurance (79.7%) (OHA Public Health Division, 2018). Washington state provides nearly identical statistics as well. The Washington State Death with Dignity Act Report of 2017 showed that out of the 196 deaths from physician-assisted suicide, 94% were white, 53% were highly educated, and 91.8% had some form of insurance (WA DOH, 2018). This even is the case in a more diverse state like California. The California End of Life Option Act Data Report of 2017 shows that the physician-assisted deaths were 88.9% white, 54.8% well-educated, and 95.2% insured (CDPH, 2018). Although these demographics were not recoded in European countries, it can be determined that at least in the United States, there is no evidence suggesting that legalization of physician-assisted suicide will lead to the marginalization of any vulnerable populations. Overall, the slippery slope argument in and of itself is not enough to justify the continued prohibition of physician-assisted suicide.

Palliative Care

Another aspect that is necessary to consider is palliative care, which the World Health Organization defines as a special type of medical care for patients with a life-threatening illness where the focus is on relieving pain and stress from the disease in hopes to improve the quality of life for the patient as well as their family (WHO, Palliative Care). There are significant

disparities in region as well as income group that exist in palliative care delivery and access. 80% of the need for palliative care exists within low-income and middle-income countries while only 30% of the total palliative care services are operating in these countries. (Connor et al., 2021). The Journal of Pain and Symptom Management reported a study from 2017 that is part of a longitudinal attempt to measure an estimated number of patients that receive palliative care. These numbers are hard to accurately measure because of the lack of a national system for collecting the data, however, through the best means possible, the results showed that the European region along with the Americas significantly make up majority of the estimated services delivering palliative care globally compared to other regions of the world, resulting in 39% and 34% respectively (Connor et al., 2021). The same trend can be seen in estimated patients receiving the palliative care globally, where 43% of the patients are in Europe while 31% of patients are in the Americas (Connor et al., 2021). A positive correlation is evident between the number of services and the patients that receive the care. As a country increases their number of services of palliative care, they are then able to help more people benefit from these services, creating an overall healthier environment. The lack of worldwide palliative care is indicative of why it is not a complete alternative to relieve suffering, especially when not everyone has the same opportunity to receive this care. Palliative care needs to be an essential aspect of the healthcare system, and anything less of that is room for improvement. Development of palliative care has been a critical component in healthcare systems over recent years but many are concerned that legalization of physician-assisted suicide will start to delay the process, mainly because of the thought that minimal effort would be put in to a greater healthcare system if there is an easy fix to the solution. This mindset could not be farther from the truth.

In 2015, a study was published that explored the relationship between countries that have legalized physician-assisted suicide and how that has impacted the development of palliative care through structural resources and government expenditure specifically. The results show that the regulation of physician-assisted suicide did not impede on the development of palliative care, and even seemed to promote the expansion of it. Luxembourg and the Netherlands showed the highest increase in all palliative care resources, initially being in the bottom of seven countries in 2005 and eventually reaching the same level, if not more, in 2012. Luxembourg had a 10.33 increase in services per million inhabitants while the palliative care services in the Netherlands increased by 6.87 per million inhabitants (Chambaere & Bernheim, 2015). Palliative care is a modern-day approach in healthcare systems and should continue to be explored. Since physician-assisted has shown no negative consequences on the development of palliative care, it should be offered to patients as an another option in their end-of-life care.

Physician Perspective

Since physician-assisted suicide involves the combination of the patient and physician, it is worth considering the physician's view as well. The New England Journal of Medicine published an article in 1994 surveying physicians working in Washington state. A questionnaire was randomly sent to physicians of varying fields including family practice, oncology, and psychiatry. The goal of this survey was to determine the physician's attitude regarding physician-assisted suicide and euthanasia in three ways: whether the practices are ethical, whether the practices should be legalized, and whether the physicians would be willing to participate (Cohen, et al., 1994). The results of the study showed slightly more support for physician-assisted suicide compared to euthanasia. In regards to ethicality, 48% thought euthanasia is never ethically justified while 42% thought it would be ethical (Cohen, et al., 1994). Comparing that to

physician-assisted suicide, only 39% thought it is never ethically justified while 50% thought it would be ethical (Cohen, et al., 1994). However, there is more of a divide among physicians' beliefs toward ethicality rather than legality, as further analysis shows that there is not a huge difference in attitudes regarding legalization, having 54% of respondents believing euthanasia should be legal in certain situations and 53% of respondents believing physician-assisted suicide should be legal in certain situations (Cohen, et al., 1994). The last aspect of the survey included physician participation, and the results showed more hesitancy with euthanasia compared to physician-assisted suicide, reporting only 33% of physicians willing to perform euthanasia themselves but 40% of physicians willing to assist a patient in dying (Cohen, et al., 1994).

The New England Journal of Medicine published a similar survey that was conducted in 1996, but this was nationwide, reaching a greater, more generalized population. This questionnaire was mailed out randomly to physicians practicing in the United States, from 10 different specialties that are most likely to be in situations involving a decision to hasten death. In the national questionnaire, out of a total of 3,102 physicians, 1,902 participated and the results were significant. Because of legal liabilities and restrictions on physician-assisted suicide at the time, results showed that 11% of physicians in the study would be willing to prescribe medication to a patient requesting physician-assisted suicide, and only 7% would be willing to provide lethal injection (Meier, 1998). However, if physician-assisted suicide were legal, the numbers increased to 36% and 24% respectively (Meier, 1998). These numbers reflect the overall idea that the legality of these practices greatly influence a physician's decision, but does not necessarily stop them from using their own conscience to make their own decision and respect their own autonomy. The results of the study also indicate that 18.3% of physicians still received a request for physician-assisted suicide, regardless of its illegal standing, and of those

physicians, 16% of them had granted the patient's request and prescribed a lethal medication (Meier, 1998). Lower numbers occurred with euthanasia, where only 11% of physicians received a request for a lethal injection and 4.7% had granted that request (Meier, 1998). The findings from both of these studies indicate a great disparity between how physicians view these practices. There is a difference between what is legal and what is ethical. Just because a state decides that physician-assisted suicide is legal and allows residents to have that decision, it does not mean that physicians ought to follow through or even want to. Likewise, just because a state decides that the practice is illegal does not mean a physician will not receive requests and/or grant them in specific circumstances. A key aspect of physician-assisted suicide is understanding the perspective of the physician, not only the patient, because ultimately they have to work together.

Conclusion

Physician-assisted suicide can be justified through the analysis of a slippery slope, palliative care, and the respect of a physician's decision. There is neither evidence supporting the notion that societies that have legalized physician-assisted suicide have been manipulated over time to also legalize euthanasia, or the notion that legalizing physician-assisted suicide will target marginalized groups in society. There is no evidence suggesting that legalizing physician-assisted suicide will stunt the development of palliative care throughout the world, rather that it could possibly promote it. There is a huge gap in access of palliative care worldwide that needs to be addressed, and until then, cannot fully replace the pain relief of physician-assisted suicide. Lastly, autonomy is a huge priority in the medical field, both for the patient and physician and respecting one's decision is critical. A patient has the right to make their own decision just as a physician has the right to make their own decision. Legalization of the practice does not mean it

is necessarily ethical, but rather it provides a safe medical procedure for patients and physicians who believe it falls within their moral compass. There are safeguards set in place to fully control physician-assisted suicide from spiraling out of control. The most strongly supported safeguard that physicians believed would prevent any undesirable action to stem from legalization of these practices was a requirement of a witness (Cohen, et al., 1994). The patient's request needed to be verified by an outside source, specifically one that has nothing to gain from the death of the patient. Other safeguards mentioned were ensuring the patient was terminally ill, had tried multiple other treatment options, was making the decision with full knowledge and also ensuring a great relationship among the physician and patient (Cohen, et al., 1994). In order to gain adequate support from physicians, these measures must be put in place and adhered to.

Physician-assisted suicide is not murder because of the multiple confirmations and consents needed to follow through. Its purpose is to provide comfort and ultimately results in giving the patient a means to control their own life, just as if they are able to forgo life-saving medical treatment. Death with dignity does not take away from the intrinsic value of a human being or the life they lived, and thereby should be legalized so everyone has the chance to take control of their life one last time.

References

- American Medical Association (2021). *Physician-Assisted Suicide*. <https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide>
- California Department of Public Health. (2018). *California end of life option act: 2017 data report*. CDPH.
- Chambaere, K., & Bernheim, J. L. (2015). Does legal physician-assisted dying impede development of palliative care? The Belgian and Benelux experience. *Journal of Medical Ethics, 41*(8), 657–660. <http://www.jstor.org/stable/44014176>
- Chambaere, K., Stichele, V. R., Mortier, F., Cohen, J., & Deliens, L. (2015). Supplement to: Recent trends in euthanasia and other end-of-life practices in Belgium. *The New England Journal of Medicine, 372*(12), 179-1181. doi:10.1056/NEJMc1414527
- Cohen, J. S., Fihn, S. D., Boyko, E. J., Jonsen, A. R., Wood, R. W. (1994). Attitudes toward assisted suicide and euthanasia among physicians in Washington state. *New Eng J Med, 331*(2), 89-94. 10.1056/nejm199407143310206
- Connor, S. R., Centeno, C., Garralda, E., Clelland, D., & Clark, D. (2021). Estimating the number of patients receiving specialized palliative care globally in 2017. *Journal of Pain and Symptom Management, 61*(4), 812–816. <https://doi.org/10.1016/j.jpainsymman.2020.09.036>
- Ganzini, L. (2016). Legalised physician-assisted death in Oregon. *QUT Law Review, 16*(1). 76-83. DOI: 10.5204/qutlr.v16i1.623
- Ganzini, L., Back, A. L. (2016). The challenge of new legislation on physician-assisted death. *JAMA Intern Medicine, 176*(4). 427–428. doi:10.1001/jamainternmed.2016.0047

- Goligher, E. C., Ely, E. W., Sulmasy, D. P., Bakker, J., Raphael, J., Volandes, A. E., Patel, B. M., Payne, K., Hosie, A., Churchill, L., White, D. B., & Downar, J. (2017). Physician-Assisted Suicide and Euthanasia in the ICU: A Dialogue on Core Ethical Issues. *Critical care medicine*, 45(2), 149–155. <https://doi.org/10.1097/CCM.0000000000001818>
- Meier, D. E., Emmons, C. A., Wallenstein, S., Quill, T., Morrison, R. S., & Cassel, C. K. (1998). A national survey of physician-assisted suicide and euthanasia in the United States. *The New England journal of medicine*, 338(17), 1193–1201.
- Oregon Health Authority Public Health Division. (2018). *Oregon death with dignity act: 2017 data summary*. OHA.
- Palliative Care*. (2020, August 5). World Health Organization. <https://www.who.int/news-room/fact-sheets/detail/palliative-care>
- Potter, J. (2019). The psychological slippery slope from physician-assisted death to active euthanasia: A paragon of fallacious reasoning. *Medicine, Health Care, and Philosophy*, 22(2), 239–244. <https://doi-org.sacredheart.idm.oclc.org/10.1007/s11019-018-9864-8>
- Quill, T. E., Back, A. L., & Block, S. D. (2016). Responding to patients requesting physician-assisted death: Physician involvement at the very end of life. *JAMA*, 315(3), 245–246. doi:10.1001/jama.2015.16210
- van der Heide, A., van Delden, J. J. M., & Onwuteaka-Philipsen, B. D. (2017). End-of-life decisions in the Netherlands over 25 years. *The New England Journal of Medicine*, 377(5), 492–494. <https://doi-org.sacredheart.idm.oclc.org/10.1056/NEJMc1705630>
- Washington State Department of Health. (2018). *Washington state death with dignity act report*. WA DOH.