YALE JOURNAL OF BIOLOGY AND MEDICINE 92 (2019), pp.747-750.

PERSPECTIVES

YALE JOURNAL OF BIOLOGY AND MEDICINE
YJBM
CELEBRATING 90 YEARS 1928–2018

# Pros and Cons of Physician Aid in Dying

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The question of a physician's involvement in aid in dying (or "assisted suicide") is being debated across the country. This article adopts no one position because its authors hold contrasting views. It aims instead to articulate the strongest arguments in favor of aid in dying and the strongest arguments opposed. It also addresses relevant terminology and reviews the history of its legalization in the United States.

Physician aid in dying is a controversial subject raising issues central to the role of physicians. According to the American Medical Association, it occurs when a physician provides "the necessary means and/or information" to facilitate a patient's choice to end his or her life [1].

This essay's authors hold varying views on the ethics of aid in dying; thus, the essay explores the subject without taking a position. It addresses its terminology; history of legalization in the United States; arguments in favor of aid in dying; and arguments opposed.

## TERMINOLOGY

Physician aid in dying goes by many names. Perhaps the best recognized is "physician-assisted suicide." Alternative terms include but are not limited to: death with dignity, doctor-prescribed death, right to die, and physician-assisted death. For simplicity's sake, we use aid in dying (AID†), although we recognize that there will be some who object, no matter the label.

A variety of factors have led to these various neologisms. Supplanting the word "physician" with "medical," for example, makes it possible for non-physician clinicians to prescribe the lethal medications. Some advocates of AID prefer not to use the term "suicide;" they contend that AID is a medical practice, distinct from the act of suicide for a depressed or hopeless person [2]. By contrast, opponents maintain that the process of prematurely and deliberately ending one's life is always suicide, regardless of motivation. Some insist that dissociating "physician-assisted suicide" from other types of suicide demeans those who die by suicide for other reasons, as if only medically-assisted suicides are legitimate [3]. People on both sides of the issue worry whether "aid in dying" or "assisted dying" might be confused with palliative, hospice, or other care of dying patients.

In the United States, physician-assisted suicide or aid in dying has always been carefully distinguished from euthanasia. Euthanasia, also called mercy killing, refers to the administration of a lethal medication to an incurably suffering patient. It may be voluntary (the patient requests it) or involuntary. Euthanasia is illegal in the United States, but voluntary euthanasia is legal in Belgium, Colombia, Luxembourg, and Canada. It is decriminalized in the Netherlands.

At risk of compounding terminology further, Cana-

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†Abbreviations: AID, aid in dying; MAiD, medical assistance in dying.

Keywords: Aid in dying, Physician-assisted suicide, End of life, Death, Dying, Ethics, Bioethics, Autonomy, Suicide

da legalized in June 2016 "medical assistance in dying" (MAiD), which includes both "voluntary euthanasia" and "medically-assisted suicide [4]."

## A BRIEF HISTORY OF LEGALIZATION IN THE UNITED STATES

In the early 1900s, advocates argued forcefully for legalizing euthanasia, which was already being secretly practiced in the US. According to Jacob Appel's work on this period, the eugenics movement strongly influenced discourse on euthanasia, and opponents of legalization tended to put forth practical rather than religious or moral arguments [5]. When efforts to legalize euthanasia failed, public discourse on the subject waned for many decades.

In the 1980s, the pathologist Jacob "Jack" Kevorkian began advertising in Detroit area newspapers as a death counselor [6]. He had studied the technique of Dutch physicians in the Netherlands, and created his own device with which patients could self-administer lethal medications. His first patient ended her life in 1990 while lying on a bed inside Kevorkian's Volkswagen van. He went on to assist with some 130 deaths by suicide over the next eight years. In 1999, after Kevorkian publicly distributed a video of himself directly euthanizing a patient, he was convicted of second-degree murder and sent to prison. Although Kevorkian reignited national debate about dying, his off-putting approach and personal idiosyncrasies prevented his becoming a national leader on the issue.

Several of Kevorkian's physician contemporaries filed suit against New York's Attorney General, arguing that the State of New York's prohibition against physician-assisted suicide violated the Equal Protection Clause of the Fourteenth Amendment. They argued, in effect, that the right to refuse treatment was effectively the same as the right to end one's life. The Supreme Court ruled in response in *Vacco v. Quill* (1997) that there is no constitutionally-protected right to die. It left such decisions to the states. The Court also ruled in *Washington v. Glucksberg* (1997) that a right to aid in dying was not protected by the Due Process Clause.

Oregon became the first to pass its death with dignity law that same year. More than a decade later, Washington legalized AID in 2008. Montana decriminalized the practice a year later. Vermont legalized it in 2013.

In 2014, a young Californian named Brittany Maynard was diagnosed with an astrocytoma and became a spokesperson for the legalization of AID. She was a newlywed facing terminal illness, and her story quickly captured the public imagination. Her well-publicized death by lethal ingestion in Oregon in 2014 influenced her home state of California to legalize AID in 2015. This was subsequently followed by Colorado in 2016, the District of Columbia in 2017, Hawai'i in 2018, and New Jersey and Maine in 2019.

## PRO ARGUMENTS

The two most common arguments in favor of legalizing AID are respect for patient autonomy and relief of suffering. A third, related, argument is that AID is a safe medical practice, requiring a health care professional.

### *Respect for Patient Autonomy*

Bioethics as a discipline gained significant traction in the 1970s, at a time when the concept of patient rights was pushing back against physician paternalism. The philosophers Tom Beauchamp and James Childress, in their well-known textbook *Principles of Biomedical Ethics,* advanced four fundamental principles as a framework for addressing ethically-complex cases: autonomy, beneficence, non-maleficence, and justice. Of these principles, autonomy undeniably exerts the most influence on current US medical practice [7].

Autonomy refers to governance over one's own actions. In the health care setting, this means a patient determines which medical interventions to elect or forgo. Patient autonomy serves as the justification for informed consent; only after a thorough explanation of risks and benefits can the patient have the agency to make a decision about treatments or participation in medical research. This logic, it is argued, naturally extends to AID; patients accustomed to making their own health care decisions throughout life should also be permitted to control the circumstances of their deaths.

### *Relief of Suffering*

At its core, medicine has always aimed to relieve the suffering of patients from illness and disease. In the West, Hippocrates's ancient oath pledged to use treatments to help the sick, but not "administer a poison to anybody when asked to do so [8]." In contrast, advocates of AID argue that relief of suffering through lethal ingestion is humane and compassionate – if the patient is dying and suffering is refractory. Indeed, some of the most compelling arguments made in favor of AID come from patients, such as Maynard, who suffer from life-threatening illnesses.

### *A Safe Medical Practice*

Aid in dying is lauded by advocates for being a safe medical practice – that is, doctors can ensure death in a way that suicide by other means cannot. Aid in dying thus becomes one option among many possibilities for care of the dying. Although individual state laws vary, most propose a number of safeguards to prevent abuses and to provide structure for an act that some people will do

anyway, albeit more haphazardly or even dangerously. Safeguards include requiring that a patient electing AID be informed of all end-of-life options; that two witnesses confirm that the patient is requesting AID autonomously; and that patients are free of coercion and able to ingest the lethal medication themselves [9].

## CON ARGUMENTS

Although opponents of AID offer many arguments ranging from pragmatic to philosophical, we focus here on concerns that the expansion of AID might cause additional, unintended harm through suicide contagion, slippery slope, and the deaths of patients suffering from depression.

### *Suicide Contagion*

The sociologist David Phillips first described suicide contagion in the 1970s. He showed that after high profile suicides, society would witness a broad spike in suicides [10]. This was particularly true for individuals whose demographic profiles were similar to those of the person who died by suicide [11]. Although Phillips's work did not focus on AID, it has been corroborated recently by the spike in youth suicidality following the airing of Netflix's *13 Reasons Why* [12].

The publicly-available data from Oregon, however, reveal that in the months surrounding Maynard's high-profile death in November 2014, the number of similarly situated individuals in Oregon who ended their lives by lethal ingestion more than doubled. Furthermore, from 1998 (when Oregon started recording data) to 2013, the number of lethal prescriptions written each year increased at an average of 12.1%. During 2014 and 2015, however, this increase doubled, suggesting that high-profile AID leads to more AID [13]. Although the data do not prove that an increase in AID causes more non-assisted suicide, a study by Jones and Paton found that the legalization of AID has been associated with "an increased rate of total suicides relative to other states and no decrease in non-assisted suicides [14]." They suggest that this means either AID does not inhibit non-assisted suicide or that AID makes non-assisted suicide more palatable for others.

### *Slippery Slope*

Some opponents of AID express concern that once doctors are involved in the business of hastening patients' deaths; they have already slid down the slippery slope [15]. Others suggest that the slope is best exemplified by an expanding list of reasons for electing AID. Refractory physical pain is no longer the most compelling reason for ending one's life through lethal ingestion. Instead, cumulative Oregon data suggest that the vast majority of patients elect AID because they are concerned about "losing autonomy" (90.6%) or are "less able to engage in activities making life enjoyable" (89.1%). Some fear a "loss of dignity" (74.4%); being a "burden on family, friends/caregivers" (44.8%); or "losing control of bodily functions" (44.3%). Concern about inadequate pain control was the reason for pursuing a lethal ingestion in only 25.7% of cases [16].

Opponents also point to increasing calls in the US for euthanasia. In 2017, Senate Bill 893 was introduced to the Oregon State Legislature; it would have enabled patients to identify in a legal directive the person they wished to administer their lethal medications, effectively legalizing euthanasia [17]. Although this bill failed, the Oregon House passed HB2217 in 2019, which expanded the definition of "self-administer" to include options in addition to the oral ingestion of lethal drugs. The House also put forward HB2903, which seeks to expand the word "ingest" for lethal medication to "any means" and also proposes to expand the definition of "terminal disease" to include "a degenerative condition that at some point in the future" might cause death. It remains to be seen whether Oregon will become the first state to legalize euthanasia.

Although Belgium and The Netherlands permit both AID and euthanasia, the latter dominates. Over the years there has been a steady increase in acceptable criteria. Currently, patients who suffer from depression, dementia, or being "tired of life" may be euthanized. In some cases, minors may also be euthanized [18]. Published data from the Flanders region of Belgium highlights that vulnerable populations are especially likely to be euthanized. From 2007 to 2013, the largest increases in rates of granting euthanasia requests were among women, those 80 years or older, those with lower educational achievement, and those who died in nursing homes [19].

### *Depression in Advanced Illness*

Up to half of patients with cancer suffer from symptoms of depression [20]. The elderly also suffer from high rates of depression and suicide [21]. Because depression often manifests somatically [22], if patients are not screened, clinicians miss half of all cases of clinical depression [23-25]. Opponents of AID are concerned that in Oregon, greater than 70 percent of patients who elect AID are elderly and have cancer, but fewer than five percent are referred to a psychiatrist or psychologist to rule out clinical depression.

## CONCLUSION

Physician AID remains a controversial subject relevant to the care of patients. The Hippocratic model

dominated medical practice for thousands of years. With the rise of euthanasia in Europe during the second half of the twentieth century, many began to rethink this stance, but hastening the death of patients still sits uncomfortably with many physicians. Although a number of medical societies have begun to reconsider their positions, the American Medical Association's House of Delegates voted in June 2019 to maintain the organization's long-held opposition to physician-assisted suicide and euthanasia [26]. Strong arguments remain both in favor and in opposition to the practice, and physicians have an ethical responsibility to remain informed on this timely issue.

**Additional Information**: Co-author Daniel Callahan, PhD, died after the first submission of this article.

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